The importance of faith-based mental healthcare in African urbanized sites

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Purpose of review

This review highlights what current research says about how local beliefs and norms can facilitate expansion of mental healthcare to meet the large unmet need for services in Africa.

Recent findings

In contemporary Africa, religious beliefs exert important influences on mental health as well as the way people with mental illnesses are viewed and cared for. Mental healthcare practices based on traditional and other religious beliefs, and offered by complementary and alternative health providers (CAPs), reflect the people's culture and are often preferentially sought by a majority of the population. Despite important differences in the worldviews of CAPs and biomedical mental healthcare practitioners in regard to causal explanations, there are nevertheless overlaps in the approaches of both sectors to the management of mental health conditions. These overlaps may provide a platform for collaboration and facilitate the scaling-up of evidence-based mental health services to underserved African populations, especially those residing in ever-expanding urban centres.

Summary

Faith-based mental healthcare is an important but informal component of the mental health system in much of Africa. Collaboration between its practitioners and biomedical practice may help to bridge the large treatment gap for mental health conditions on the continent.

Keywords

African collective unconscious, African ethnicity, African religion, mental health gap

INTRODUCTION

Ethnicity and religion are interconnected social and spiritual agencies that shape the ways in which a person or group is represented within a much wider global context. In the African context, ethnicity, religion and the self are multiple dimensions of the collective identities of the same person [1]. In this way, the African is seen as a three-dimensional person (Fig. 1). For example, the African concept of Ubuntu [2] envisages that a person is a social being that exists in the true sense as he is part of a community (i.e. family, clan, ethnic group, etc.). In addition, the sustenance of the African person within that community is enabled by a supreme, or multiple supreme spiritual entities, including a God, multiple equal gods, other divinities, spirits and ancestors [3]. For many Africans, connectedness to the relevant spiritual entities occurs through the vehicle of religion. Spirituality and religion are thus often used interchangeably in the African context. As such, the well known epistemological distinctions between the two constructs [4] is almost nonexistent in Africa and will not be assumed in the present article.

Spirituality, religion and places of worship play important roles in the life of Africans. In a recent nationwide panel study in South Africa [5▪], approximately 90% of the population perceived religion to be important in their day-to-day lives, and 92% identified themselves as religiously affiliated. A global survey of adults from 114 countries [6] conducted nearly a decade before the South African study found even higher prevalence estimates of religious importance, for example, 100% in some African countries. The observed high prevalence of

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KEY POINTS

- Religious beliefs are important to the way most Africans think about health, disease and healing.
- Although Christianity and Islam have a strong foothold in the African religious worldview, beliefs based on traditional African religions remain important in several aspects of life.
- Traditional and faith healers are frequently the first point of help-seeking for mental health conditions in view of the synergy of their worldviews with those of the community.
- Although healers' practice differs in important ways from those of biomedical practitioners, there are important overlaps in their approaches to care.
- Collaboration between biomedical practitioners and traditional/faith healers hold the promise of helping to bridge existing treatment gap for persons with mental health conditions in Africa.

religiosity on the continent stems from the importance an African places on maintaining a sustained link to his spirit entity, the source of his physical and psychological existence and wellbeing [1].

As it is well known, the experience and understanding of psychopathology are influenced by social and cultural contexts in which people live [7]. Thus, along with social and economic misfortune, signs and symptoms of illness are among the common evidence of disconnectedness of the African from his or her spirit entity and/or community [1]. Also, the route to recovery for the African patient may involve seeking to reconnect with the relevant social and spiritual entities. This is often achieved by his participation in prescribed religious activities and rituals, while at the same time enlisting the involvement of family and/or community in the process [5▪,8,9]. Religious leaders, such as shrine priests, pastors or other clergy, mallams as well as witchcraft practitioners, thus play key roles in the recovery process [10▪] and are often available to observe and respond to changes in social, psychological and spiritual circumstances of their devotees [11▪]. Social and cultural views affect help-seeking and determine to what extent a given intervention proffered for a mental health condition by the practitioner is seen as credible and likely to be efficacious [12]. As such, psychosocial interventions based on the reconnection of the African patient to his original three-dimensional person may be more readily acceptable and perceived to be effective in the African traditional context [3].

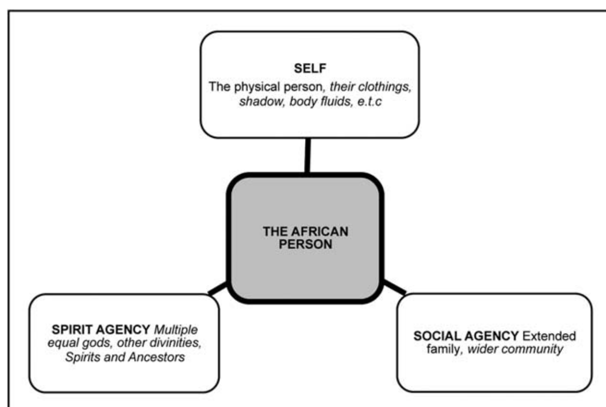

FIGURE 1. Model of the African collective unconscious.

CONTEXT

Africa has a multiplicity of ethnic groups, cultures, languages, norms and religious affiliations [1,13], and similar to other cultures globally, African cultures are constantly changing [14]. In particular, African societies are currently undergoing rapid social transitions characterized by epidemiological shifts, urbanization and a reorganization of family structures [15]. In the current era, globalization, information technology and social media are enabling a constant intersection within, and between, African, Eastern and Westernized cultures, including through rapid migration of youth to urbanized sites within and outside Africa [16].

These transitions are creating influences that cut across previously well defined traditional, religious and cultural boundaries; assimilation of new cultures, affiliation to novel religious identities [17], and other mental health consequences of migration that, for example, produces many disaffiliated youths in urban African slums [18]. The result of these changes is the emergence of more complex social configurations, as well as a reconsideration of the roles of extended family systems and community. The many transitions provide new challenges for current and future understanding of the social and spiritual context of mental health in Africans, as well as the narrowing of the widening mental health service gap produced by the rapidly increasing urbanized populations in Africa. Notably, complementary and alternative practitioners (CAPs) are the de facto mental healthcare providers in Africa [10▪,19–21].

In the present article, CAPs are healthcare providers who draw on African traditional or other faiths as the basis of their practices [22]. These practitioners are close to the populations they serve, and are readily accessible. In a survey of patients with schizophrenia in Xhosa-speaking South Africa, 84% had consulted CAPs for their symptoms.

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Conservative estimates from other African countries suggest that approximately 60% of patients using CAPs as the first point of contact for a variety of health conditions, do so because of mental illness [21].

An important reason for the popularity of CAPs in Africa is that users find the underlying tenets of CAP practices to be congruent with their own beliefs, values and norms [10▪]. CAPs rely on the concept of a three-dimensional African person discussed in earlier sections of the present article [1,3,14]. They are, thus, able to probe into the social, psychological and spiritual bases of mental illnesses [10▪]. Along with their ability to provide care for health problems, CAPs are consulted for clairvoyancy [10▪], as well as for solutions to a wide range of social and economic challenges including prowess in career, dating, fertility and finances [23].

RECENT AFRICAN STUDIES

Key information about the studies identified for the present review is presented in Table 1. The main themes of the studies are summarized in Table 2. In all, causal explanation of mental illness by CAPs included mostly spiritual factors. This is regardless of whether they were catholic priests [11▪], shrine priests [24,25] or neo-pentecostal pastors [26]. Many CAPs expressed beliefs that mental illnesses result from curses, witchcraft, demon possession and punishment for sin committed at various times either by the patient, their family or community. Many CAPs also expressed biopsychosocial causation. However, CAPs expressing biopsychosocial models believed that such mental health condition may have initially started as, or be made worse by, 'spiritual attacks' [25].

Kenyan patients from minority Ewe ethnic group [adjusted odd ratio (aOR) = 0.1, 95% confidence interval (CI) = 0.03–0.31] were significantly less likely to choose biomedical treatment, compared with CAPs, as their preferred initial point of mental healthcare [27▪]. In multiracial South Africa, compared with blacks, mixed race patients (aOR = 0.29, 95% CI = 0.11–0.70) were significantly less likely to use CAPs alongside biomedical treatment they received [20]. However, religious affiliation was not a significant predictor of use of CAPs along with biomedical mental health services [20].

Tomita and Ramlall [5▪] in 2018 demonstrated that across 4 years of observation of a nationwide sample of adult South Africans, religious affiliation was protective against onset of depression (aOR = 0.85, 95% CI = 0.76–0.96). In South Sudan, Strohmeier *et al.* in 2018 found that spirituality, as assessed using items in the spiritual transcendence scale [28], was significantly associated with a lower risk of hazardous alcohol consumption among humanitarian workers (coefficient = 0.32, standard error = 0.09) [29].

Esan *et al.* [10▪] in 2019 found that CAPs in Ghana, Nigeria and Kenya receive training through many years of apprenticeship. The categories of CAPs in that study [10▪] were not mutually exclusive and included combinations, such as herbalist-christian or herbalist-muslim. The authors also reported that a majority of CAPs (70%) provided both physical and mental health services [10▪]. In the restive Niger Delta region of Nigeria, a qualitative exploration [30▪▪] of the efficacy of CAPs for treatment and rehabilitation of mental health conditions found that reconciliation rituals were perceived as having efficacy in the rehabilitation of torture victims. Through several prescribed rituals, both the perpetrators and the victims were able to be re-integrated into regular community life [30▪▪].

In a qualitative study conducted in Uganda [31▪], barriers to collaboration between CAPs and biomedical mental health services included beliefs that biomedical doctors are not competent in treating mental health conditions. There was also mutual distrust between practitioners in the two sectors based on perceived superiority of respective groups of CAPs and Biomedical mental health services providers. In particular, there was suspicion of possible copyright violations by biomedical doctors if they *'steal'* the knowledge of CAPs during collaboration. Pathways to collaboration included governmental support through legislations that would, for example, outline boundaries of expertise for the respective groups and provide support for CAPs through remunerations. CAPs in the same study [31▪] were found to integrate aspects of biomedical treatments, such as use of chlorpromazine, into their practice. They also referred patients to biomedical practitioners in cases with physical health complications, such as dehydration [31▪].

DISCUSSION OF FINDINGS

The present review suggests that the prevailing religious beliefs of the population exert influences on mental health as well as the way people with mental illnesses are viewed and cared for. Complementary and alternative mental healthcare practices, which are largely based on local beliefs and norms have wide-ranging applications for the management of mental health conditions. In Africa, CAPs and biomedical mental healthcare practitioners share many overlaps, especially in terms of their causal explanatory models and management of mental health conditions. These overlaps could provide a platform

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Table 1. Key information about recent African studies reflecting importance of traditional and faith-based mental healthcare services

Reference	Country	Method	Participants	Objectives	Analyses	Findings
Tomita *et al.* [5■]	South Africa	Longitudinal observation of a nationally representative community sample	15,571 adults	Relationship between depression and self-reported religious involvement	Logistic regression models	Religious affiliations and importance were significantly associated with a lower risk of depression
Strohmeier *et al.* [29]	South Sudan	Cross-sectional survey	277 humanitarian workers	Predictors of mental illnesses in humanitarian workers	Ordinary least squares regression	Higher levels of spirituality were significantly associated with lower risk of hazardous alcohol consumption
Kpobi *etal.* [25]	Ghana	Qualitative: in-depth interviews	36 traditional and faith healers	Beliefs, perceptions of CAPS about epilepsy and its treatment	Thematic analyses	Belief in the influence of the moon in epilepsy along with biological, social and supernatural causes Treatment depended on perceived cause and orientation of the practitioner
Kpobi *et al.* [24]	Ghana	Qualitative: in-depth interviews	36 traditional and faith healers	Beliefs, perceptions of CAPS about intellectual disability and its treatment	Thematic analyses	Causal explanations included maternal negligence during pregnancy and spiritual factors Belief that intellectual disability was a congenital, lifelong condition, which could not be cured
Kpobi *et al.* [26]	Ghana	Qualitative: in-depth interviews	10 Pentecostal healers	Beliefs of faith Pentecostal healers about mental disorders and their treatments.	Thematic analyses	Belief in supernatural causation Diagnoses and treatment based on prayer, oils and holy water, and counselling
Iheanacho *et al.* [11■]	Nigeria	Cross-sectional descriptive	45 Catholic Clergy	Attitudes and beliefs about mental disorders and perception of their treatability	Multivariate analysis of variance	A majority believed that drug/alcohol use, stress and genetic inheritance could cause mental illness Clergy with contact with people with mental disorders were more likely to perceive depression as treatable
Nartey *et al.* [27■]	Ghana	Cross-sectional descriptive	542 attendees at biomedical mental health facilities	Factors influencing treatment pathways to mental health services in Ghana.	Multiple logistic regression	Patients from minority ethnic group are less likely to subscribe to biomedical mental healthcare Patients who perceived mental illnesses as noninfectious and are treatable were more likely to access biomedical mental health services
Zingela *et al.* [20]	South Africa	Cross-sectional descriptive	258 patients attending biomedical mental health services	Pattern of use of traditional and alternative healers among psychiatric patients	Logistic regression	Thirty-one percent of respondents had consulted a healer in the past year Predictors of consultation were being of Black African ancestry
Esan *et al.* [10■]	Nigeria, Ghana and Kenya	Cross-sectional descriptive	693 CAPs, (Mostly Herbalists)	Profile, practices and distribution of CAPs	Descriptive statistsics	CAPs have between 2-fold and 10-fold the admission capacity of conventional mental health facilities
Babatunde [30■■]	Nigeria	Qualitative: in-depth interviews and FGDs	60 (Victims of torture, youth militias, priests, secret cults, community leaders, law enforcement)	The efficacy of traditional practices in the rehabilitation of victims of torture	Thematic analyses	Reconciliation rituals were effective for 'Mental healing' and re-integration of victims and perpetrators into the community life
Akol *et al.* [30■■]	Uganda	Qualitative: in-depth interviews	20 traditional healers	Views of collaboration of faith healers with biomedical practitioners	Thematic analyses	Traditional healers' willingness to collaborate with biomedical providers is hampered by mistrust

FGDs, focus group discussions; CAPs, complementary/alternative practitioners.

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Table 2. Thematic focus of recent African studies reflecting importance of traditional and faith-based mental healthcare services

Thematic focus
Risk and causal models of mental disorders (six studies) [5▪,11▪,24–26,29]
Pathways to mental healthcare (two studies) [20,27▪]
Profiles and practices of CAPs (one study) [10▪]
Perceived efficacy of CAPs interventions (one study) [30▪▪]
Collaboration between CAPs and biomedical mental healthcare practitioners (one study) [31▪].

CAPs, complementary/alternative practitioners.

for collaboration between CAPs and biomedical mental healthcare. Such collaboration could be energized by enabling policy provisions.

The causal explanations provided by CAPs were mostly in keeping with the local and traditional religious beliefs. Their expressed opinions about cause of mental disorders link well with the conceptualization of spiritual entities as the basis of physical and psychological wellbeing [1]. Beliefs that mental illnesses may be contagious, and are the result of punishment for wrongdoing may result in negative attitudes and stigmatization of patients and families by members of their community [32]. Traditional remedies for wrongdoing may include ritual cleansing that restores social balance and reintegration into community life [33]. Similar to the study by Babatunde in 2018, several prior African studies have shown that CAP interventions are perceived to have efficacy for prevention, treatment and rehabilitation of mental health conditions [34,35]. CAPs have long expressed the belief, among many others held, that the ability to offer cleansing that may lead to reintegration of the mentally ill into community life and reduce stigma is an important area of superiority over biomedical-based mental healthcare [31▪].

We observed in this review that the categories of CAPs in Africa are not mutually exclusive, and reflect an overlap between the African traditional religion and other predominant non-African religion of the population [10▪]. African CAPs, thus, tend to base their practice on multiple overlapping religious beliefs and systems depending need. Similar to the finding reported by Esan *et al.* in 2019, a previous study in Ghana, where CAP practices are mostly based in neopentecostal churches and prayer camps, activities reflecting the prevailing African traditional beliefs were incorporated in treatment protocols, such as prayer and fasting objectives [36]. In the study by Esan and colleagues in 2019, herbs, divination, rituals and physical restraints were the common treatment deployed by African CAPs for mental disorders. The finding that CAPs relied on signs and symptoms for diagnoses and routinely used chlorpromazine reflects the crossover between biomedical and traditional treatments. Other CAP remedies for mental illnesses identified in older African studies include the use of haloperidol [37], alongside sorcery, forced fasting by the patient, fasting by proxy (e.g. by CAPs or patients family), prayers, giving offerings or alms, use of anointing oil, incantations or chanting, scarification and flogging [8,9].

Anderson and Newman [38] in 1960 suggested in their model of pathways to healthcare that ethnicity, culture and religion are key predisposing factors determining preference for use of particular healthcare delivery system. The two recent studies [20,27▪] investigating pathways to mental healthcare in Africa found that ethnoracial factors predicted the choice of whether to use CAPs or not. In particular, study participants from minority ethnic groups were more likely to prefer CAPs as their default mental health service provider [27▪]. As it is the case globally, it is feasible that Africans from minority ethnic groups face several socioeconomic challenges that systematically preclude access to the few available biomedical mental health services. As highlighted in the earlier sections of the present article, limited access to biomedical mental healthcare is a key reason for the popularity of CAPs in LMICs especially those in Africa [39].

Findings by Akol *et al.* in 2018 reflect enthusiasm of the majority of CAPs to collaborate with biomedical mental health practitioners. However, the interest of CAPs in collaborating was often tempered by logical concerns, for example, about copyrights and delineation of boundaries of respective expertise. In one previous study conducted in Ethiopia [40], many CAPs were reported to express willingness to receive biomedical mental health training. A key challenge to collaboration is inter-professional rivalry. Although many CAPs do not see the value of biomedical practitioners in treating mental illnesses [31▪,41], medical doctors do not appreciate the professionalism and skills of CAPs [42].

CONCLUSION

The importance of improving access to mental health services in Africa is emphasized in the post-2015 United Nations Sustainable Development Goals, which envisages that no one is left behind in the global effort to improve wellbeing of the population [43]. Other global policy briefs underline the engagement of providers who are culturally competent and who respects patients' beliefs [44]. CAP

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practices are based on the African conceptualization of a three-dimensional person [1]. Therefore, it is imperative to recognize their contributions to the provision of mental healthcare in Africa.

Apart from being the defacto mental health service providers, traditional healers in Africa treat mostly moderate-to-severe mental health conditions [34], which as it is well known, often require evidence-based pharmacological treatments [45] alongside any nonpharmacological approaches [46]. Furthermore, CAPs have extensive capacity for in-patient treatment, far beyond what could be achieved by the biomedical mental healthcare system in contemporary Africa [10▪]. It is, therefore, important to explore ways of bringing these healers into the mainstream of mental healthcare in Africa.

Potential facilitators of integrations may include the observed overlaps between some beliefs, as well as practices, of African CAPs and biomedical mental health practitioners. For example, along with beliefs in spiritual causes of mental illnesses, many CAPS identify biopsychosocial causation including hereditary, substance abuse, fevers, and head injuries [11▪,31▪]. In addition, patient's management by CAPs mirrors many aspects of biomedical mental health practices. For example, CAPs management also include history taking, physical examination, excellent communication skills, as well as social and pharmacological [37] interventions that underly their beliefs in spiritual and biomedical causation [10▪,11▪]. Furthermore, some CAP practices, such as prayers and ritual cleansing ceremonies can provide valuable psychological support for patients and their families [47].

The many overlaps between CAPs and biomedical mental health practitioners in Africa could be explored in enhancing collaboration between the two sectors drawing on the theoretical foundation of Kleinman, as well as those expressed by Cross [48,49]. The findings of the present review should, therefore, encourage policy makers to take the lead in providing enabling laws that establishes guidelines and stipulate boundaries beyond which appropriate referrals, in both directions, is indicated [10▪].

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Conflicts of interest

There are no conflicts of interest.

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▪▪ of outstanding interest

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