Perceptions of traditional healers and allopathic practitioners towards collaborative mental healthcare in low and middle-income countries: a systematic review [accepted version without the final pageproof changes]

Abstract

Access to mental healthcare in low and middle-income countries is one of the greatest challenges in public health today and one suggestion for improving accessibility is through collaboration with traditional healers. As this has not yet been systematically examined, this review aims to explore the perceptions of traditional healers and allopathic practitioners towards collaboration in order to increase our understanding of how it could be implemented. Five databases, five journals and reference lists were searched for papers that explored the views of traditional healers and allopathic practitioners towards collaboration. Eligible papers were assessed for quality and study characteristics and qualitative data demonstrating participants' views were extracted using a self-designed tool. Fourteen papers from seven countries were included. The published literature on this topic is relatively homogenous and studies are of mixed quality. The findings suggest that despite differing conceptualisations of mental illness causation, both traditional healers and allopathic practitioners recognise that patients can benefit from a combination of both practices and demonstrate a clear willingness to work together. There are concerns over patients' safety and human rights regarding traditional methods and some healers are sceptical about the effectiveness of Western psychiatric medication. Despite keeping the inclusion criteria open to all low- and middle-income countries (LMICs), 13 of the studies were conducted in Africa, seven of which were in South Africa. This limits this review's findings to the wider LMIC context. Nonetheless, this paper concludes with recommendations for both research and practice.

Keywords

traditional healer, collaboration, low- and middle-income countries, community care, mental health

INTRODUCTION

Access to mental healthcare in low and middle-income countries (LMICs) is one of the greatest challenges in public health today, with almost 90% of people with severe mental disorders receiving no treatment (WHO, 2015, p.8). Barriers to care are wide-ranging, including a lack of funding and of trained medical professionals, the centralisation of services in urban areas, and a lack of prioritisation of mental health in public health leadership (Saraceno, 2007). Despite psychiatric illness representing a monumental burden on the economy and compounding human suffering, financial and professional resources for therapeutic support are lacking, prompting the need to find innovative ways of reducing this treatment gap (Kohn, 2004). A landmark series of articles in The Lancet in 2007 called for mental health services to be 'scaled up' across the so-called 'developing world,' spawning a flurry of research and policy bodies that would attempt to improve access to care. However, these initiatives have been criticised for being rooted in Eurocentric assumptions about illness, with some arguing that they will be ineffective unless simultaneous steps are taken to address people's help-seeking behaviour (Cooper, 2016). This view has been echoed by leading academics in the field who have urged policymakers to 'think outside the box' in regards to mental health care (Patel, 2012). In an attempt to develop services within local frameworks, the World Health Organisation has suggested working more closely with 'informal' healthcare providers, including traditional healers, to widen access to care (WHO, 2015).

The relationship between allopathic and indigenous forms of care has historically been tense, characterised by a belief that the two systems would not be able to work together due to their diametrically different understandings of mental illness (Calabrese, 2013). It has also been widely believed that patients' use of traditional

healers simply reflected a lack of an alternative. However, recent research shows they are used even when psychiatric facilities and medication are readily available and it is now generally accepted that the appeal of healers lies in their ability to understand patients' illness experience within their cultural framework (Read, 2012; Burns, 2015; Heaton, 2013). This is particularly true of mental illness, where social and cultural determinants play a heightened role in psychopathology. As widespread usage of traditional healers shows no sign of abating, it seems logical to streamline the efforts of formal and informal providers to create a mental healthcare model that represents patient help-seeking preferences. Furthermore, aligning professional and lay narratives of illness can improve positive clinical outcomes, thus tailoring the healthcare system to users' demands should improve patient care (Lakes, 2006; The Health Foundation, 2014). This was also shown in the ethnographic documentary 'Breaking the chains' (Colucci, 2015;2016).

Traditional healers have been successfully integrated into HIV care as educators and counsellors since the 1990s (UNAIDS, 2006, p.10). In mental healthcare, a growing body of research in LMICs demonstrates that lay people or community health workers can be trained to deliver psychosocial interventions for people with a range of mental disorders (Thornicroft, 2013). Commonly known as 'task sharing', it is a popular method for addressing shortages of specialist health resources and its evidence base is consistently positive (Patel, 2012, p.8). However, research and best practice for working specifically with traditional and faith-based healers is scarce.

The WHO (2012) proposes four approaches to adopting traditional practices into primary care:

- **Tolerant**: a select group of traditional practitioners are allowed to practice in some capacity;
- **Inclusive**: traditional healers are recognised but not integrated into policy, regulation or education;
- **Parallel**: both traditional and conventional forms of healing are practiced simultaneously in the healthcare system;
- **Integrated**: the healthcare and medical education system incorporates both traditional and conventional practices.

In addition, the following principles have been highlighted by several studies as crucial in establishing a collaborative relationship: education, trust, mutual understanding, cross-referral and shared working spaces (Osafo, 2016; UNAIDS, 2006; Pretorius, 1991).

Whilst useful, the above framework illustrates the contentious nature of the conversation around traditional healing. Some argue that the idea of 'allowing' traditional healers to practice in their native country is steeped in complex colonial rhetoric. Similar criticism is given to the body of global mental health research that emphasises 'scaling up' services or 'increasing mental health literacy', a concept that generally translates as being 'literate in a medico-scientific system of knowledge' (Cooper, 2016, p.710). On the other hand is the romanticising of traditional healing and delegitimising of psychiatric treatments, many of which have significant benefits for those struggling with mental illness. This paradox was summed up by the WHO, which stated that the body of work surrounding traditional healing is underlined by 'uncritical enthusiasm or uninformed scepticism' (2002).

A more nuanced understanding of the role that traditional healers play in their respective societies is needed. Recent research has shown that there may be 'subjective benefits' that patients reap from seeing a traditional healer that may not be quantifiable in a Western framework; this must be explored in more depth (Nortje, 2016). This will hopefully increase our understanding of how collaboration could be implemented in practice.

METHODS

Search strategy and definitions

The databases Pubmed, PSYCHinfo, Web of Science, Scopus and PsycEXTRA were searched in August 2016. Five journals deemed most relevant to the subject matter were searched: Transcultural Psychiatry; International Journal of Culture and Mental Health; Culture, Medicine and Psychiatry; Medical Anthropology; International Journal of Social Psychiatry. Reference lists were searched manually.

It was decided that an operational definition coined by Nortje would be used, which defined traditional healers as those 'who explicitly appeal to spiritual, magical or religious explanations for disease and distress' (Nortje, 2016, p.155). The focus on magico-religious healers was due to the widespread belief in LMICs that mental illness is caused by spiritual/magical factors, and a large amount of published literature that highlights that these healers tend to be specifically sought out for mental complaints (Robertson, 2006; Nortje, 2016; Abbo, 2011). Further, the authors are particularly interested in how collaboration can prevent the unethical practices associated with faith/traditional healing, which are not widely associated with methods that rely on physical or humoral explanations, such as Ayurverda and Chiropractic.

Following the Cochrane guidelines multiple terms for each element of interest were entered using Boolean operator OR/AND (2011). Through a process of trial and error, the following search string was employed: ("traditional healer" OR "spiritual healer" OR "religious healer" OR diviner OR shaman OR "traditional practitioner") AND ("healthcare professional" OR "healthcare worker" OR doctor OR psychiatrist OR nurse OR psychotherapist) AND ("mental health" OR "mental disorder" OR "mental illness" OR "mental health services" OR "mental healthcare").

Neither the concept of 'collaboration' nor 'perspectives' was included in the initial search string. There are multiple ways of conceptualising these elements and through familiarity with the literature and practice searches, it was determined that their inclusion could lead to exclusion of relevant studies.

Whilst interest in the potential of collaborating with traditional healers, most notably recognised by TA Lambo's 'village psychiatry' model, began in the 1950s, it was decided to focus the review on research post-1970 as it is arguable that this is the point at which it entered mainstream public health discourse (Jegede, 1981). The Alma-Ata Declaration saw the WHO formally acknowledge the role of traditional practitioners in primary healthcare for the first time (1978). It was decided that whilst publications on the subject matter were produced as a result of the interest in the 1950s, they were largely of an anthropological/observatory nature opposed to relevant qualitative studies that actively explored practitioners' views towards collaboration.

Study inclusion and exclusion criteria

All studies that met the following criteria were included: (1) those reported in the English language; (2) those that related to the treatment of psychological disorders; (3) those that explored the use of both traditional and allopathic mental health

practices; (4) those that explored the perceptions of either traditional healers or allopathic practitioners; (5) those that used qualitative methods; (6) those that reported data from LMICs.

Exclusion criteria were: (1) those studies published before 1970 (2) those that did not report primary research.

Data extraction and methodological quality

All studies that were identified as being potentially eligible were examined full-text to ensure that they fulfilled the inclusion criteria. Key study characteristics were extracted from the eligible studies into a table designed by the authors. This included information on author name, country, study type, study aim, recruitment, data collection and sample used. For study findings, this review followed Thomas and Harden's approach to data extraction, focusing on 'all text labelled as 'results' or 'findings' in study reports' (Thomas, J. and Harden, A., 2008, p.4). These sections bore the closest resemblance to the raw data used for the original studies and where possible, direct quotations were used.

To support comparative analysis, a table was designed that recorded all three studies' data under identified codes. This meant each study's findings for each code could be compared more easily and allowed for a broader and more critical analysis. Visual diagrams were also used to explore the coded data and establish overarching themes.

This review used qualitative studies, as they are most effective in exploring the views and perceptions of a particular topic. This made a statistical approach to research synthesis inappropriate and narrative synthesis was therefore employed as the most effective way of analysing the qualitative material (Popay, 2006, p.1). This approach

allowed the author to synthesise and analyse the existing material, going beyond the summaries of findings in the individual studies to generate new insights.

Overall, the process of extraction and synthesis was an iterative process, which involved moving between the original studies, the code tables and the mapping diagrams until it was felt that the themes were representative of the concepts raised in the studies.

The quality of the included studies was assessed through the use of the adapted version of the Critical Appraisal Skills Programme (CASP) quality assessment checklist for qualitative studies (2014). It comprised of ten elements: aims; methodology; research design; recruitment method; data collection; relationship between researcher and participants; ethical issues; data analysis; findings and value of research.

RESULTS

Literature search

The online search strategy produced 1,527 articles in August 2016, with seven articles identified through other sources. There were 1,312 articles once duplicates were removed. This was reduced to 37 full-text articles that were assessed for eligibility.

Figure 1 illustrates the screening process for eligible studies.

[INSERT FIGURE 1 HERE]

Eligible papers

Fourteen studies were eligible. They were published between 1999 and 2016, and included 393 participants across 12 of the papers. Two papers did not offer sample included traditional healers, faith-based healers, psychiatrists, nurses, healthcare professionals or healthcare facility staff. Details on age or gender were rarely

provided, making it impossible to draw any conclusions about whether either were factors that altered participants' perceptions of collaboration. Despite having the inclusion criteria as open to all LMICs, 13 of the studies were conducted in Africa and seven of those were in South Africa. Only one paper, from India, looked at a successful example of formal collaboration; all others were exploring participants' views of organic collaboration.

The geographical spread of studies (or lack thereof) highlights not only the lack of research regarding collaboration with traditional healers but also the concentration of research in the region where traditional healers have the most recognition (particularly in South Africa where they are formally regulated).

All studies used qualitative or mixed methods to collect data, with the majority employing structured/unstructured interview techniques and/or focus groups.

The key characteristics of each study are reported in Table 1.

[INSERT TABLE 1 HERE]

Quality of papers

In line with the CASP guidelines, the first two questions were used to screen studies' quality, resulting in rejection if they do not receive a 'yes' answer to both (2014). Scales indicating high or low quality were not used; yet the number of 'yes' answers indicates the extent to which studies met crucial criteria.

All studies received a 'yes' answer to the screening questions. Of the subsequent eight questions, they were of mixed quality, with the lowest and highest receiving four and eight 'yes' answers respectively.

Themes

Thematic analysis identified three dominant themes, and six sub-themes, as follows.

Recognition of the potential of healers in mental healthcare provision.

Perception of cultural acceptability.

Effectiveness in providing psychosocial support.

Strategies for collaboration.

Comanagement of patients.

Capacity building and exposure to one another's practice.

Perceived barriers to collaboration.

Perceived illegitimacy of one anothers practice.

Lack of regulation in traditional healing.

Table 2 demonstrates the distribution of themes across the included studies.

[INSERT TABLE 2 HERE]

Recognition of the potential of healers in mental healthcare provision

Resounding across all the studies is the recognition that traditional healers are widely sought out and play a key role in the provision of mental healthcare. Their popularity is attributed to two key factors: a shared cultural understanding with patients of the spiritual cause of mental illness and their ability to provide effective psychosocial support for less severe mental disorders.

Perception of cultural acceptability

It was consistently reported that the popularity of traditional healers was rooted in the fact that their approach to mental illness is 'firmly embedded within wider belief systems and are synchronous with dominant constructions of health and illness' (Ae-Ngibise, 2010, p.561).

Allopathic practitioners expressed the belief that healers are sought out because they are from a 'more culturally familiar psychiatric milieu' than biomedical professionals (Kahn and Kelly, 2001, p.42) and can therefore comprehend the meaning of mental illness from a similar perspective to the patient.

For some healthcare professionals, there was a sense of reluctant acquiescence. Whilst they may not subscribe to the same worldview as healers, they understood the reasons why they were sought out. Given the widespread and continued use of traditional healers, some doctors felt that they may as well work together, as explained by this doctor, 'traditional healers have been part of our societies for a very long time and whether we like it or not people with mental problems are going to go to them' (Ae-Ngibise, 2010, p.560). However, some allopathic practitioners seemed genuinely enthusiastic to work with healers because of their position as 'gatekeepers of care' in the local community (Shields, 2016).

Effectiveness in providing psychosocial support

It was recognised by some healthcare professionals that whilst healers are not able to cure severe mental health issues, they may be effective in providing psychosocial support to patients suffering from less critical disorders (Ae-Ngibise et al, 2010; Campbell-Hall, 2010; Kahn and Kelly, 2001; Teuton, 2007). For instance, a psychiatric staff member in the study by Teuton (2007):

> *[I]f you get an illness like either hysteria or these neurotic illnesses […] in the process of praying, they might be doing psychotherapy without knowing they are doing psychotherapy and the patient gets cured. But not with bipolar, because bipolar is a major psychotic illness which cannot go with that (*p.1268).

This notion was also reflected in healers' statements, in which they claimed they could provide 'words of comfort' to patients (Campbell-Hall, 2010, p.618). Interestingly, descriptions of their therapeutic strategy were strikingly similar to Western models of talking therapy, in which exposure and discussion of a distressing experience is encouraged to avoid traumatisation. These descriptions suggest that healers perceive themselves as effective counsellors.

Strategies for collaboration

Both allopathic and traditional practitioners suggested strategies to improve the likelihood of successful collaboration, with capacity building and the establishment of a referral system to co-manage patients emerging as the strongest factors (Agara, 2007; Jansen Van Rensburg, 2014; Kayombo, 2007; Kahn and Kelly, 2001; Musyimi, 2016; Shield et al, 2016). These were largely in line with current research and guidance on the topic.

Co management of patients

In regards to what form collaboration would take, a system of co-referral seemed preferable (Bulbia, 2013; Campbell-Hall, 2010; Janse van Rensburg, 2014; Kahn and

Kelly, 2001; Musyimi, 2016; Ovuga, 1999; Shield, 2016; Teuton, 2007). Healers had a tendency to want a more integrated system, suggesting that taking rooms in health centres and hospitals would facilitate collaboration (Ovuga, 1999, p.278). Allopathic participants did not seem keen to share working spaces with healers, with one study stating that establishing joint clinics was rated lowest priority by conventional practitioners (Kayombo, 2007). Another stated that healers should only visit hospitals to receive health education and orientation but not treat patients 'as it would confuse them' (Kahn and Kelly, 2001, p.44). There was perhaps a fear that working with traditional healers would in some way grant indigenous practices medical legitimacy, which could reflect badly on their own profession (Ae-Ngibise, 2010). Similarly, it is possible that healers wanted to work closely with allopathic providers in order to enhance the legitimacy of their own work, rather than because it would lead to greater co-working.

Although most participants expressed willingness to collaborate in some form, there seemed to be very few formal structures in place (Campbell-Hall, 2010; Musyimi, 2016; Janse van Rensburg, 2014). Reports from traditional healers imply that instances of referring patients were one-sided (Campbell-Hall, 2010; Kayombo, 2007; Keikelame, 2015). One psychiatrist stated that 'we rarely refer patients to faith healers or traditional healers. The patients can choose to go, but we do not initiate the referral conversation' (Musyimi, 2016, p.5).

Interestingly, the case study of successful collaboration in India opposes the view that referral should be formalised, demonstrating that encouraging it as an option better reinforced the idea of mutual respect. As one doctor described, 'we train faith-based healers how to identify, who to refer, when to refer, and made clear that it is not a

compulsion for them to refer. It is their own free will to refer a person' (Shields, 2010, p.376).

Capacity building and exposure to one another's practice.

Recognising that traditional healers are often sought out as the first point of care, three studies explicitly stated that their training should focus on teaching them how to recognise the signs and symptoms of mental illness in order to reduce the delay in getting psychiatric care and function as an 'early detection system' (Campbell-Hall, 2010; Kahn & Kelly, 2001, p.45; Kayombo, 2007; Shields, 2016).

Healers expressed interest in training to improve their patient management skills, indicating that they would be 'willing to attend workshops organised by government' (Agara, 2007, p.118). Some suggested that they would like training to understand 'how Western medicine explains and deals with mental health problems' (Campbell-Hall, 2010, p.619). This idea of improving healers' understanding of psychiatry was supported by allopathic practitioners, who suggested that an 'understanding of psychiatry and the benefits of psychopharmacology should be promoted to healers' (Jansen Van Rensburg, 2014, p.43). Allopathic practitioners also wished to learn about traditional medicine and undergo training that would 'sensitise' them to working with traditional healers (Kayombo, 2007, p.6).

Study participants expressed that healers should be educated to recognise the symptoms of mental illness and to distinguish 'what they could treat […] and when to refer to the Western based health care system' (Campbell-Hall, 2010, p.619).

The acute stage of illness in which biomedical practitioners thought it necessary to have Western medical intervention was often identified by a patient's aggression.

> *We tell them [traditional and faith healers] that there are conditions, especially the acute phase, where the person may be very restless or aggressive, and they should know that is not their area. […] After the person has settled, we tell them that the person can go to them where they can take care of the spiritual side.*
>
> *Nurse in: Ae-Ngibise, 2010, p.654*

Interestingly, this was the same for some healers, who claimed that 'violence and aggressive behaviour by patients warranted referral to psychiatrists', as well as referencing the Western doctor's injection that 'pacifies even a violent mentally ill person (Agara, 2007, p.118; Sorsdahl, 2010, p.599).

It is interesting that healers are able to recognise the limits of their own treatment. The recognition that biomedical intervention is needed somewhat contradicts their spiritual health beliefs, suggesting that they are more flexible than previously thought.

Perceived barriers to collaboration

Perceived illegitimacy of one another's practice

Both allopathic and traditional practitioners expressed a scepticism regarding the effectiveness and legitimacy of one another's treatment of mental disorders (Ae-Ngibise et al, 2010; Agara, 2007; Campbell-Hall, 2010; Keikelame, 2015; Khan and Kelly, 2001; Shield, 2016; Sorsdahl, 2010; Teuton, 2007). Allopathic concerns were primarily rooted in patient safety and human rights (Ae-Ngibise et al, 2010; Campbell-Hall, 2010; Janse van Rensburg, 2014; Kayombo, 2012; Sorsdahl, 2010; Teuton, 2007). Allopathic practitioners frequently expressed concerns that traditional

healers' conduct fell short of ethical or professional standards (Ae-Ngibise, 2010; Kayombo, 2012; Khan and Kelly, 2001; Teuton, 2007). Traditional healers equally doubted the effectiveness of psychiatric medication (Sorsdahl, 2010).

Whilst traditional healers acknowledged the successes of allopathic medication for physical illnesses, namely HIV/AIDs and Tuberculosis, they were sceptical about the effectiveness of psychiatric treatment (Ae-Ngibise et al, 2010; Teuton, 2007). The frequently expressed the idea of a 'band-aid' treatment that could only treat the symptoms, rather than the root cause, of mental illness. As one healer put it, 'Western doctors cannot cure a mental illness. They only help some symptoms' (Sorsdahl, 2010, p.600).

Lack of regulation in traditional healing

Both traditional and allopathic practitioners suggested that the lack of regulation was a barrier to effective collaboration (Campbell-Hall, 2010; Hopa, 1998; Kayombo, 2007; Keikelame, 2015; Khan and Kelly, 2001). Reference was also made to regulating traditional medicine, which was seen by doctors as lacking scientific validity (Kayombo, 2007). Healers expressed frustration that their knowledge was not respected and some presented regulation as a means of professionalising healers so that they could be recognised as 'legitimate partners' in healthcare provision (Campbell-Hall, 2010, p.621). One participant suggested that healers should be registered with a controlling body, either locally or centrally (Hopa, 1998).

Examples of criticisms of the traditional healing system was that it was 'not well developed' and that there was an 'absence of clear guidelines' (Ae-Ngibise, 2010, p.563). Whilst some doctors accepted that traditional healers had a role in the

healthcare system, they felt that their practice should be subject to the same standards as psychiatric medicine. Some suggested that legislative measures should be taken to regulate traditional medicine, and that a pricing system would help to reduce the chance of financial exploitation (Kayombo, 2007).

DISCUSSION

This review aimed to explore the perceptions of traditional healers and allopathic practitioners towards collaborative mental healthcare. Whilst it was expected that their differing views of mental illness would serve as a barrier to collaboration, this did not stand out as an obstacle. Despite holding different beliefs about the cause of mental illness, this did not impact on their willingness to work together. Even more surprising was the recognition by both parties that traditional and allopathic treatment could complement one another. It is obvious that there are very limited structures in place to facilitate co-working.

The findings have implied that there are three key factors that should be focused on in future research and policy: building an effective system that allows for the shared management of patients; regulating and increasing the evidence-base of traditional healing; and developing trust between and capacity of all practitioners.

Facilitating shared management of patients

In line with existing literature, these studies demonstrated that traditional healers are widely used in the countries studied (Robertson, 2006; Tilburt, 2008). However, traditional healing is not integrated into healthcare policy, regulation or education, leading to widespread concerns about its unregulated nature (Ae-Ngibise, 2010; Kayombo, 2012; Khan & Kelly, 2001; Teuton, 2007). According to the WHO

framework cited in the introduction, current practice therefore seems to adopt a tolerant model in the countries studied (2012). Given that allopathic practitioners require regulation and formalisation of traditional healing practices, this review suggests that an integrated system would be preferable. This would allow for traditional healers to be recruited into the healthcare system and trained up to identify and treat mental illness. However, this would also lead to both practices having an equal status in the healthcare system and further research should be carried out to explore whether this would cause resistance from allopathic practitioners, who currently enjoy superior status.

To establish an effective referral system would require agreeing upon referral criteria and designing referral processes. Similar to the multidisciplinary model frequently utilised in modern Western healthcare systems, this collaborative approach will require open dialogue, effective communication and a mutual appreciation for one another's practice. This will not be without its challenges. For example, if referral forms are to be used, the use of paperwork may be an alien concept to healers who are accustomed to an oral tradition. The use of written documentation would also require a basic level of literacy that may exclude some healers. This is particularly significant given the concerns expressed by some doctors regarding the lack of literacy amongst healers (Khan & Kelly, 2001).

The willingness to collaboratively manage patients based on the severity of their illness complements recent research that demonstrated that traditional healers could provide an effective psychosocial intervention for common mental disorders such as depression and anxiety but that there is 'little evidence to suggest that they change the course of severe mental illnesses' (Nortje, 2016, p.154). That healers have expressed an awareness of the behaviours that there is flexibility in their health beliefs, and that

there is scope to develop a framework in which care could be divided, possibly with healers delivering psychosocial interventions and psychiatric treatment being offered for severe mental illness.

By carving out an area in which each practitioner feels they were the 'specialist', participants seemed to feel more comfortable relinquishing an element of care to the alternative practice. Significantly, it seems this would allow both practitioners to retain a sense of autonomy and a proactive role within the healthcare system. This finding is congruent with recent research by Bantjes who states that for healers working 'in the context of global inequality and the dominance of bio- medicine, the protection of spheres of the indigenous becomes very important' (2018, p.85).

Regulation and evidence base of traditional healing

For allopathic practitioners, their willingness to collaborate is hinged on a requirement for evidence-based practice, which whilst understandable, can be problematic for traditional practitioners. Recent research, such as Calabrese' exploration of the use of psychedelic cactus Peyote as a form of 'postcolonial healing' in America, demonstrates that traditional forms of therapy can be highly effective when they are embedded within a unique cultural or socio-historical experience (2013). However, in the same way that successful Western therapies such as CBT and psychotherapy may not work within societies that are not rooted in Cartesian dualism, we may not see the same therapeutic benefits if we subjected indigenous therapies to Western standards of analysis, such as randomised control trials. We therefore may need to explore innovative ways of researching the effectiveness of indigenous treatments for mental illness.

A recent systematic review by Gareth Nortje has attempted to develop this field, by assessing the quantitative outcomes of traditional healing practices globally (2016). Similarly, organisations such as the Association of the Promotion of Traditional Medicine (PROMETRA) in Senegal is dedicated to quantitatively measuring the effectiveness of traditional medicine, striving to 'reduce health workers' scepticism and strengthen mutual appreciation, understanding and respect between practitioners of the two health systems of medicine' (Busia & Kasilo, 2010). Research continues to explore traditional healers' understanding of mental illness and suicidal behaviour, yet the effectiveness of their prevention strategies remains largely untested (Bantjes, 2018).

Abusive practices within healing centres as documented, for instance, in Human Rights Watch reports and the ethnographic documentary research *Breaking the Chains*, need to be investigated and discouraged (Colucci, 2015; 2016). Chaining, beating and other such abusive practices are an infringement on a patient's human rights and cause severe suffering and development of further mental and physical disabilities. However, the widespread view of healers as 'charlatans' is not representative of the entire sector and the widespread dissemination of that view may hamper efforts to bring healers into the fold of mainstream care. Legislation that has deliberately been enacted to prevent malpractice, such as South Africa's Witchcraft Suppression Act, has been met with widespread opposition from the Traditional Healers Organisation due to the belief that it unconstitutionally suppresses religious or cultural beliefs but also that criminal acts should be dealt with under existing human rights legislation (South African Law Reform Commission, 2016).

Preventing human rights abuses will be one of the most challenging areas to tackle and recent evidence has thrown open its complexities. Chaining has commonly been

perceived purely as a method of restraint, or a result of a lack of medication and safe accommodation. However, a recent RCT in Ghana which evaluated psychiatric and prayer camp care against standard prayer camp care found that despite a significant reduction in symptoms, there was no significant difference in days in chains (Offori-Atta, 2018). This is surprising and shows that the methods such as chaining and beating are more closely interlinked to the spiritual ideology of mental illness and concepts of punishment over care.

In order to alleviate human suffering but also build stronger ties with traditional practitioners, those methods associated with traditional healing that have shown to be beneficial, such as counselling and praying should be actively encouraged in place of beating or forced restraint.

Capacity building

A collaborative approach should serve to improve accessibility to acute care and ultimately bring cost benefits. Delays in access to care are associated with longer hospital stays, poorer health outcomes and higher costs for both the patient and the healthcare system (Weissman et al. 1999; Kraft et al. 2009). Furthermore, the socioeconomic cost of long-term mental health to both patient and society should not be underestimated. Early intervention is therefore essential in creating a cost-effective system; both in terms of monetary and individual value. Integrating healers, so frequently sought out as the first point of contact by patients and/or their carers, and enabling them to recognise the signs of acute mental illness or suicide that require immediate support, could serve to reduce delays in accessing acute interventions. Long-term, this will alleviate some of the financial burden on healthcare services in LMICs.

The findings in this review suggest that collaboration must go further than training up healers to merely assist allopathic practitioners. Whilst the task sharing approach can increase healthcare services in areas with few resources, it 'co-opts [healers] cultural acceptability in order to deliver conventional treatment, [but] makes little use of their unique skills and specific advantages' (Gujere, 2015, p.8). They must be adopted as a true colleague of the mainstream healthcare system, taking advantage of their localised cultural insight. This is supported by the documentation of a successful collaboration in Shields' paper, in which there was no attempt to impose ideological change onto healers (2016). The programme instead focused on recognising symptoms of mental distress without requiring healers to subscribe to the biomedical paradigm of disease aetiology. Historical examples of professionalising folk healers support the success of this approach and suggest that educative measures should focus on practical skills, recognising the signs and symptoms of acute mental illness, encouraging signposting to mainstream care and recognising the points at which biomedical intervention would be beneficial.

It could be assumed that healers would not be receptive to the idea that biomedical intervention is necessary, as it would involve them recognising a limit to their spiritual powers and appear to threaten the entire rational for their practice. However, the fact that healers highlighted aggressive patients as requiring psychiatric assistance demonstrates that the ideology underlying their practice, as with most spiritual ideologies, may be more fluid than previously thought. This nuance in health beliefs is not limited to healers but has been seen in nurses in Nicaragua who work in a collaborative system. Regarding the importance of plurality in the healthcare system, they emphasised 'ends before means, practice before theory, and the well-being of the

patient before strict biomedical reasoning, [they] did not find biomedicine to be contradictory to other healing systems in their daily work' (Wedel, p.54).

Research has also shown that resistance to biomedicine may stem from fear of lost livelihood (Shields, 2016; Kayombo, 2007). This is highlighted in the India example, in which healers made the majority of referrals and the clinic ensured that patients were referred back to healers for follow-up care (Shields, 2016). This gave reassurance that healers would not lose their role in the healthcare system and community.

Where this may pose difficulties however, is regarding psychotropic medication, as there is a tendency for healers not to believe in its effectiveness. This was often because it did not work immediately and the belief that the causative agent had not been cured when patients' symptoms relapsed on stopping medication. This could lead to difficulties in collaborative management of patients because healers' notions of mental illness as a curable disease, rather than a disorder as it is viewed in the West, may mean they encourage patients to stop taking medication once the symptoms have reduced. These concerns mirror recent research that showed that the failure of antipsychotics to achieve a permanent cure 'casts doubt on their efficacy and strengthens suspicions of a spiritual illness which would resist medical treatment' (Read, 2012, p.448). Given that there are similar concerns regarding the effectiveness of long-term use of psychotropic medication in Western Psychiatry, measures taken to educate healers should not present psychotropic medication as the panacea to psychiatric illness. Educative measures should be clear on explaining the rationale behind psychotropic medication including: dosages, the proposed mechanism of action, areas of knowledge limitations, side effect profile, and

expected length of time before effects are felt. There should also be a focus on the dangers of drug interactions and polypharmacy to increase patient safety.

Further community education may also be required as patients beliefs will likely reflect those of their traditional healers.

Implications for research and practice

Medical pluralism is common in most societies and the 'need for integrated models is arguably more a concern of planners and academics than of the public' (Helman, 1990, p.42). Unlike in the West, practitioners working in the LMIC context are adjusted to working in a pluralistic healthcare environment, with many seeing the two health beliefs not as contradictory but as complementary. Given their prevalence in LMICs, it is likely that those trained in the biomedical professions will have experienced or made use of indigenous healers at some point in their lives. This acceptance of diverse beliefs bodes well for collaborative projects and future efforts should encourage practitioners on both sides to share their lived experiences and views of the other practice.

As the global mental health movement continues to develop strategies that enhance the skill set of non-medical professionals to deliver effective interventions, there should be an increased focus on the contribution that traditional healers already make towards health provision in LMICs. Efforts should be directed towards increasing their skill set in a culturally sensitive way so they are more readily equipped to provide effective care. Task sharing models could be adapted to build on unique pre-

existing traditional practices. Mainstream healthcare training should include guidance that sensitises providers to local expressions and treatment of mental illness.

A 1981 World Health Forum report stated that 'only lip service seems to have been paid to promoting the process of integrating the traditional practitioners into the general medical services' (Ramesh, p.498). Despite increasing awareness and advocacy for collaboration, almost 40 years later this sadly remains the case for mental health care. We must heed the findings gathered from working with healers in recent Ebola epidemics and HIV/AIDS care. Further research should focus on documenting existing examples of successful collaboration in mental healthcare and comparing them cross-culturally to develop best practice guidance. Due to the complex nature of indigenous healing in each country, it is unlikely that one single best practice model will be developed that can be followed and implemented across all LMICs. However, successful collaborative care can be achieved through the 'sensible local application of broad principles' (WHO, 2008, p.11). Local pilots of collaborative care programmes, such as that discussed in Shields' paper, must be encouraged (2016). This review highlights that research regarding collaboration with healers is concentrated in Africa and mainly in the wealthiest part of the countries studied. Further qualitative research should be conducted across other LMICs in order to gain a fuller understanding of how collaboration is perceived internationally and in diverse religious and spiritual contexts.

Limitations of this review and included studies

This review has a number of limitations. By restricting the search strategy to LMICs, valuable studies that explored traditional healing in the Navajo, Maori and Aborigine populations were excluded. Secondly, most of the included studies employed

purposive sampling method, with several working with an organising body to recruit healers (Agara, 2007; Keikelame, 2015; Ovuga, 1999; Sorsdahl, 2010). Whilst the latter grants contact to healers who would otherwise be inaccessible, it may have led to selection bias, compromising methodological validity.

Only two studies critically examined the 'role, potential bias and influence' that the researcher may have had on participants during data collection (CASP, 2014). Given that traditional healers often express concern that 'their knowledge will be stolen by the West', leading to lost livelihood and dilution of traditional practice, it is crucial that investigators acknowledge the impact their presence could have on healers' participation in research (Kayombo, 2007, p.8). The positive attitude towards collaboration in these studies may therefore exaggerate the extent to which healers would work with allopathic practitioners in reality. This is supported by a recent study that found that although 99% of healers reported a willingness to refer to biomedical services, only 43% were doing so in everyday practice (Peltzer et al, 2006).

CONCLUSION

Contrary to historical belief, this paper demonstrates that the two health systems are not entirely incompatible and that when faced with a lack of resources, both types of practitioners have expressed a promising willingness to work together in order to provide a holistic service that reflects patient behaviour, preference and belief with a shared common goal of improving patient outcomes.

As evidenced by the widespread use of both systems, patients are evidently engaged in a pluralistic model. A healthcare system that formally integrates multiple modes of healing can be an effective way of addressing a large treatment gap and limited resources, bringing cost and health benefits.

Figure 1: PRISMA diagram

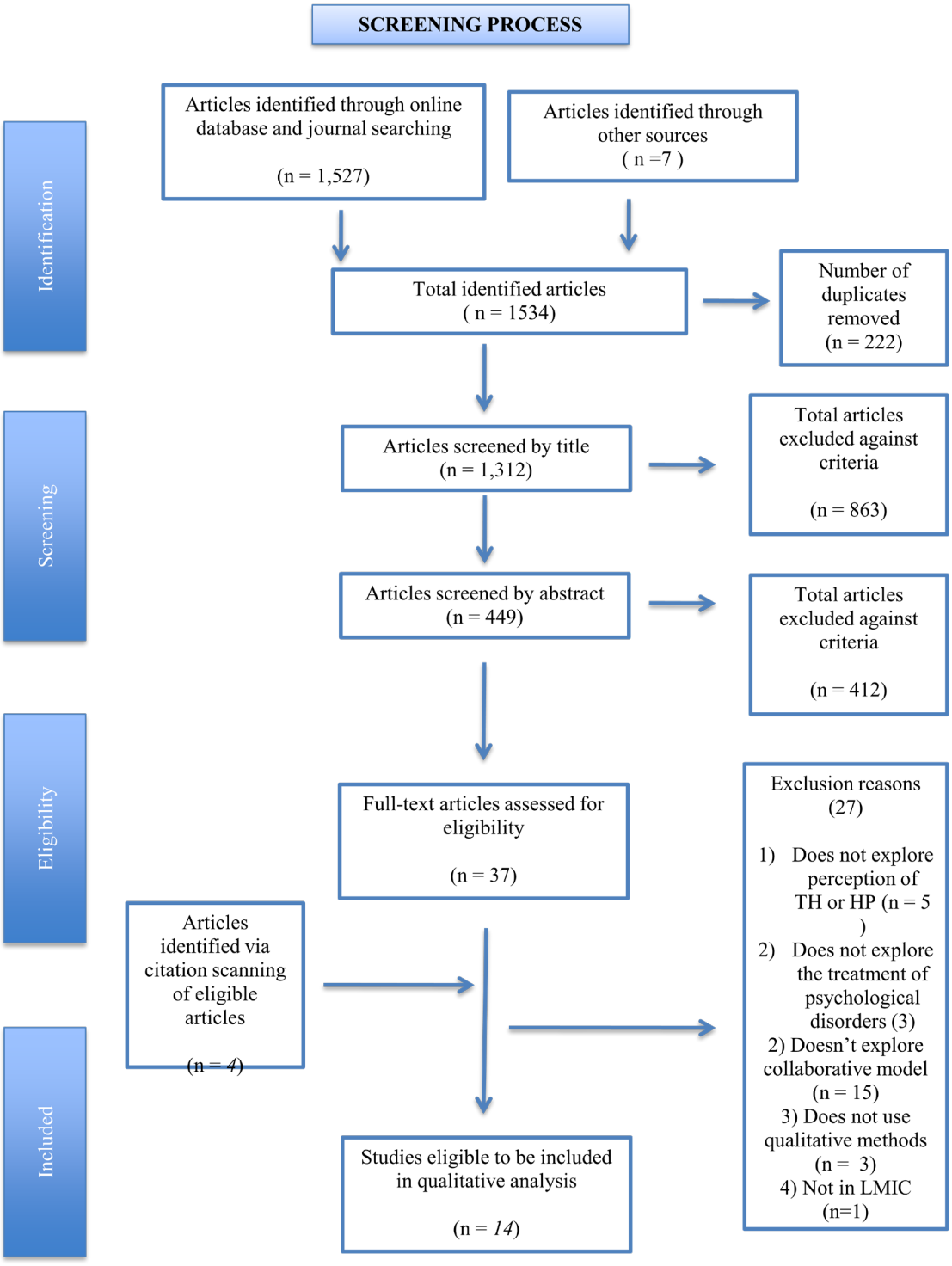

Table 1: Study characteristics

AUTHOR NAME (DATE)	QUALITY	COUNTRY	STUDY TYPE	STUDY AIM	RECRUITMENT	DATA COLLECTION	SAMPLE
Ae-Ngibise et al. (2010)	7	Ghana	Qualitative	1) To explore the reasons underpinning the widespread appeal of traditional healers. 2) To identify what barriers or enabling factors may exist for forming bi-sectoral partnerships.	Data gathered as part of a situational analysis of the status of mental health policy, legislation and services in Ghana, conducted as part of the first phase of the Mental Health and Poverty Project. Participants purposively sampled from among the major stakeholders in mental health at the national, regional and district levels.	Semi-structured interviews and focus groups.	122 Policy makers, health professionals, users of psychiatric services, teachers, police officers, academics and religious (Christian and Islamic) and traditional healers. *Individual details not reported.*
AGARA, MAKANJUOLA & MORAKINYO (2007)	7	Nigeria	Mixed methods	To examine the knowledge, attitude and practice of mental health care among a syncretic Church's healers, and their readiness to cooperate with Psychiatrists.	Convenience sample of local parish. Purposive sample of key informants.	Focus group discussions/key informant interview.	Traditional healer (n=15) Church elder (n=1) Prophet (n=1) Evangelist/healer (n=1)
BULBULIA & LAHER (2013)	6	South Africa	Qualitative	To explore perceptions of mental illness, particularly in terms of the role of Islam in the understanding of mental illness among South African Muslim psychiatrists practicing in Johannesburg.	Convenience sample	Semi-structured interview.	Muslim psychiatrists (n=7)
CAMPBELL & PETERSON (2010)	8	South Africa	Qualitative	To explore perceptions of service users and providers of current interactions between the two systems of care and ways in which collaboration could be improved in the provision of community mental health services.	Purposive sample of key stakeholders	Semi-structured interview/focus group discussion	Stakeholders from formal health sector. Stakeholders from the NGO sector. Traditional practitioners. Sample size not given.

Author name (date)	Quality assessment	country	Study type	Study aim	Recruitment	Data collection	Sample
Hopa, M., Simbayi, L.C. du Toit, C.D. (1998)	7	South Africa	Qualitative	To investigate the perceptions of various stakeholders (viz. psychiatrists, medical doctors, psychologists, traditional healers and consumers) on integration of the traditional and Western healing systems in South Africa.	Krueger's list strategy/ piggy-back focus group / snowball sample	Focus group interview with topic guide	Psychiatrist (n=2) Medical doctor (n=7) Traditional healer (n=6) Psychologist (n=8)
Janse van Rensburg, Poggenpoel, Szabo & Muburgh (2014)	7	South Africa	Qualitative	To capture the views of some local psychiatrists on referral and collaboration between SA psychiatrists and religious or spiritual advisors.	Purposive sample.	In-depth, semi-structured interview.	Psychiatrist (n=13)
Kayombo, Uiso & Mahunnah (2012)	5	Tanzania	Qualitative	To get an experience of health care utilization from both urban and rural areas of seven administrative regions in Tanzania.	Purposive sample.	Face-to-face in-depth interview	Health facility managers (N=33)
Keikelame & Swartz (2015)	7	South Africa	Qualitative	To explore traditional healers' perspectives on epilepsy and collaboration with biomedical health care in Cape Town.	Purposive sample. Access to these healers was gained through assistance from an executive committee member of Traditional Healers Organization (THO).	Individual in-depth interview/focus group discussion using semi-structured interview guide.	Xhosa-speaking traditional healers (n=15)
Kahn & Kelly (2001)	7	South Africa	Mixed methods (qualitative and quantitative)	To examine the views of a sample of Xhosa-speaking psychiatric nurses on traditional healing and its role in mental health care in South Africa.	Questionnaires disseminated to all Xhosa nurses at Fort England Psychiatric Hospital, Grahamstown.	Questionnaire (including open-ended questions)	Xhosa nurses (n=77)

AUTHOR NAME (DATE)	QUALITY ASSESSMENT	COUNTRY	STUDY TYPE	STUDY AIM	RECRUITMENT	DATA COLLECTION	SAMPLE
MUSYIMI, MUTISO, NANDAYO & NDETEI (2016)	6	Kenya	Qualitative	To form dialogue and establish collaboration among the informal (faith and traditionalhealers) and formal health workers	Not clear.	Focus group discussion.	Traditional healers, faith healers and clinicians (registered nurses and clinical officers).
OVUGA, BOARDMAN & OLUKA (1999)	4	Uganda	Qualitative	To carry out a survey of the beliefs, knowledge and practice towards mental illness of 29 traditional healers in the Pallisa district of Uganda.	The healers were identified for interview with the assistance of the Chairman of Traditional Healers. Fifty-one traditional healers were identified of whom 29 were randomly selected for interview.	Semi-structured interview.	Traditional healers (n=29)
SHIELDS ET AL (2016)	7	India	Mixed methods case study (qualitative and quantitative)	To explore the origins, use, and outcomes of a collaborative programme between faith-based and allopathic mental health practitioners in India.	Purposive sample.	Semi-structured interview	Key stakeholders instrumental in the set up and maintenance of the programme. Faith-based healers (n=3) Allopathic mental health practitioners (n=3)
Sorsdahl & Stein (2010)	7	South Africa	Qualitative	To use the constructs of the Theory of Planned Behaviour (TPB) to gain an understanding of traditional healer referral practices of their patients with a mental illness.	Convenience sample selected from the South African Depression & Anxiety Group (SADAG), a mental health advocacy group that runs workshops for traditional healers to increase mental health literacy.	Focus groups with an open-ended semi-structured interview in Xhosa.	Diviners (n=21) Herbalist (n=1) Both Diviner and Herbalist (n=2) All traditional healers were members of the Traditional Healers Organisation (THO).
Teuton, Dowrick & Bentall (2007)	6	Uganda	Qualitative	To analyse the discourse of respondents from different parts of the healing system to establish how they view each other.	Snowball/ purposive sample.	Informal/unstructured interview with healers. Structured interview using EMIC format.	Baganda indigenous healers (n = 10) Religious healers based on Christianity and Islam (n = 10) Psychiatrists (n = 2) Qualified Psychiatric Clinical Officer (n=3) Trainee Psychiatric Clinical Officer (n=1)

n=number of participants

Table 2: Distribution of themes across studies

THEME	**Recognition of the potential of healers in mental healthcare provision**	**Strategies for collaboration**	**Perceived barriers to collaboration**
Ae-Ngibise et al. (2010)			
Agara, A.J., Makanjuola, A.B., Morakinyo, O. (2007)			
Bulbulia, T. & Laher, S. (2013)			
Campbell-Hall, V. & Petersen, I. (2010)			
Hopa, M., Simbayi, L.C. du Toit, C.D. (1998)			
Janse van Rensburg, A., Poggenpoel, M., Szabo C., Myburgh, C. (2014)			
Kayombo, E.J., Uiso, F.C., Mahunnah, R. (2012)			
Keikelame, M.J., Swartz, L. (2015)			
Kahn, M. & Kelly, K. (2001)			
Musyimi, C., Mutiso, V.N., Nandoya, E.S., Ndetei, D.M. (2016)			
Ovuga, E., Boardman, J., Oluka, E. (1999)			
Shields, L., et al. (2016)			
Sorsdahl, K., Stein, D., Flisher, A.J. (2010)			
Teuton, J., Dowrick, C., Bentall, R. (2007)			

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Agara, A.J., Makanjuola, A.B., Morakinyo, O. (2007). Management of perceived mental health problems by spiritual healers: a Nigerian study. *African Journal of Psychiatry,* 11: 113-118

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