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Contribution of Traditional Healers to the burden of mental health conditions in Five African Countries and England

Abstract

Purpose: Mental health conditions (MHCs) such as depression and anxiety, mental illnesses like schizophrenia and bipolar disorder, and alcohol use disorders are leading causes of disability and mortality worldwide. However, the understanding of the burden of these conditions varies across countries, as does the access to and utilisation of services for those who seek help. Many Africans depend on traditional healers as their primary source of mental health care due to cultural beliefs and easier accessibility compared to biomedical services. This study aimed to understand the burden of mental health conditions in selected countries, evaluate the contributions of traditional healers as a support source, and identify future directions for mental health and traditional healing research.

Design/methodology/approach: The study focused on five African countries (Burkina Faso, Ghana, South Africa, Uganda, and Zimbabwe) and Black African communities in England. The study was primarily a desk review, complemented by a priority-setting exercise and a consensus-building workshop with traditional healers and mental health researchers to validate and strengthen the findings. A predefined template co-created during the priority-setting process was used to guide the non-systematic review mapping and covered three areas: 1) burden of these conditions, 2) contributions of traditional healers, and 3) mental health policy and legislative frameworks. Data analysis from the non-systematic review was conducted descriptively. Cross-country similarities and differences, as well as future research directions, were collaboratively discussed during the consensus-building workshop.

Findings: In terms of the burden of conditions, the study revealed that depression was recognised as the most prevalent condition among all six countries. The contributions of traditional healers were more acknowledged in the African countries than in England, although their exact roles in providing mental health support across all six countries were not fully known or understood. Additionally, mental health policies and legislation existed in all the African countries and recognised the presence of traditional healers, albeit to varying degrees. None of the mental health policies or legislation in England acknowledged the contributions of traditional healers. These findings and the consensus-building process led to the establishment of the Pan-African Mental Health Research Network to advance research on mental health and traditional healing in Black African societies.

Originality/value: The burden of mental ill health varied across different countries, and the potential contribution of traditional healers in alleviating this problem in Africa and among African communities in England was not well understood. Active engagement with traditional healers is necessary to enhance their visibility and investigate their potential contribution to mental health support.

Keywords: desk review, mental health conditions, traditional healers, African countries, African communities, England.

Background

Globally, more than 1 in 10 people live with some type of mental health condition [1]. These include individuals with common symptoms such as depression and anxiety, mental illnesses like schizophrenia and bipolar disorder, and alcohol use disorders [2]. It is well-known that mental ill health significantly contributes to the global burden of disease and mortality rates worldwide [3]. The World Health Organization (WHO) estimates further indicate that mental ill health causes individuals to live 1 in 5 years with a disability [4]. Moreover, mental ill health affects people's quality of life [5], for instance, by impacting employment opportunities and serving as a precursor to social issues like poverty [6, 7]. However, the burden of mental ill health and access to mental health care vary widely between countries. For example, the true extent of the mental health burden in African countries is not well understood due to limited data and a lack of consensus about what constitutes a mental health condition or illness [8, 9]. Inadequate data on the burden of mental ill health and a lack of consensus on its causes lead to an underestimation of the burden, challenges in guiding future research and policymaking on the prevention and management of mental ill health, and fragmentation of mental health care in these regions.

In relation to understanding what constitutes mental ill health, existing evidence shows that discrepancies exist both within and across geographical locations. For instance, a recent systematic review and meta-analysis concluded that cultural differences influence the understanding of the causes of mental ill health [10]. According to Choudhry et al.'s systematic review, these cultural differences are shaped by perceptions of the causes of mental illness, which may relate to social relationships, supernatural or spiritual beliefs, as well as biomedical or psychological factors [10].

These beliefs and knowledge inherently shape mental health help-seeking behaviours. Misconceptions about mental health issues can significantly limit access to mental health services. Evidence from several studies indicates that misconceptions about mental illness may lead individuals to believe that mental disorders are untreatable, which can increase stigma, discrimination, and reduce access to effective mental health services [10, 11, 12]. Consequently, people may turn to traditional healers who might not have the means to provide adequate help. In most African countries, especially in rural areas, culturally explained attributions of mental illness influence pathways into care and often do not lead to biomedically trained mental health professionals. For example, many Africans attribute poor mental health to supernatural or divine powers [11, 12] and will therefore seek help from a faith or traditional healer. This is primarily because African countries have their indigenous medical traditions that existed long before modern biomedicine, and they continue to trust these belief systems.

In England, mainstream mental health services are provided through the National Health Service (NHS). Although there is better availability of mental health services in England compared with Africa, Africans living in England experience issues with access [7, 13]. Challenges related to access are influenced by a lack of cultural understanding of services and concerns associated with the stigma attached to their use [13-15]. A report by the Sainsbury Centre for Mental Health, published in 2002, reported mainstream mental health services as 'inhumane', 'unhelpful' and 'inappropriate' and perpetuating circles of fear among Black Africans [16]. These perceptions have not improved for many years, according to a more recent report that described mental health services in England as culturally insensitive and not holistic

[14]. Efforts around establishing Afrocentric mental health services in England have been hampered by a lack of funding, such as the Pattigift Centre in Birmingham [14].

Access to mental health services is challenging for African countries that face a significant shortage of infrastructure and human resources for mental health care [8, 9]. It is estimated that Africa has an average of 4 mental health workers per 100,000 people, which is far below the global average of 10 per 100,000. Furthermore, Africa has a limited number of hospital beds for individuals with mental illnesses requiring inpatient care [17]. The limitations of Africa's conventional mental health system continue to drive many Africans to seek support from traditional healers for mental health issues [12]. The use of traditional healers for physical and mental health care in Africa is well documented, with estimates suggesting that as many as 80% of Africans rely on traditional medicine [18, 19]. Another study has shown that approximately 48.1% of mental health care users in Africa utilise traditional healers as their first point of contact for seeking physical and mental health treatment [12, 20], compared to less than 25% who access the services of biomedical mental health professionals [18]. Integrating traditional healers, including faith healers, with Western-based psychiatric practices can present challenges, and some studies have reported difficulties accessing certain services along with harmful practices [21]. While there is no universally accepted definition of what constitutes a traditional healer, it typically includes diviners, faith-based healers, and herbalists whose practices are rooted in the indigenous knowledge systems and cultural beliefs and values of their community [9, 14, 22].

For African communities in England, there is limited literature on the use of traditional healers, although existing evidence suggests that ethnic minority communities, such as Africans and Asians, utilise traditional medicine and therapies rooted in their cultural beliefs and values [14, 23]. However, this contribution tends to be hidden and lacks recognition from biomedical mental health professionals and policymakers [24]. Therefore, the aims of this study were 1) to understand the burden of mental ill health in five African countries and among African communities in England, and 2) to better understand how traditional healers currently contribute to existing mental health care systems in these countries.

Methods

Study approach and conceptual framework

This study primarily employed a desk review approach, complemented by a priority-setting exercise and a consensus-building workshop. The desk review formed the main research approach and was guided by Murphy et al.'s situational analysis framework for global mental health research [25]. This approach integrates qualitative insights, secondary data review, and consensus-building activities to provide a comprehensive overview of the study focus. The study utilised two theoretical frameworks to explore how cultural beliefs and knowledge systems influence access to mental health services: the Health Belief Theory (HBT) and the Indigenous Knowledge System (IKS) theory [26]. These frameworks provide a comprehensive understanding of the factors that shape individuals' decisions to seek mental health care from either formal or informal sources.

Health Belief Theory (HBT)

The Health Belief Theory (HBT) is a psychological model developed to explain and predict health-related behaviours, particularly with the uptake of health services [27]. The HBT posits that individuals' health behaviours are influenced by their perceptions of the severity of a health condition, their susceptibility to the condition, the benefits of taking preventive action, and the barriers to taking such action [27]. In the context of mental health, HBT helps to understand why individuals may choose to seek or avoid formal mental health services. For example, if individuals perceive mental health conditions as severe and believe they are susceptible to these conditions, they may be more likely to seek formal mental health services. Conversely, if they perceive significant barriers, such as stigma or a lack of cultural competence in formal services, they may avoid these services and turn to informal sources, such as traditional healers.

Indigenous Knowledge System Theory

Indigenous Knowledge System (IKS) theory emphasises the importance of cultural beliefs and practices passed down through generations [28]. IKS encompasses traditional healing practices, spiritual beliefs, and community-based approaches to health care. This theory highlights the role of indigenous knowledge in shaping health behaviours and decisions. In many African countries and among African communities in England, traditional healers play a crucial role in mental health care [29]. IKS theory explains why individuals may prefer to seek help from traditional healers rather than formal mental health services. Traditional healers are often more accessible, culturally relevant, and trusted within their communities. They provide holistic care that aligns with the cultural beliefs and values of their patients, which can be more appealing than the biomedical approach of formal mental health services [30].

The integration of Health Belief Theory and Indigenous Knowledge System theory for this study provides a robust framework for understanding how cultural beliefs and knowledge systems influence access to mental health services. By examining the interplay between these theories, this study offers information on the strengths of each theory and the factors that drive individuals to seek help from formal and informal sources, providing valuable insights for improving mental health care delivery in diverse cultural contexts.

Study context

The study involved five African countries: Burkina Faso, Ghana, South Africa, Uganda, Zimbabwe, and African communities in England. These countries were purposely selected based on an existing collaboration between Nottingham Trent University and higher education institutions in the African countries. England was included because of the rise in Black Africans in the country, with 3% of Black/African/Caribbean/Black British residing in the UK [31], and the overrepresentation of this group in mainstream mental health services in England [32].

Priority setting exercise

The first phase of the study comprised a two-day priority setting exercise conducted in South Africa in 2019. This exercise involved academic researchers from South Africa and the UK (n=7) with a public health and psychology background, and traditional healers in South Africa (n=15). One of the participants was both a researcher and a traditional healer. The group met to explore and understand first-

hand how traditional healers delivered care for mental health conditions and their potential contribution to the wider mental health care system. The priority setting exercise led to the co-creation of a data search template (Table 1), which guided the review phase.

Table 1: Template co-created from the priority setting workshop

Area	Title	Scope
1.	The burden of mental health conditions in the country	• Types of mental health conditions
2.	Contributions of traditional healers	• Description of traditional healers • Roles of traditional healers
3.	Mental health policy and legislative framework	• The extent to which policy and legislation help or hinder the contributions of traditional healers.

Non-systematic review

We conducted a non-systematic review [33] of secondary data between December 2019 and January 2020 to provide an overview of the available evidence on the three key areas identified from the priority-setting exercise. A non-systematic review was deemed appropriate since our focus was on providing an overview of relevant evidence regarding the contribution of traditional healers to the management of common mental health disorders in the selected study settings. As the aim of our research was not to systematically assess the evidence on traditional healing and mental health but to present an overview of the prevailing situation, a purposeful

overview of relevant evidence was sufficient to provide the necessary insights required for our study objectives. The strength of a non-systematic review is similar to qualitative research, which enables the generation of novel insights from an emerging field of research [34].

While it lacks the definitive structure of a systematic review, a non-systematic review is typically favoured for its ability to allow more breadth and for avoiding limitations imposed by rigid search terminologies [33]. Indeed, non-systematic reviews are recognised as a crucial approach to advancing medical research [34] and have been utilised across several disciplines, including children's mental health research [35], education research [36], and sustainability [37].

The non-systematic review gathered evidence from empirical and grey literature published until December 2019. We conducted a rapid search on official government websites, repositories, university libraries, accessible academic databases, and the Google search engine (Table 2). Relevant policy documents, peer-reviewed articles, doctoral theses, commissioned reports, and grey literature were identified from these data sources.

Table 2: Sources of secondary data

Country	University Libraries	Websites/repositories/Reports	Search databases
Burkina Faso	University of Ouagadougou	Office of statistical and health information, Ministry of Health; Erudit; Lefaso.net; Fasopic; Ouaga.com; Health sciences; Office of Traditional Medicine and Pharmacopoeia.	Science direct
England	Nottingham Trent University Online Library	Adult Psychiatric Morbidity Survey (2014); NHS England website- mental health section; Department of Health; National Institute for Health and Care Excellence	Scopus Science direct, Google Scholar
Ghana	University of Ghana	Ghana Mental Health Authority; Ministry of Health, Ghana; Ghana Psychology Council.	Google Scholar
South Africa	University of Limpopo	Statistics South Africa; Department of Health.	PubMed, Google Scholar
Uganda	Makerere University	Ministry of Health; Butabika National Referral Mental Hospital; Uganda Bureau of Statistics.	Google Scholar

	School of Public Health		
Zimbabwe	University of Zimbabwe	Ministry of Health and Childcare, Demographic Health Survey (2016); Zimstats.	Pubmed, Highwire, Researchgate, Google Scholar

Consensus-building workshop

The last phase of the study was a week-long consensus-building workshop conducted in February 2020 in South Africa. To strengthen and validate the findings from the desk review, a consensus-building workshop was conducted with traditional healers and researchers specialising in mental health across the six participating countries. This workshop provided an opportunity to collectively review and interpret findings from the desk review, identify key similarities and differences across contexts, and agree on priority areas for future research. During the consensus-building, country-specific data collected and analysed from the non-systematic review were consolidated and collaboratively reviewed for commonalities and differences, and to inform future research direction. Similar to the priority setting exercise, the consensus building workshop included academic researchers with expertise in public health, psychology and global health and development (n=15) from the UK, South Africa, Ghana, Burkina Faso, Uganda and Zimbabwe. Two traditional healers from South Africa were also in attendance and contributed to the workshop.

Data analysis

The priority-setting exercise was conducted to identify research priorities, which led to co-creating a guiding template for the non-systematic review. Analysis of the non-systematic review data was carried out descriptively using a narrative approach to draw key insights relevant to the study focus. The review findings were presented and discussed during the 2020 consensus-building workshop to facilitate rigour and identify similarities and differences across countries. Although no verbatim quotes are included, the workshop discussions informed the cross-country synthesis presented in the results. The discussions from the workshop also culminated in the formal establishment of the Pan African Mental Health Research Network.

Results

The results are presented in relation to the three key areas of the predefined template (Table 1): 1) burden of mental health conditions, 2) contribution of traditional healers, and 3) mental health policy and legislative framework.

Demographic characteristics of participants

A breakdown of participants involved in the priority setting exercise and consensus-building workshop is presented in Table 3 below.

Table 3: Demographic characteristics of participants

	Country	Profession	Number of participants disaggregated by sex	Total
Priority setting exercise	South Africa	Academic researchers	M: 3 F: 1	22
		Traditional healers	M:3 F:12	
	UK	Academic researchers	F: 3	
Consensus building workshop	Burkina Faso	Academic researchers	M: 1	17
	Ghana	Academic researchers	M: 1	
	South Africa	Academic researchers	M: 2 F: 5	
		Traditional healers	F: 2	
	Uganda	Academic researchers	M: 1 F: 1	

	UK	Academic researchers	F: 3	
	Zimbabwe	Academic researchers	M: 1	

Burden of mental health conditions

In Burkina Faso, depression was identified as the most prevalent mental health condition [38]. Epilepsy was considered a mental illness, alongside hysteria and schizophrenia, in Burkina Faso [39]. This is different to Black African communities in England, where anxiety was reported as the most prevalent condition, although others included depression, phobias, panic disorder and obsessive-compulsive disorder [40]. Similar to Burkina Faso, in Ghana, schizophrenia and epilepsy were reported as mental illnesses presenting to the mental health facilities [41]. Depression and psychosis were also identified as mental illnesses presented at psychiatric hospitals in Ghana [41]. Due to the prevalence of substance use in Ghana, mental illnesses due to psychoactive substance use were identified as commonly presenting to services [42].

In South Africa, results from the South African Stress and Health Survey (SASH) showed that the most prevalent conditions were major depressive disorder, agoraphobia, and alcohol/substance-related mental conditions [43]. Mental health conditions in South Africa were also more prominent among specific populations, notably in people living with HIV/AIDS [44]. This is similar to Uganda, and a recent study showed that depression affected up to 31% of people living with HIV/AIDS [45]. Although data on mental health conditions in Uganda were very limited [46], the

country ranked sixth in Africa for the prevalence of depressive disorders at 4.6% in the general population [47]. In Zimbabwe, depression affected 47% of HIV-negative people compared to 65% among people living with HIV [48]. In Zimbabwe, the Shona Symptom Questionnaire tool identified depression and anxiety as the most prevalent conditions, closely followed by substance/alcohol-related mental health conditions [49]. The conditions that contributed most to the burden of mental ill health across the 5 African countries and Black Africans in England are summarised in Table 4 below.

Table 4: Conditions contributing to the burden of mental ill health

Mental health conditions	Burkina Faso	England	Ghana	South Africa	Uganda	Zimbabwe
Anxiety		✓				✓
Depression/major depressive disorder	✓	✓	✓	✓	✓	✓
Obsessive-compulsive disorder		✓			✓	
Panic disorder		✓				
Phobias (including agoraphobia)		✓		✓		
Psychosis			✓		✓	
Epilepsy	✓		✓		✓	
Hysteria	✓					
Schizophrenia	✓		✓		✓	

Mental conditions due to psychoactive substance use			✓	✓	✓	✓

Traditional healers' contribution to mental health care

According to Order No. 2005_233 / MS / CAB relating to traditional medicine in Burkina Faso, traditional healers include naturotherapists, traditional birth attendants, ritualists, and herbalists [50]. In Burkina, traditional healers took the lead in mental health management and are reported to cure all kinds of epilepsy [51]. Traditional healers in Burkina Faso were the first resort for support with mental health conditions, and they used herbal teas, sacrifices, offerings and even astrology as therapeutic means of mental health care [52]. People with mental health care needs sought biomedical help through psychiatrists if their condition was unresolved by the traditional healer or in cases of chronic mental health conditions [39].

Limited literature exists on the contributions of traditional healers to mental health care in African communities in England. The literature that does exist suggests two broad categories of traditional healers, traditional and faith-based healers [14]. These were different to those known as complementary and alternative medicine (CAM) practitioners. CAM practitioners were recognised providers of mental health care in England, and in a recent national survey comprising 4,863 adults, 12% reported visiting CAM practitioners for support with their mental health. However, only 3% of the respondents were from a Black African ethnic background [53].

Traditional healers in Ghana include herbalists, spiritualists and faith-based healers [54]. In Ghana, it was estimated that traditional healers provided health care services to over 70% of people with mental health conditions [55]. Therefore, the Ghana Mental Health Authority recognised the important role of traditional healers in mental health care delivery.

The existence of traditional healers in South Africa was well recognised. In 2009, it was estimated that there were over 500 traditional healers for every 100,000 people compared with 77 medical doctors for every 100,000 people [56]. Traditional healers in South Africa generally included diviners, traditional birth attendants, traditional surgeons and herbalists [57, 58]. A recent study suggested that about 72% of black people in South Africa used traditional healers in one way or another to access primary care services [59]. These people often utilised traditional medicine owing to a lack of access to appropriate health care services, especially in rural areas.

In Uganda, traditional healers comprised traditional mental health attendants and traditional medical practitioners. Like other parts of the world, traditional healers were widely consulted in Uganda to treat various ailments, including mental health conditions. Studies show that up to 60% of Ugandan patients who sought health care services from traditional healers suffered from moderate to severe mental illness [60]. Traditional healers' perceived effectiveness and greater accessibility compared with biomedical practitioners influenced why many Ugandans sought mental health care from them [61]. While it has not been possible to determine the total number of traditional healers in Uganda, estimates indicate at least one traditional healer for 700 Ugandans [62].

Traditional healers in Zimbabwe mainly included herbalists, diviners, spiritualists, faith-based healers and traditional birth attendants [63]. The major reasons for using traditional healers in Zimbabwe were affordability of medicines, accessibility and user-friendliness of their services [64]. There were 3,500 registered and practicing traditional healers in Zimbabwe [65], yet despite the increasing acceptance of traditional medicine for mental health in Zimbabwe, their contributions were not adequately documented [66]. However, the existing evidence showed that traditional healers predominantly treated conditions believed to be of spiritual origin such as evil spirits, possessions and spiritual influences that can manifest as either physical or mental ill health [57].

Mental health policy and legislation

In Burkina Faso, there was no specific legislation guiding mental health service delivery. However, mental health was recognised in some legislative documents, such as the Penal Code and the Code of Public Health. Additionally, traditional medicine was framed within specific decrees, articles and laws within the Code of Public Health. Institutionally, traditional healers in Burkina Faso came under the Department of Medicine's supervision and the Traditional Pharmacopoeia of the Ministry of Health.

The overarching legislative framework in England and Wales was the Mental Health Act 1983 and the Mental Health Act 2007, which amended certain sections of the previous legislation. Several national documents and guidelines also recognised the value of equality and cultural diversity [14] in mental health service delivery. However,

there remained a lack of clarity in policy guidance and legislation to support the implementation of culturally appropriate services for ethnic minority groups.

In Ghana, efforts to promote and recognise traditional health care systems existed since the 1960s. Following independence from colonial rule, Ghana's first president established the Ghana Psychic and Traditional Healing Association to promote the study of herbal medicine in the country and encourage a more formal organisation of alternative health care services [66]. By 1999, the Ministry of Health had developed a National Strategic Plan for Traditional Medicine, through which the Traditional Medicine Practice Act (Act 575) was promulgated in 2000. This Act established a Traditional Medical Practice Council to license and regulate non-biomedical health care providers [67]. More recently, Ghana's new Mental Health Act 846 (2012) emphasises the importance of recognising the roles of traditional healers in providing mental health services. Policies and guidelines have thus been developed to promote partnerships with traditional and faith healers who provide mental health care, aimed at developing an integrated mental health system in the country. Specifically, community mental health workers across all districts of Ghana have built or were building relationships with traditional and faith-based healers to support collaborative care for people who choose to visit these healing centres. Although these partnerships were already occurring informally, Section 3 of the Mental Health Act mandated such collaborations. In 2018, the Mental Health Authority developed guidelines for mental health workers to collaborate with traditional and faith healers [68].

South Africa leads efforts on the African continent to incorporate traditional healers into a legal framework. The implementation of close collaboration policies between

biomedical mental health professionals and traditional healers had been advocated for a long time. Consequently, policy developments have aimed to recognise traditional healers and their potential role in mental health delivery in South Africa. Examples of government efforts include (i) the 1997 White Paper on the Transformation of the Health System in South Africa, which recognised the importance of traditional health practitioners in primary health care; (ii) the Indigenous Knowledge Systems (IKS) Policy (2004), which sought to recognise, affirm, develop, promote, and protect indigenous knowledge systems, including traditional healing; (iii) the South Africa Traditional Health Act (2007), which regulates traditional healing in South Africa; and (iv) the Mental Health Policy Framework and Strategic Plan 2013-2020, which advocates for the decentralisation of mental health care to the district level, ensuring that mental health users receive the best possible care, treatment, and rehabilitation services at the level closest to them. While existing legislation and policies favour closer collaboration between traditional healers and biomedical mental health professionals, they lacked practical guidance on how healthcare providers in the two systems should collaborate.

In Uganda, mental health services were guided by the Mental Health Act (2019) and a mental health policy [69]. However, these were poorly implemented and did not recognise the role of traditional healers in mental health. In Zimbabwe, the biomedical mental health care sector was governed by the Mental Health Act of 1996, the Mental Health Policy of 2004, and the Mental Health Strategic Plan 2014-2018. The Mental Health Strategic Plan was reviewed in 2018 with the support of the World Health Organization to formulate the Mental Health Strategy for 2019-2023. Although the Mental Health Policy in Zimbabwe focused on decentralisation to strengthen

Community Mental Health, biomedical mental health professionals and traditional healers operate predominantly as parallel services with minimal integration. While traditional healers function outside formal health structures, they were recognised by the government under the Traditional Medical Practitioners Act of 1981. How traditional healers were included in the policy and legislative frameworks for the different countries is outlined in Table 5 below.

Table 5: Recognition of traditional healers in mental health policy and legislative framework

Country	Policy Framework & Government Initiatives	Legislative Framework	Association of Traditional healers	Strengths	Limitations
Burkina Faso	Strategic Mental Health Plan (2014-2018); Directorate of Traditional and Alternative Medicine within the Ministry of Health; Centre of Traditional Medicine and Integrated Healthcare	Law No. 23/94/ADP on the Public Health Code	National Federation of Traditional Healers of Burkina Faso	Contribution of traditional healers recognized in legislation and policy developments concerning mental health conditions.	This mental health policy conflicts with other health policies and regulations that discriminate against mental health healers The design of the facilities did not accommodate traditional mental health healers

England	Department of Health 2011, No Health without Mental Health: A cross-government mental health outcomes strategy for people of all ages	Mental Health Act 1993 and the Mental Health (Amendment) Act 2007; Modernising the Mental Health Act: increasing choice, reducing compulsion.	None	Both the policy and legislative frameworks provided clear strategies for providing mental health care in England.	Traditional healers were not recognized nor mentioned in the policy document and legislative framework.
Ghana	Five-year mental health plan (2006-2011); Training for community mental health nurses to engage with traditional healers	Mental Health Act, 846 (2012); Traditional Medicine Practice Act, 575 (2000)	Ghana Federation of Traditional Medicine Practitioners Associations (GHAFTRAM)	Emphasized the importance of formally engaging non-medical health service providers, developing an integrated mental health system, and fostering collaboration	The collaboration efforts as stated in the policy document between biomedical mental health professionals and traditional healers was not effective.

				between biomedical mental health professionals and traditional healers.	
South Africa	Indigenous Knowledge Systems Policy (2004); Mental Health Policy Framework and Strategic Plan 2013-2020; Traditional Health Practitioners Act of 2007	1997 White paper on the Transformation of the health system; Traditional Health Practitioners Act [1] 22 of 2007	Several traditional healers' associations exist at national and provincial levels.	The White paper recognized the importance of Traditional healers as key stakeholders in mental health care. The Mental Health policy framework called for collaboration between biomedical	The policy pronouncements are not accompanied by actual collaboration between the two health care systems.

				practitioners and traditional healers.	
Uganda	Mental health programme initiated in 1996; The national policy and Health Sector Strategic Plan 1999-2000; Draft Mental Health policy 2011; National Child and Adolescent Mental Health Guidelines.	Mental Health Act (2019)	Association of Indigenous Knowledge holders present but is not recognized or integrated into the Ministry of Health or health service delivery structure.	Traditional healers sometimes referred patients to biomedical health workers and the health system.	National mental health policy did not recognise the role of traditional healers in the management structure of MH. National Mental Health policy did not address critical issues such as financing and how funds are allocated to the

					different mental health service needs.
Zimbabwe	Health Professions Authority Mental Health Policy (2004); Department of Traditional Medicine within the Ministry of Health.	Mental Health Act (1996); Mental Health strategy of 2019-2023; Traditional medical practitioners ACT (1981)	Statutory Board called the Traditional Medical Practitioners' Council	The contribution of traditional healers recognised by legislation.	Traditional Medical Practitioners Council suggested an alliance with biomedical mental health professionals rather than traditional healers' contribution.

Establishment of a multi-country network

The consensus-building workshop culminated in the establishment of the Pan African Mental Health Research Network to advance research, capacity building, and bi-directional learning in traditional healing and mental health research.

Discussion

This study aimed to understand the conditions that contribute to the mental health burden in five African countries and African communities in England, including how traditional healers contribute to mental health care and support. Generally, the desk review revealed minimal data on traditional healers' contributions to mental health in these African countries and communities in England. This is primarily attributed to limited research, as reinforced by a recent study, which found that only 3% of the research conducted in low- and middle-income countries was on mental health [8]. Data regarding the current burden of mental ill health and service provision in African countries and black African communities in England is mostly derived from data sets and surveys that reflect the contributions of biomedical professionals to the system of care delivery.

The study showed that depression was highly prevalent across all countries. This supports existing evidence that by 2030, this mental health condition will be the leading cause of disease globally [70]. The heterogeneity of types of mental health conditions and illnesses differ from the WHO's broad categorisation of mental health conditions into depressive and anxiety disorders [71]. Some countries include neurological conditions such as epilepsy and hysteria as types of mental illness, making it difficult to have a unified approach to understanding the global burden of mental ill health.

The study revealed that traditional healers in African countries are diverse, encompassing categories such as traditional birth attendants, faith healers, herbalists, spiritualists, and diviners. This finding supports the existing body of knowledge regarding Africans and people of African origin [56]. Although our study established that traditional healers were recognised and regarded as important first contacts for mental health support by the public, their exact roles in continuing mental health care are not well known or understood. Limited literature exists on the contributions of traditional healers to mental healthcare in African communities in England, presenting a hidden and poorly understood contribution. Nonetheless, some studies report positive outcomes for adults seeking mental health care from traditional healers in sub-Saharan African countries, including Uganda [60, 72].

In England, the emergence of complementary and alternative medicine (CAM) as an option to mainstream healthcare has seen a significant and recent increase in use and practice. Although CAM is well recognised as a professional practice in England, this is not the case for traditional healers, who remain unrecognised and whose contributions to mental health care are less well known. The under-representation of Black Africans in the utilisation of CAM warrants further investigation. The 'invisibility' of traditional healers within African communities in England and the limited understanding of traditional healers' contributions in African countries call for their involvement in global mental health research. Involving traditional healers to scale up the availability of mental health interventions is central to the WHO's global agenda for change, using a country-by-country approach [4]. The WHO's global agenda would benefit from an evidence-informed understanding of the existing scope and scale of

mainstream mental health services and the opportunities this affords for traditional healers to contribute in ways recognised as safe and proportionate.

The study revealed gaps in the current mental health policy and legislative documents regarding the recognition of traditional healers. Policy and legislative frameworks vary in the extent to which they attempt to recognise the role that traditional healers can play and could do more to acknowledge this contribution, including how contributions could dovetail with biomedical knowledge systems and interventions for mental health conditions in African countries and communities. Almost half (46%) of African countries either lack or do not implement national policies specific to mental health [73]. Although some African countries, such as Burkina Faso and Ghana, had policies that recognise the role of traditional healers in mental health service provision, these policies were not up to date and enforced a top-down approach that prioritises biomedical services and community-led health initiatives [66]. There was a progressive and supportive policy framework for mental health in South Africa, but its implementation was weak. Therefore, the policy framework for mental health care for Africans needs to look beyond policy development to practical implementation.

Finally, the study resulted in the formal establishment of a multi-country network. The network will seek to generate timely evidence to enhance the visibility of traditional healers and promote collaboration between traditional and biomedical healing systems to ensure the delivery of person-centred care in managing common mental health conditions. On a global scale, the network will contribute to the WHO's global agenda on traditional, complementary, and integrative medicine.

Conclusion

Findings from the study highlight significant variations in the types of mental health conditions across five African countries and African communities in England, with depression being the most common condition identified. Despite the widespread use of traditional healers for mental health care in African countries, their roles and contributions remain poorly understood and under-documented. The integration of traditional healers into formal mental health care systems is limited, and their contributions were not adequately recognised by existing mental health policies and legislation. This lack of recognition and integration poses challenges for the effective delivery of mental health services and highlights the need for more inclusive and culturally sensitive approaches to mental health care.

The study highlights the need for a more holistic and culturally sensitive approach to mental health care that recognises the contributions of traditional healers. By bridging the gap between formal and informal mental health care systems, access to mental health services and support for individuals in diverse cultural contexts can be improved. Further studies are required to enhance the understanding of traditional healers' roles and to develop integrated mental health care models that leverage the strengths of both biomedical and indigenous knowledge systems.

Study strengths, limitations and future direction

This study provides valuable insights into the contribution of traditional healers to the burden of mental health conditions across five African countries and African communities in England. One of its major strengths lies in its multi-country, cross-

continental perspective, which integrates both African and diaspora contexts. By comparing evidence across diverse cultural and policy environments, the study highlights the similarities and differences in how traditional healers contribute to mental health care systems.

Another key strength is the inclusivity of the research process. The combination of a desk review with a consensus-building workshop involving traditional healers and academic experts strengthened the validity, credibility, and contextual relevance of the findings. This participatory approach ensured that both scientific and indigenous perspectives were represented in interpreting and validating the evidence base. The use of a non-systematic review enabled exploration of the topic in a broad yet focused manner, drawing on our research experiences and philosophical standpoints.

However, several limitations must be acknowledged. First, the study was primarily a desk review, relying on secondary and grey literature rather than direct primary data collection. As such, the findings depend on the availability and quality of existing data, which varied considerably across countries. Second, while the consensus-building workshop added depth to the interpretation of findings, verbatim qualitative data from participants were not included, limiting the ability to capture the nuanced voices and lived experiences of traditional healers. Third, inconsistencies in data reporting between countries constrained the ability to make direct cross-national comparisons. Despite its utility and appropriateness in providing a breadth of overview of our topic of interest, its lack of structure limited the comprehensiveness, transparency and reproducibility of our study.

Future research should aim to build on this foundational work by incorporating primary qualitative and mixed-methods approaches to capture the lived experiences of traditional healers and service users. Despite the methodological limitations, the study testifies to the positionality of traditional healers as typically marginalised from contributing support to mental health care systems. Multi-country comparative studies could further explore the integration of traditional and biomedical mental health systems, while longitudinal research could evaluate the effectiveness and safety of collaborative care models. Strengthening cross-sector partnerships and establishing shared frameworks for culturally appropriate mental health care remain critical for ensuring equitable and inclusive mental health systems across Africa and its diaspora.

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Contribution of Traditional Healers to the burden of mental health conditions in Five African Countries and England

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Competing interests

Di Bailey is currently part of the editorial of JMHTEP while being a co-lead investigator on the project.

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Authors' contributions

Development of the proposal: DB, TS, LG; Coordination of the workshop: MaM, MpM, TS, LG, DB, DI; Secondary data collection: All; Writing original draft: DB, MaM, SN, DI; Internal peer review and editing: TS, DB, LG, MuM, DM, MoB; All authors read and approved the final manuscript.

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