



Traditional healers for mental health care in Africa

Vikram Patel*

London School of Hygiene & Tropical Medicine, London, UK; Sangath, Goa, India

Global mental health is primarily concerned with reducing inequalities in the access to health care and health outcomes for people with mental illness within and between countries (1). Reducing the vast treatment gap and promoting the rights of people with mental illness to live with dignity are major goals of adherents of the field such as the Movement for Global Mental Health (www.globalmentalhealth.org). In this context, the thesis by Abbo summarised in her PhD Review paper in *Global Health Action* (2) is a timely reminder of the role of a key player in the mental health care system in African countries where the biomedical treatment gap is notably large – the traditional healer. Her series of studies in Uganda show that a variety of indigenous labels are used by traditional healers to describe what biomedical psychiatry categorises as psychotic disorders and that these are associated with a range of explanatory models, from supernatural/spiritual causes to somatic causes such as HIV. The prevalence of any mental illness amongst patients seeking help from traditional healers is very high and, notably, the vast majority of persons with psychotic disorders were also concurrently seeking help from the biomedical sector. There was a strong association of mental illness with indicators suggestive of poverty, such as lack of food or indebtedness and, amongst those patients who had a psychotic disorder, being in debt was associated with poorer outcomes. These findings serve to replicate a rich record of evidence from several countries in the region, going back several decades that testify to three major findings: severe mental illness is clearly recognised as causes of illness and suffering by indigenous communities, poverty and mental illness frequently co-exist, and traditional healers plays a prominent role in mental health care. Each of these findings has important implications for global mental health.

Firstly, the demonstration that not only were descriptions based on the biomedical classifications of psychoses recognised by the traditional healers, but that the indigenous taxonomy closely mapped on to the biomedical categories, is a major piece of evidence in support

of the universality of these diagnoses across cultures and is consistent with the observations made in a review of explanatory models of mental illness in sub-Saharan Africa (3). This is a particularly relevant observation in the context of critiques of biomedical classifications of mental illnesses, which argue that they are largely derived from a cultural construction of ‘western’ thinking about mental health and represent an ‘Americanization of mental illness’ (<http://www.nytimes.com/2010/01/10/magazine/10psyche-t.html>). That traditional healers with a completely different orientation to biomedicine should utilise a comparable framework to understand mental health problems serves, at least in part, to validate the biomedical framework and to demonstrate that people experiencing such psychological phenomena consider themselves sick or, at the very least, struck by some misfortune and have sought help from times well before biomedicine became established. Put simply, this evidence demonstrates that severe mental illnesses are not the fabrication of a universalist biomedical psychiatry.

Secondly, the demonstration of the strong association between indicators of poverty and the prevalence and outcome of mental illness is consistent with the large body of evidence from all regions of the world that poverty and mental illness frequently co-exist (4). While Abbo’s research does not offer clues to the mechanisms that underlie this relationship (2), it is clear from other evidence that the pathways between mental illness and poverty are complex and bi-directional (4). Crucially, this evidence not only demonstrates that living in poverty increases the risk of developing a mental illness but that, as Abbo’s work also shows, living in poverty is associated with a worse outcome of the illness. A key question that arises is the potential for interventions targeting the alleviation of poverty on mental health; a recent systematic review has found that the evidence on the mental health impact of poverty alleviation interventions was inconclusive, with the exception that some conditional cash transfer and asset promotion programmes showed benefits (5). The inconclusive evidence was largely due to the very limited quality research addressing this

question. However, the review did observe that mental health interventions were associated with improved economic outcomes. In short, mental illness is not just a public health priority, but also a priority for development (5), and improving access to care for mental illness may help improve the economic outcomes of those who are affected.

Third, perhaps the most important finding from Abbo's work is that despite the considerable growth in the awareness of biomedical perspectives on mental illness and the evidence base on the effectiveness of biomedical treatments, very substantial numbers of people with a mental illness continue to seek help from the traditional sector. Given the enormous shortage of skilled mental health human resources in Africa and the great inequities in their distribution (6), the obvious question that emerges is whether traditional healers may play a role in the formal mental health care system alongside biomedical providers. This is clearly the position taken by Abbo when she argues that 'health cannot be achieved without achieving a balance in life with others and with the environment' and that while there was very little formal interaction between the biomedical and traditional sectors, 'it may be impossible to meet patient's needs in the near future' in Uganda without addressing the role of the traditional sector in the mental health care system. This issue has been debated and discussed for several decades, but sadly it seems there is little consensus on the way forwards.

The greatest obstacle to such collaboration has been the mutual suspicion between the two sectors and the concerns of the biomedical sector and the religious establishment regarding the 'unscientific' and unorthodox practices of traditional healers. The considerable diversity of traditional healers, encompassing a wide range of practitioners including herbalists, spirit mediums, diviners, traditional birth attendants (TBA), and faith healers is a major barrier. Related to this barrier is the lack of agreement on what constitutes evidence to guide policy and practice when the epistemologies of traditional medicine differ so vastly from that of biomedicine. Furthermore, there is also no doubt that some traditional healers do harm, not least through imposing considerable financial burden on the unwell. Notwithstanding these difficulties, the inescapable reality is that they are far more numerous than biomedical providers and appear to play a particularly important role for mental health care.

This combination of the widespread use of traditional healers and the shortages of biomedical human resources highlights the need for innovative experiments in making traditional healers potential co-partners in mental health care. In order for such a collaboration to succeed, one must begin by acknowledging that different therapies

are not competitive but complementary. The very fact that large numbers of people with mental illnesses in well-resourced countries (such as in western Europe) consult complementary practitioners in spite of affordable access to biomedical services, suggests that the preference for complementary care is not simply the result of lack of availability of biomedical care. What then of a system of health care that is as old as human existence itself? It may be argued that the very survival of traditional healers as a profession is evidence of its efficacy at least in the eyes of the communities they serve. The World Health Organisation (WHO) declared that 'the full and proper use of traditional medicine makes an important and clear contribution to countries' efforts to achieve health for all by the year 2000' (7) two decades ago; we are still as far from that goal today as we were then. It is clear that an active effort is needed to transform such ideals into reality, guided by evidence and common sense, to enable a mutually rewarding partnership between biomedical and traditional health care providers to reduce the treatment gap for mental illnesses in Africa.

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*Vikram Patel

Professor of International Mental Health & Wellcome Trust Senior Research Fellow in Clinical Science
 London School of Hygiene & Tropical Medicine
 London, UK; Sangath, Goa, India
 Email: vikram.patel@lshtm.ac.uk