

# Faith-based mental health provision in Africa: A Mixed Methods Systematic Review

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## Abstract

Faith-based mental health provision as a model of mental health service delivery is not widely acknowledged or researched, despite being highly utilised, especially in the African context. There is currently limited empirical research or review work on the various types of faith-based health providers which contribute mental health services, the magnitude of these services, or their quality.

This mixed-methods systematic review study looked at these aspects of faith-based mental health provision in the African context. In the first phase of this study, we conducted a scoping review with a wider, which resulted in a typology of models of faith-based mental health provision. The typology included five different types of faith-based health individual and organisational providers (herbalists, traditional and faith healers, Christian and Muslim clergy, faith-based organisations, and chaplains). In the second phase of the study, we conducted a systematic review based on the typology in which we assessed these models of FBHP against service type and level (facility or community, individual or organisational providers); medical provision type (biomedical or alternative).

There were 53 studies included in this systematic review and the findings suggest that there is a wide array of types of faith-based providers providing a variety of mental health services across Africa. The research question formulated for the purposes of the systematic review aim to address the types, magnitude and quality of faith-based mental health services in Africa. For the purposes of this review, magnitude was categorised as including frequency of utilisation and availability of faith-based mental health services, but the information was limited. In addition, there are red flags regarding the quality of these mental health services which include human rights abuses that were discussed in this review.

This exploratory review demonstrates some of the challenges in dealing with the complex variety of 'religious entities' in Africa. To some degree, developing conclusions that are applicable to all faith-based mental health providing entities is counterproductive – and instead a main conclusion is that future research and engagement needs to take this variety into account. There are a few common trends – for example challenges facing most faith-based providers in relation to faith-based provision of mental health services is financial support for mental health services. Regarding both traditional/alternative and biomedical mental health services, it has been noted that, there is a need to consider cost to the patient (e.g., reduce out of pocket payments). In addition, the literature suggests that better training for some types of faith-based health providers is urgently needed, especially those working close to community. Community mental health education interventions could strengthen faith-based provision of mental healthcare, and prevent some human rights abuses (religious perils), and improve the quality of faith-based mental health service provision. Better referral systems and improved communication between faith-based health providers and biomedical practitioners is required. In addition, varied types of faith-based health providers need to be included in mental health policy development and implementation. Finally, the most comprehensive conclusion of this exploratory review, is that further research is needed on specific types of faith-based providers engaged in mental health service provision, and further research is needed on the integration of mental health services in African health systems.

## Abbreviations and Acronyms

BMP	Biomedical practitioner
CBO	Community-based organisation
DALY	Disability adjusted life year
EIPP	Evidence-informed policy and practice
FBHP	Faith-based health provider
FBO	Faith-based organisation
HIV/AIDS	Human immunodeficiency virus/ acquired immunodeficiency syndrome
HPSR	Health policy and systems research
LMIC	Low- and middle-income country
MHS	Mental health service
NGO	Non-government organisation
NHS	National Health Service
NSP	Non-state provider
NGO	Non-government organisation
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
UK	United Kingdom
WHO	World Health Organisation

## Glossary

<b>Traditional healer</b>	individuals who get guidance through ancestral spirits. In some cases; they utilise traditional medicine and other rituals (1)
<b>Faith healer</b>	Individuals who get guidance from God. Examples of faith healing include; utilising prayers, divination or rituals (1)
<b>Clergy</b>	Leaders from religious entities/ groups which provide spiritual care. Examples are Christian and Muslim clergy such as Imams (2)
<b>Faith-based organisations</b>	Organisations whose values are inspired by beliefs or faith, which are mission centric founded on social ideologies and services stemmed from a specific faith group (3)
<b>Chaplains</b>	A chaplain provides emotional and spiritual support to patients and hospital staff. They give support during crises and among ongoing recovery as well as support for bereavement (4)
<b>Herbalists</b>	These are practitioners of herbal medicine who try to locate the root reason of an illness. They also recommend treatment based on a consultation with patient founded on ailments and symptoms (5)
<b>Health system</b>	“all organizations, people and actions whose primary intent is to promote, restore or maintain health” (6)
<b>Mental health system</b>	A system of mental health services and policies including providers of “mental health care” and the various components of the health system (7)
<b>Community level of the health system</b>	This level is where faith-based health providers deliver “community based mental health services” and refers to the positionality of the service (8).
<b>Facility level of the health system</b>	This level refers to faith-based mental health services delivered at a facility level of the health system, in terms of positionality of the service (9)
<b>Biomedical types of mental health services</b>	These mental health services are categorised as biomedical or standard types which include counselling, community mental health education, faith-based home care and faith-based psychiatric standard mental health care (10)
<b>Alternative types of mental health services</b>	These are religious types of services and alternative types of treatment such as herbs, prayer, oils, sermons, and traditional medicine (11)
<b>Organisational types of providers</b>	These types of providers are larger scaled providers which can be categorised as organisations which include churches, mosques, prayer camps, prayer forests and faith-based organisations (12)
<b>Individual types of providers</b>	These types of providers are larger scaled providers which can be categorised as organisations which include churches, mosques, prayer camps, prayer forests and faith-based organisations (12)
<b>Religious perils</b>	These are religious dangers pertaining to faith-based mental health services and include chaining, beating, use of ropes and clothes particularly found in prayer camps and prayer forests (13)
<b>Human resources and technology</b>	These are the availability of faith-based health providers for mental health and the issues with these types of resources (14). Technology refers to mental health infrastructure issues such as lack of resources in prayer camps.
<b>Information supported systems</b>	This focuses on health systems which educate individuals on mental health through information support (15)
<b>Socially acceptable systems</b>	These are health systems supported by social networks which include family, friends, and especially faith-based mental health providers (16, 17).
<b>Culturally acceptable health systems</b>	These are health systems which attain cultural appropriation and abide by cultural values when delivering mental health services (18, 19)
<b>Magnitude of faith-based mental health services</b>	This is the extent of service related to faith-based mental health services and providers, mainly the prevalence of utilisation, footprint, availability (accessibility, affordability and acceptability) of mental health services of faith-based health providers (various types) for mental health services (20).
<b>Quality of faith-based mental health services</b>	The quality pertains to whether there was mental health training involved among faith-based health providers and the mental health services they provide as well as whether religious perils were used (16, 21).
<b>Finance mechanisms</b>	These are funding mechanisms either provided by government entities, but in the case of this study, the focus is on the lack of financing (21).
<b>Mental health training</b>	This involves whether the faith-based health providers were trained so that they could provide higher quality mental health services and address serious mental illness cases (16).

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## Part A: Protocol

### Background

A health system consists of “all organizations, people and actions whose primary intent is to promote, restore or maintain health” (6).<sup>1</sup> Non-state providers are acknowledged to contribute to health care service delivery and meeting broader health system goals (22). Non-state providers are present globally in most health systems, for example, as “private-for-profit or not-for-profit organisations, pharmacies, civil society organisations, non-governmental and community-based organisations” (NGOs and CBOs) and individual health providers (23).

There is an interest in the role NSPs play in strengthening health systems, especially in lower- and middle-income country (LMIC) settings (24, 25). So far, this interest is predominantly focused on more ‘formal’ types of NSPs (such as biomedical services provided by NGOs). However, there is some recognition that it is also important to understand the complex array of other (informal) types of NSPs and their influence on, and contributions to, LMIC health systems (26, 27).

‘Faith-based health providers’ (FBHPs) are a type of NSPs about which particularly little is known. FBHPs come in various forms and can be formal or informal entities. FBHPs can be defined as “...faith-based development and humanitarian NGOs, religious leaders, religious institutions such as Mosques, Churches, and their affiliated NGOs; and independent local community entities” which are inspired by principles of faith (28). In this study, the term ‘faith’ is used broadly to include traditional healers and faith healers (29) (see Box 1 definitions). Therefore, FBHPs can include a wide variety of NSPs, including individuals and organisations, providing any type of service (such as biomedical or alternative) that self-identify as being influenced by faith. The terrain of FBHPs is therefore complex (more below).

It has been argued that FBHPs may have some ‘comparative advantages’, such as being particularly ‘community-centric’ (30), and providing culturally sensitive as well as contextually appropriate services (31). Globally, it has been widely acknowledged that there is a lack of evidence on the scale of FBHPs within health systems – although in the past decade it has been shown that FBHPs play a significant role in many LMIC health systems where there are service availability gaps (27). However, it is more also noted that additional robust data is needed, which more thoroughly assess FBHPs, to assist in policy development (32, 33).

“The WHO estimates that more than 80% of African populations attend traditional healers for health reasons and that 40%-60% of these have some kind of mental illness,” (35). However, the magnitude of the various other types of FBHPs is currently unknown and needs furthermore accurate exploration (34-38). Generally, mental health services are lacking in LMICs, and in Africa in particular. The third goal of the SDGs adopted by all governments in 2016, includes commitments to enhance mental health outcomes with the prevention and treatment of substance use disorders (39). However, it is widely acknowledged that in LMICs generally and in Africa specifically, there is a large service gap in terms of mental health services (40-42), “The scarcity of research mirrors the weakness of mental health services on the continent and the blind eye turned to the problem by many Africans and their governments” (43).

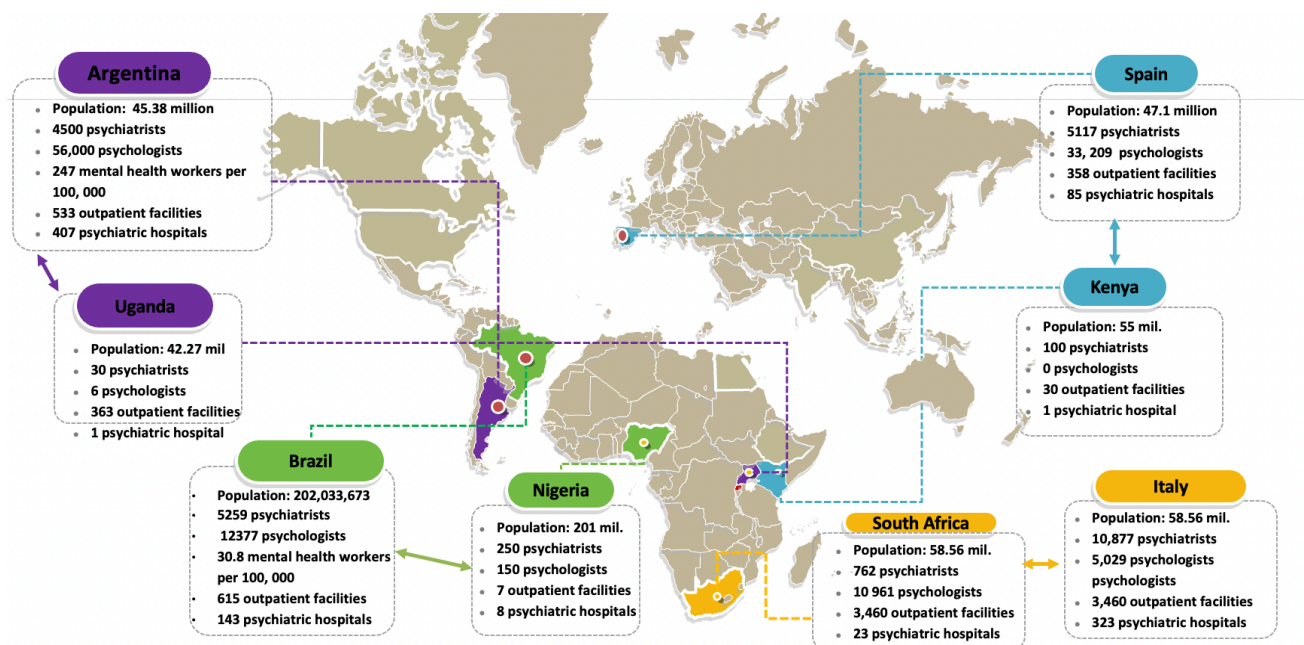
In 2016, over 1 billion people globally (7% of the burden) were affected by mental health disorders (44). In Africa, mental illnesses contribute to almost 10% of the overall disease burden (45). In Africa, existing mental

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<sup>1</sup> For the purposes of dissertation formatting, the numbered references run from the glossary (above) into the protocol text (below)

health services are insufficient, according to the population ratio [27, 28], and data also suggest that the mental health treatment gap is widening – with over 70% of people in Africa needing access to mental health services that are more easily available and are unable to access them currently (46). The African region has “1.4 mental health workers per 100,000, whereas the global average is 9.0 per 100,000” (43). It is also stated that for 83% of the African there is less than one bed per 10 000 people in biomedical mental health facilities (see Figure 1). According to a worldwide report by the WHO’s 2014 Mental Health Atlas survey, it was indicated that 46% of African countries have not implemented any standalone mental health policies (43).

Not only are more mental health services urgently needed, but the World Health Organization (WHO) has also argued for the need to create mental health services and initiatives which are suited to Africa’s context and population needs from a cultural and religious perspective (47, 48). It was noted that, “when a mental health professional understands the role that cultural differences play in the diagnosis of a condition, and incorporates cultural needs and differences into a person’s care, it significantly improves outcomes,” (49). In the African context, there are examples to indicate that populations gravitate towards health services that are culturally acceptable and thereby, influences the mentally ill’s perception and utilisation of mental health-seeking behaviour(50, 51). However, the importance of culturally-appropriate mental health services, particularly in Africa, is often unrecognised (29). In addition, there is a dearth of research on the intersection between faith and health-seeking behaviour



**Figure 1 Showing the limited mental health services in selected African countries compared to global countries with a similar average**

Note: Related colours show similar reported mental health system magnitude (availability of mental health professionals and biomedical facilities), estimated here as number of psychiatrists and psychologists per population Sources: (52-71).

In Africa, some vulnerable and marginalised populations who suffer with mental illness “do not have access to affordable mental health services” (72) (Figure 1). Faith-based health providers are prevalent in Africa, and often fill health service-delivery gaps (73), providing services that embrace local cultural beliefs, and maintain trust with local communities (29, 74). These faith-based entities are therefore potentially well-positioned to fill an important mental health service gap, that is also culturally and contextually appropriate (11). It has been suggested that, “faith-based mental healthcare is an important but informal component of the mental health

system in much of Africa” (73). However, at present, the evidence-base for faith-based mental healthcare is weak. There is therefore a question as to whether FBHPs do or can contribute to mental health service delivery in Africa, and if so, to what extent (74).

### **Literature review**

A scoping review was conducted across databases (EBSCOhost, Google Scholar, Scopus and PubMed), using search terms relating to ‘faith-based mental health provision’ on a global scale, in order to establish “*What is known about the types of faith-based mental health provision globally and particularly in Africa, and the challenges facing them?*” (see Methods below).

The focus on ‘types’ was necessary considering the diversity and complexity of this terrain. There are already a variety of typologies relating to ‘faith entities’ (discussed more below). For example, FBHPs can be individuals or organisations which/who provide biomedical or alternative mental health services at different levels of the health system (community and facility level) (75). Authors have highlighted the challenges of overly simplistic definitions of this complex array of entities (76-78). Therefore, this scoping review provided some foundational framing of FBHPs and the services they provide at a facility and community level of the health system (See Box 1).

For this study, we utilise the term ‘faith-based health provider’ as the generic term inclusive of all types of faith-inspired entities, including: faith-based/religious/faith-inspired organisations, religious leaders, faith-healers, traditional healers, herbalists, mission hospitals, faith-based psychiatric care and chaplains (see Box 1&2). The scoping review, reported next, discusses these, and the broader territory of issues relating to them in the global literature.

#### *The relationship between religion (religious practices) and mental health services*

‘Religiosity’ is defined as an “organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent” (81). Religion has been identified both a benefit a detriment to individuals experiencing mental health issues (82). There is an example which explains that individuals have a tendency to have an over dependence on religion when dealing with their mental illnesses (83). Those experiencing mental health issues might face forms of disapproval or being exposed to harmful practices based on their religious community and culture (84). A particular study has shown that when faith leaders and healers ‘pray away’ mental illness, sometimes the underlying condition is not dealt with (85). For example, in Ghana, prayer camps run by a Prophet or Prophetess were shown to have negative effects on participants’ mental health (16, 85-87). Other more extreme ‘religious perils’ (human rights abuses) facing those with mental health challenges that are reported in the literature include beatings, incarceration, chaining and over-long fasting periods often encouraged by traditional practitioners, faith healers and other religious leaders (86, 88). Other studies have suggested ethical failures and as a result, human rights violations occur (86-88).

In contrast, the positive or beneficial effects of religiosity on mental health are widely acknowledged. For example, religious institutions act as a supportive mechanism for those suffering with depression, where increased rates of church attendance correlated with decreased anxiety and depression (89). Religious services can provide emotional support, build morale, and provide health information for individuals suffering with mental illness through church programs as an example (90). For example, confession can give patients an opportunity to share their experiences and receive counselling from someone they trust (79). Other mental health ‘services’ common in religious settings are prayer, meditation, congregation practices, linking scriptures to make sense of modern events, dance, and other ritual and worship activities (91, 92). Spiritual therapy or

spiritual care is a form of counselling, common across traditional-and faith healers, as well as clergy which can take on various forms such as exorcism to help the mentally ill (79, 93) – although this can certainly have negative effects (see below) (16, 91, 94, 95). In Islamic counselling, Islamic teachings are integrated into therapy processes (96, 97). There is also a broad literature that indicates that religious practices (local cultures and traditions) provide substantial coping mechanisms for those who are mentally ill (98).

### Box 2 Typology of faith-based health providers developed as a result of this scoping review

**Faith-based organisations:** organisations whose values are inspired by beliefs or faith, which are mission centric founded on social ideologies and services stemmed from a specific faith group.

**Religious leaders:** leaders from religious entities/ groups which provide spiritual care. Examples are clergy and imams.

**Faith-healers:** individuals who get guidance from God. Examples of faith healing include; utilising prayers, divination or rituals.

**Traditional healers:** individuals who get guidance through ancestral spirits. In some cases; they utilise traditional medicine and other rituals.

**Herbalists:** are practitioners of herbal medicine who try to locate the root reason of an illness. They also recommend treatment based on a consultation with patient founded on ailments and symptoms.

**Mission hospitals:** A hospital that is based on faith/ religion and provides health services to its region. Mental health services are provided as part of their standard mental health services.

**Faith-based psychiatric care:** Mental health services hospitals based inspired by faith.

**Chaplains:** A chaplain provides emotional and spiritual support to patients and hospital staff. They give support during crises and among ongoing recovery as well as support for bereavement.

Source: Author (76, 78-80).

The above addresses the potential positive and negative correlations of religiosity on mental health in the broadest of terms. This is obviously also an area of great sensitivity – both in relation to religion and mental health, and the blurred points of view between them.

Despite the possibility that some religious practices may be harmful to those with mental illness, the high levels of religiosity in Africa suggest that the role of FBHPs in service provision is a worthwhile area of research. For example, the rapidly growing Charismatic and Pentecostal forms of Christianity in Africa emphasise prophecies, healing and miracles (99). Traditional African beliefs, practices and forms of healing focus on ancestral spirits, herbal medicine, prayers, fasting and other rituals, and presently remain prominent (1). The mainstream types of religious practice continue alongside these modern institutions – and are often blended with traditional and cultural views in pluralistic ways. This is evident, for example, in pluralistic health-seeking behaviours where religious and cultural norms, rituals, and ideologies are merged (100). For example, African churches and Christian rituals can incorporate traditional treatments (101), such as in South Africa where religious-healing is practiced within some Zionist and Apostolic churches (99). This is shown especially when there are cases of utilising “baptism, prayer, holy water and the laying of hands and spirit exorcism types of services” (99). Another example a merger between Western and tradition religions is in Ghana where, “the churches that undertake faith healing typically belong to the neo-prophetic or charismatic tradition, which espouses a somewhat syncretic doctrine of Christianity” (102). It can also be argued that the Islamic church in Ghana has blended elements of Ghanaian indigenous ideas as well as practices. The merging of traditional beliefs together with religious practices can also be seen in the use of herbal medicine. In some contexts, herbalists have acquired a ‘sacramental value’ in some religious spaces such as in African Independent Churches, where rituals include therapeutic substances infused with spiritual power for healing.

The above has focused on the benefits and perils of religiosity on *individual* mental health (103) – however there is also great potential with regards to faith-based institutional<sup>2</sup> engagement with mental health which similarly has both positive or negative health effects (16, 92). For example, some religious leaders may be well-equipped to deal routinely with mental health issues in their ‘congregations’, providing emotional support and care at an individual and ‘institutional’ level (as a type of routine service). Of course, others may be poorly equipped, and might provide misleading information or impart detrimental religious views within their communities and congregations that have a negative effect on mental health (92, 103). More broadly, religious interpretations may work in support of, or against biomedical mental health services and systems, and ideological clashes are not infrequent within this terrain (104). In the literature, the most commonly discussed ideological clash is between biomedical (science-based) and the area of religious diagnoses as well as treatment of mental health issues (105). For example, there are circumstances where religious leaders either portray or diagnose schizophrenia as a punishment from god or the possession of evil spirits (106, 107), whereas biomedical practitioners may diagnose a certain mental illness as being the result of a scientific chemical imbalance of the brain.

This is only a small indication of how complex the relationship between ‘religion’ and mental health. In the African context, with pluralistic health systems and multiple traditions and ideologies, the connection between religion and mental health is particularly complex. Nonetheless, given the general trend of high religiosity plus (biomedical) mental health service gap in the African context, this is an important area of research. Related to this are calls for ‘frameworks’ that help to make sense of the complex relationship between religion and mental illness (82, 98, 106, 108-110).

Author, year and country	Type of Study & Thematic area (Typology of providers and mental health services)	Reviewed assessment (Summary and critical appraisal)
Ae-Ngibise (2010). Ghana	Qualitative Faith-based (alternative)-alternative providers in informal health services (faith and traditional healers)	There is currently 1 traditional healer for every 200 in Ghana. Traditional and faith healers are vastly used and see most of the mental health patients. Faith and traditional healers have a community and underpinning cultural understanding of mental illness. It is evident that the mental health systems of traditional and faith healers are fundamentally “embedded within greater belief systems with overpowering dominant constructions” of health and illness. They provide psychosocial support with a spiritual understanding such as counselling methods. Traditional and faith healers are also more affordable and accessible. For some the widespread use is because of religious beliefs. Religious perils exist. Many countries like Ghana have a paucity of mental health staff and medications making traditional and faith-healers a better option for MHS.
Asamoah, Osafo & Agyapong (2014). Ghana	Qualitative Faith-based (alternative) providers (Clergy) Faith-based (biomedical) types in informal health services.	An example of a Christian phenomenon which utilises the potential role of clergy in mental health is Pentecostalism which started about 20 years ago. The clergy probe into both the physical and spiritual causes of mental illness but are more inclined towards the spiritual. There is a misconception about exorcism, this can include the removal of spiritual agents through religious practices and rituals like prayer and fasting. These clergy also offer social support in the form of financial services, counselling services and visit the hospitals of the patients to provide alternative services in formal health systems. The counselling services were not professional and were based on more of an advisory role on religious practices such as; trusting in God. Community mental health education is provided by the clergy on church sites. Issues arise because there are a lack of pastors and a lack of funds to provide the patients with. Most of these clergy lack formal training to provide these MHS. Religious perils exist in prayer camps and prayer forests where the clergy have been known to abuse their patients.
Aja (2019). Nigeria	Qualitative Faith-based biomedical types provided by Chaplains	Biomedical types of providers; emotional and spiritual support. Effective spiritual care in Africa needs to have cultural underpinnings and which explicates concern for the family, health and overall well-being of the patient.
Iheanacho (2021). Ghana.	Mixed methods Clergy (Individual providers- alternative mental health services)	Counselling was the type of mental health service mentioned. Clergy were contacted as spiritual counsellors which were helpful in the churches and faith communities. Examples of this is counselling were both 'biomedical types', however were more towards alternative types such with folk magic (evil spirits and charms). Examples in this study were shown when perinatal women were open to counselling and therapy from trained clergy.

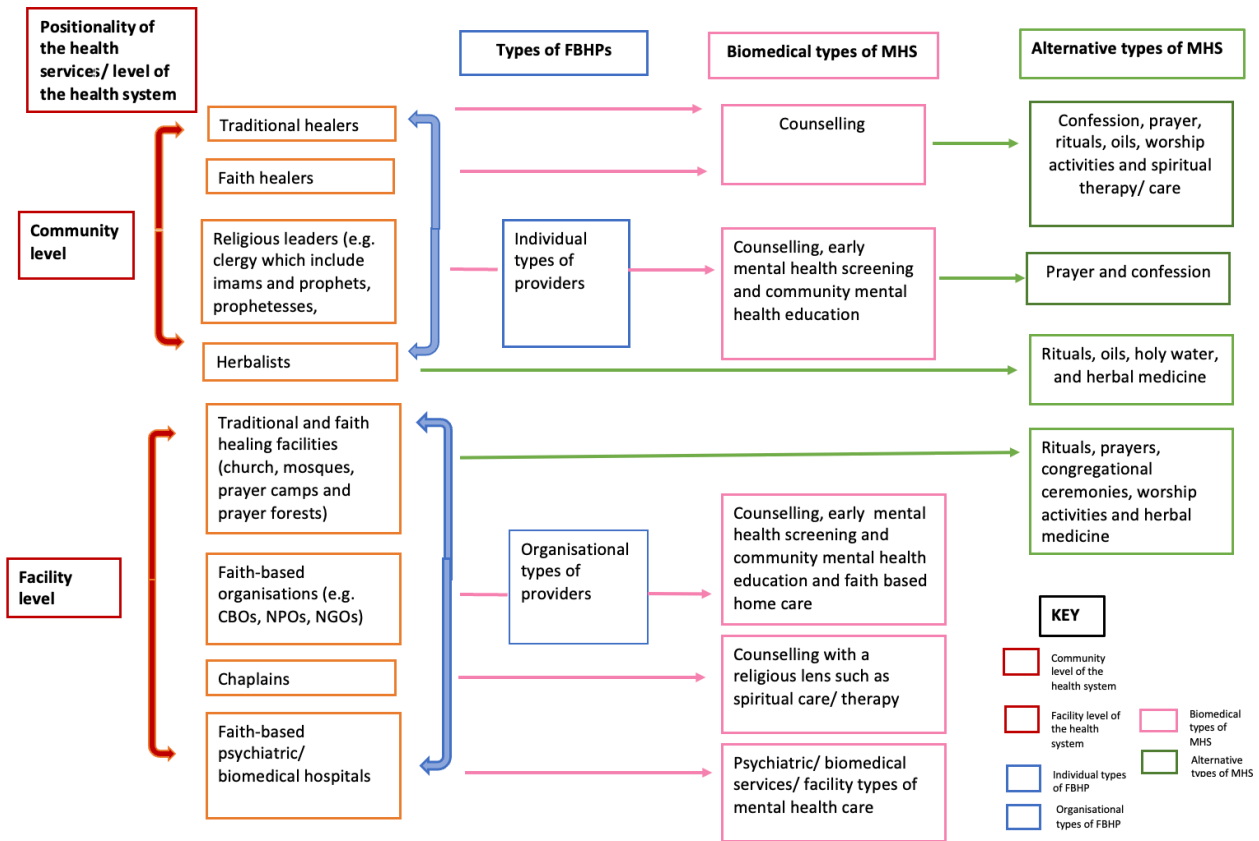
<sup>2</sup> Note that we classify religious leaders as ‘institutions’ according to the types presented below

		The clergy (faith leaders) who were trained for counselling were at 92.9%, whereas the traditional healers who were trained were only at 10.7%. (Increases quality of the MHS). Further, there is a need for training of clergy to be culturally sensitive due to cultural embedded issues which arise and to understand cultural appropriation types of MHS.
Selamu (2015). <b>Ethiopia</b>	Individual and organisational providers: Herbalists, traditional and faith-based practitioners, organisations, churches and mosques.	Alternative types of mental health services; Holy water is usually utilised as a first point of call when a family member has a mental health condition. There are groups called Tsewa which are usually owned by community members and “have an Orthodox Christian lens; activities include group prayer, singing and meals.” There are orthodox Christian Churches in each sub-district as well as mosques and protestant churches. Each church has minimum one priest and one imam.
Ofori-Atta (2018). <b>Ghana.</b>	Qualitative Faith-based (non-biomedical) providers	Prayer camps were set up across Ghana. Each of the camps were run by a prophet or prophetess. They served as a coordinator of all the healing and responsible for assessing faith-based issues and treatment, some in the form of religious perils such as fasting.
Osafo (2015). <b>Ghana.</b>	Qualitative- Phenological study Faith-based (non-biomedical) providers	“These clergy view mental illness as a spiritual issue rather than a biomedical type of issue. The treatment they recommend for mental illness are under two types of methods”; the hope induction approach and prophetic deliverance approach.
Musyimi (2018). <b>Kenya.</b>	Qualitative Traditional health practitioners (Individual providers, community level)	The mental health services provided mainly included counseling to treat depression. Further, prayer was discussed as a type of faith-based MHS where prayer was mentioned as the main solution but not the only treatment for mental illness in Kenya. Mental health services types include; counselling used to treat depression which involves
Salifu Yendork (2016). <b>Ghana.</b>	Qualitative Churches (Organisational providers-alternative mental health services)	Alternative types of mental health services; Congregants mention main aims of their community mental health education interventions are related to caring for the mentally ill and lowering stigma around mental illness. There were also healing schools which used bible teachings for the mentally ill. It has been found that some of these teaching can induce envy and demonic possessions. Churches believed that spiritual methods and the potential of the church to deliver spiritual solutions for the mentally ill. Congregants believed they could cure the mentally ill and use the power of prayer to create a permanent cure.
Ndetei (2013). <b>Kenya</b>	Quantitative Faith-based (non-biomedical and biomedical) providers in informal health services (Traditional healers)	Traditional healers were able to identify the type of mental illness of the patient and provide various types of MHS. These MHS types included; counselling, herbal medicine, home-based traditional care and herbal medicine combined with counselling. It was shown that 95.1% of the patients were satisfied with the traditional mental health service received in this study.

**Table 1 Author’s ‘top 10’ studies found on the types of FBHPs delivering mental health services in Africa**

Source: Adaptation from (11, 13, 15, 16, 85, 111-114).

Acknowledging the complexity of this terrain, Figure 2 presents some of the main categories of FBHPs mental health services, as described in the literature. However, it should be noted that to some extent the complexity of pluralistic health systems defies categorisation, so this is offered as a heuristic device rather than a theoretical framework.



**Figure 2** Merging of types of FBHPs and the type of mental health services they provide

Source: author adaptation from (14, 16, 53, 79, 115-122)].

*Descriptions of dominant types of FBHPs in Africa and their known contributions to mental health services*

In this section we briefly summarise five common types of FBHPs (found globally, and particularly in Africa) to demonstrate the variety engaged in mental health service provision, but also to demonstrate organising categories (see Appendix 1). Categorisation organises items by the positionality of the mental health service in the health system (which can occur at a community and facility level), then by the types of FBHPs (which can be individual or organisational providers). The five common types include: herbalists, clergy, traditional- and faith-healers, chaplains, faith-based biomedical health providers.<sup>3</sup>

*Herbalists*

Herbalists have been shown to provide herbal medicines, which are context-specific. There are multiple examples of herbal medicine used for mental illness in China and India (123, 124). In India, Ayurveda is commonly used as an alternative to biomedicine as a form of treatment for mental illness and has been fully integrated into health systems nationwide (124). In Africa, there are a variety of traditional and herbal

<sup>3</sup> There are obviously multiple other types – which we do address below, but we present these as five common categories which appear more frequently in the available literature

medicines which are largely unregulated, lack standardisation, and are under-researched (125). Herbal medicines can have negative side effects when treating mental disorders (131). However, others have argued that it can also have positive effects in some cases for mental health with less long-term side effects than biomedical options (132). Therefore, there is a need for further research on herbal medicine and its application for mental health in Africa (18).

#### *Clergy (Christian and Islamic)*

In the available literature, 'clergy' (of any religious tradition) engage with formal and informal, biomedical and alternative forms of mental health services. Formalised biomedical services are more closely categorised to include mental health screening, counselling services, community mental health education and faith-based-home care which involves clergy (16, 94, 95, 126, 127). Clergy are engaged in providing such services 'close to community' often leveraging longstanding relationships – and it is noted in the literature that being at the front-line allows them to intervene during the first signs of mental distress (11, 94). Improved early-stage screening can help to prevent serious mental illness. Clergy have also been known to provide additional support in the form of financial services and visiting patients within formal biomedical facilities, as well as providing community mental health education at churches. However, lack of funding is a frequently mentioned barrier, as is the lack of formal training (16). It is noted that in Africa, there is great variation in clergy's training to provide mental health services (95). For example, a study conducted in Benin City in Nigeria, showed that 32% of 101 clergy were well-equipped to provide mental health services, 23% were prepared to provide mental health services alongside trained professionals, and 62% were (untrained, but) willing to receive training to help severe mental illness cases (95). In other accounts, it has been shown that clergy do not have sufficient formal training, experience or qualifications to conduct formal mental health counselling on more severe mental illnesses among Latino communities and African Americans globally (79, 128).

#### *Traditional- and faith-healers*

Traditional- and faith-healers provide alternative forms of mental health services, including divination, acting as conduits of Gods, rituals and exorcisms, prayers, spiritual care, herbal medicine, and traditional medicine (102, 129). Traditional- and faith-healers are still widely used by mental health patients especially in African countries, and apply cultural understandings to treat mental illness as well as psychosocial support through counselling (11). They are understood to look at some of the causes of mental illness from a wholistic perspective, providing varying explanations, from alcohol, stress and substance use, anxiety, genetic as well as ancestral spirits, demons and witchcrafts (130, 131). The mental health services offered by traditional- and faith-healers takes various forms including prayer as spiritual therapy, religious services in traditional and faith-healing facilities such as prayer camps, and offering herbal medicine (86). Traditional healers have been known to offer forms of home-based care (111). There are some studies which indicate high levels of satisfaction with traditional- and faith healing experiences in Africa, for example, a study of 305 patients in Kenya, showed 95.1% of patients being satisfied with the quality of mental health services they received (94)

#### *Faith-based organisations*

It is acknowledged that 'FBOs', which are usually community- or non-governmental organisations, are well-positioned to contribute towards mental health services, often providing home-based care, or supporting referral pathways towards biomedical types of mental health services (79, 117, 132). Community-based mental health education (a more biomedical type of mental health service) is commonly provided by faith-

based organisations (FBOs) within hard-to-reach areas globally, including in Africa (117, 133, 134). Faith-based organisations function in a variety of settings offering mental health services, including: mental health education and literacy, mental health training of FBHPs, and encouraging help-seeking behaviour (117, 133, 134). They are known to often offer mental health education to support individual coping – usually through culturally tailored mental health workshops (79, 127, 133, 135-137). For example, a Muslim Food Bank and Community services charity, operating in Canada, implements a multi-level outreach intervention educating children and inmates on addiction and mental health issues in schools, mosques and prisons (119).<sup>4</sup>

Faith-based organisations also provide home-based care – and related supportive activities such as grocery shopping, house cleaning and help with daily activities (79). However, while the extent of home-based care provided by African FBOs in relation to HIV/AIDS (for example) has been evidenced, the magnitude of FBO provision of home-based care relating to mental health is less evidenced (150). It has been suggested that in contexts where mental health stigma is higher, there might be resultant hesitancy to seek or accept home-based mental health services (151) – although this needs to be explored further (138).

There are programs provided by FBOs which are implemented with an aim to address mental health stigma and have been delivered within populations with low mental health literacy rates such as in American Latina communities (77, 136). In USA-Latina communities, programs reach stigmatised populations where there are lower rates of mental health literacy (77, 136). In the literature, it has been suggested that there is a need for mental health training among FBOs (135), although how much, where, or what type of training remains unclear. It has also been noted that there is a need for research exploring referral systems that include FBOs – which might enable mentally ill individuals to access services more easily and more consistently (79). There are however examples also where education workshops can improve this low mental health literacy also and thereby, mental health help seeking behaviour as shown in USA-Latina communities (123, 148, 149).

### *Chaplains*

Chaplains usually operate within biomedical facilities, and are more commonly found in high-income settings, providing counselling and support in sync with biomedical services (115, 121, 139, 140). Swinton (141), argued that chaplains have “an important role to play in mental health care and are in a perfect position to make a major contribution to the process of care and assessment” (p. 154). Chaplains provide religious and spiritual advice, and pastoral counselling for the mentally ill who seek biomedical mental health services (137). The Mental Health Foundation in the UK, noted that the Chaplains’ experiences of “...working with service users from a variety of faiths represents an important resource that should be drawn upon” (142). Chaplains have been integrated into the NHS for decades, and are thought to be uniquely situated to provide a religious and spiritual dimension complementing biomedical mental health services (115, 143). Patients who seek such services are usually given the option of additional alternative services offered by the chaplains (121, 139, 140). Some studies indicate that chaplains usually offer empathetic listening and affirmative therapy (focused on hope and forgiveness), which are identified based on individuals’ faith and cultural belief systems (115, 121, 140). They can also play a vital role in the referral mechanisms of mental health systems, provide mental health education, and offer alternative mental health services through rituals and faith-based funerals (121). For example, chaplains have been known to create internal referral systems to other faith leaders and community

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<sup>4</sup> These studies above especially the one which included Islamic counselling, also discussed how the FBOs went beyond community mental health education and provided services such as extracurricular activities and social support for children of refugees and immigrant communities in Canada

support services (92). However, there are some considerations that are consistently raised, such as conflict with patient families (who do not want chaplaincy services), and therefore also informed consent (137).

*Faith-based (biomedical mental) health providers*

There are also biomedical facilities providing mental health services at some levels of the mental health system, which are nominally faith-based in ownership; for example, mission hospitals or faith-based psychiatric facilities (53, 144-147). There is limited evidence on the magnitude and quality of this type of FBHP – although they are present in many contexts throughout the world, and there is some suggestion that they are more accessible to hard-to-reach populations because of their existing networks and community connections (144, 145). There is also little evidence on comparative variations in quality or type of service provided within these facilities, although it has been suggested that as a result of patient utilisation of religious- and spiritual- and other culturally appropriate components to the service, patients are known to have a longer duration of stay at faith-based biomedical facilities (144, 145).

An example of an FBO called the Shifa Project that started as program which then led to a psychiatric hospital was founded in 2014, which provides evaluation and treatment of patients with mental disorders through pharmacotherapy and electroconvulsive therapy (146). As noted above, faith-based facilities such as this tend to have networks of linked services and activities (offered through linked clergy, congregations or FBOs). For example, the Lutheran faith-based hospital in Betul Madha Pradesh also has a community mental health education and outreach program, Project Shifa (146).

In Africa, there is not significant evidence of this kind of FBHP providing biomedical mental health services. It is anecdotally noted that they do exist – and it has been suggested that they are sometimes the only mental health service providers in their area (given the common limitations of the public mental health systems) (148, 149). However, empirical evidence on the magnitude, quality and reach of these is extremely limited. One example is, the Lutindi Hospital in Tanzania (Lutheran owned by the Church of Tanzania), that primarily functions as a rehabilitation centre as well as assisting those with severe cases of mental illness (53). Other examples include the mental health specializing Lutindi Mental Hospital (120 beds available) in Kenya, and Muhimbili National Hospital (54 available beds) in Tanzania (116). Other examples in East Africa include the Ruharo Mission Hospital in Uganda where, private-public partnerships have been established in order to improve mental health outcomes (147). There are some small bits of evidence on service differences, especially in relation to human resources - for example, in Uganda, nurses in these FBHP facilities supported the incorporation of religious beliefs and culturally-appropriate methods for the treatment of mental health (144). In Brazil, there is an example of psychiatric hospitals that offer fluidotherapy (laying on of hands and magnetised waters) as well as dispossession (spirit release therapy) – offering further evidence of the usefulness of pluralistic treatment (150). In contrast, however, in a study at a multicentre within a hospital in the United States said that 30% of the respondents indicated they did not receive adequate spiritual treatment (151). Generally, more research is required to understand how these types of FBHPs function, and how they integrate spiritual and religious beliefs into mental health services (151).

All of these five common types of FBHP, are thought to potentially provide valuable mental health services in their contexts, but these contributions are rarely evidenced. There is an urgent need to conduct deeper research into the contributions of FBHPs to mental health services and systems, the magnitude of that contribution, as well as the potential outcome on the overall quality of mental health services provided. This

is particularly relevant in the increasingly religious African context, where there is also a focus on integration of FBHPs into the health system at individual, community and organisational-levels.

Therefore, the research question for the systematic review component will be as follows: *What is known about the magnitude, types and quality of faith-based mental health provision in Africa?*

## **Methodology**

We will answer the above research question through a *mixed-methods systematic review* study with two phases – an initial scoping review, followed by a systematic review.

Mixed-methods research cohesively ties together qualitative and quantitative research techniques, concepts and approaches into a single study (152). Systematic reviews are a type of review study that typically involves rigorous and transparent review of the literature on a particular topic and have become an imperative part of the move towards evidence-informed policy and practice (EIPP). Systematic review are known to provide policymakers and practitioners with a rigorous and transparent process to synthesize large amounts of research literature, minimise the overreliance on single studies as well as highlight opposing findings from various studies (153).

This exploratory systematic review will involve a multistage critical appraisal process using a mixed-methods tool, and predominantly qualitative data analysis (154). Further, all data collection, appraisal, and analysis processes will be fully described to ensure methodological (154, 155). This systematic review will be primarily narrative in nature, developing themes through thematic analysis across the qualitative data gathered (154, 156). Narrative review is appropriate for this study because it accommodates the sensitivities and complexities inherent in studying faith-based provision of mental health services. There will be a smaller quantitative component which conducts secondary analysis on the quantitative data relating to magnitude (number of facilities, programs, number of FBHPs and utilisation as frequency of use) of FBHPs mental health services across Africa. Magnitude will also be conceptualised as availability (accessibility, affordability and acceptability).

We will attempt to extract assessments of service quality (although we expect these to be limited), primarily based on whether the mental health service improved mental health outcomes of the respondents. Further, it will be discussed what ‘religious perils’ existed (as human rights issues) – tracing mention of actions such as beatings or chaining, which might have a negative effect on mental health outcomes.

### *Phase 1 scoping review*

A scoping review was conducted (reported above), focusing on the question of what types of non-state, FBHPs contribute to mental health services globally, with a focus on Africa in particular. The scoping review sought to rapidly establish key concepts, as well as the sources and forms of evidence available on this topic (157). The rapid scoping review method was informed by Tricco, Thomas (158) “which recommends the following steps: 1) identifying the research question, 2) identifying relevant studies, 3) selecting studies, 4) charting the data, and 5) synthesizing and reporting the results” (158).

The scoping review focused on the *types* of FBHPs delivering mental health services globally and in Africa. Data was extracted on the type of FBHP, the ‘location-level’ of the mental health service (individual, community or organisational level), as well as the types of services provided (biomedical and non-biomedical/alternative frames). There were several complexities that arose in the process of categorisation, as many types resisted categorisation, and there are multiple plural types. For example, faith and traditional healers can provide

biomedical services within informal health systems; or faith-based biomedical providers such as chaplains providing 'alternative' types of services within the 'formal' health system. Therefore, the scoping review required to a multi-dimensional categorisation (described above).

Since there are different types of FBHPs, the search strategy for the scoping review included a wide array of search terms:

Main term	Variation
Faith-based health providers	'Clergy', 'Imams', 'Chaplains', 'faith-based', 'faith healers', 'faith leaders', 'religious leaders', 'faith based organisations', 'mission hospitals', 'religion', 'faith-based biomedical care', 'faith-based psychiatric care'
Mental Health	'Mental Health', 'Mental Illness', 'Quality of Life', 'Psychosocial support', 'emotional support', 'social support', 'mental health education', 'screening', 'counselling', 'mental health home-based care'

**Table 2 The main terms and variations used for the scoping review phase**

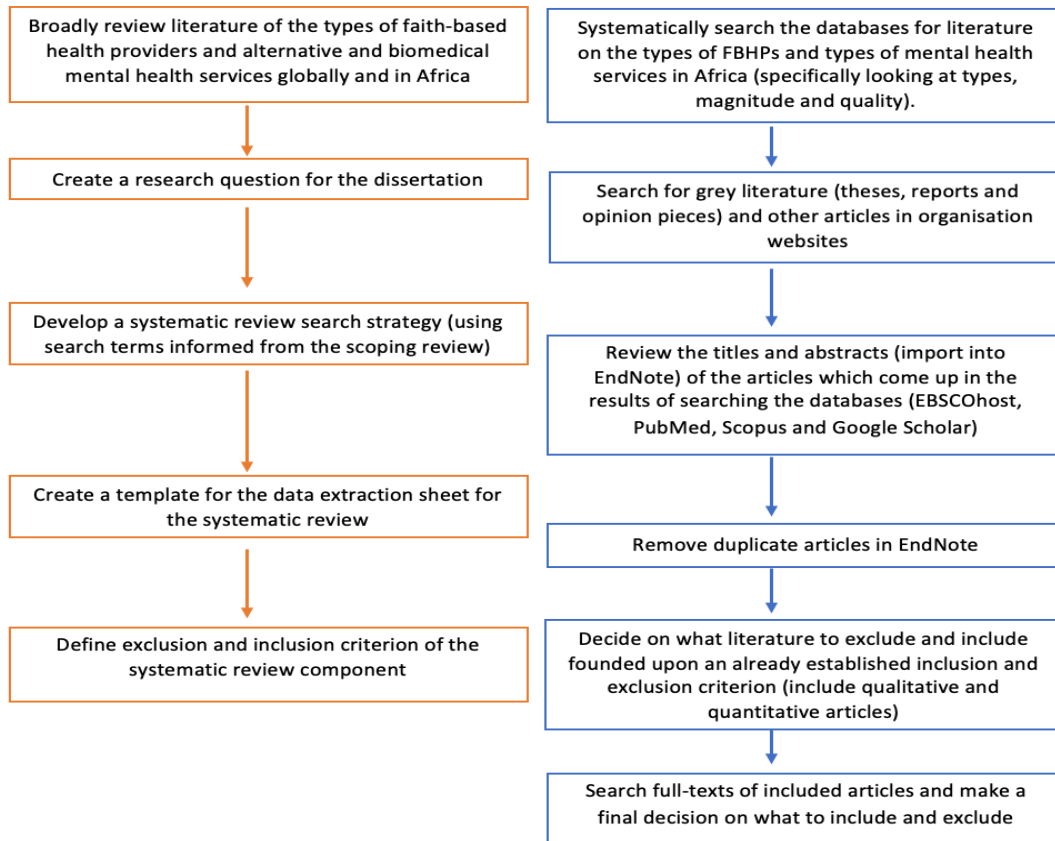
The scoping review included peer-reviewed and grey literature. Variations on these terms were inputted into several databases, namely: Google Scholar, PubMed, Scopus, and EBSCOhost: Medline, CINAHL, Africa-wide, Atla (religion) and PsycArticles, PsycInfo. Further institutional databases were also searched. Studies from 2007-2020 were included and all in the English language. A deliberate decision was made not to only focus on traditional medicine, but to be inclusive of the more diverse (and 'not so clear') array of mental health services provided by diverse FBHPs. The review was global, without geographic limits, but specific queries were run using African country names to ensure that relevant literature for Africa was identified. After the initial search, reference lists of included material were scanned, and further relevant items included.

### *Phase 2 Systematic review*

The systematic review phase will apply a set search strategy informed from the scoping review and will include a full search performed electronically through databases to screen and collect both quantitative and qualitative peer-reviewed items relating to the magnitude, type and quality of the mental health service that FBHPs are delivering in Africa. This systematic review approach is a commonly utilised method to searching, interpreting, and conducting a synthesis of literature, where each step is recorded so that it can be replicated (154, 159). Aromataris and Riitano (160) state that "A hallmark of a systematic review is its reproducibility; another researcher should be able to review the same question and arrive at the same results," (161). As noted above, the review is mainly a qualitative thematic analysis, but an additional quantitative data analysis will be conducted to assess the magnitude (as utilisation, number of beds, number of facilities available, whether faith-based mental health services are available (accessible, affordable, and acceptable) of FBHPs mental health services across Africa, as far as possible given the varied, non-comparative forms of quantitative evidence.

The thematic analysis of the systematic review will synthesise the evidence in a data extraction sheet in order to answer the three components of the research question (154). The data extraction sheet will be developed based on the categories established in phase 1 (see Appendix 1) (162). This sheet will be further tested prior to full use, and the changes will be fully reported (162).

This mixed methods systematic review includes quantitative methods (the collection of numerical data and the use statistical methods to analyse the data) and qualitative methods (the collection and analysis of qualitative data (including peoples experiences and perspectives) to establish what is known about the types, magnitude and quality of mental health service delivered by FBHPs (163).

**Figure 2 Summary of the key methods for the scoping review and systematic review study (two phases)**

An imperative part of this review will be data synthesis – where data and findings are extracted and integrated to answer the research question. Synthesis is known as, “the process or result of building up separate elements, especially ideas, into a connected whole, especially a theory or system,” (153). In systematic reviews, data synthesis involves the construction of various themes, concepts and ideas identified in the literature into a whole interconnected system or theory in a rigorous and transparent manner (153). This study presents a particular challenge with respect to evidence synthesis because of the limits of existing knowledge on the topic, the diverse types of data to be synthesised, and the variety and complexity of FBHPs providing the different types of mental health services.

This study includes a narrative thematic synthesis for the qualitative data in order to answer the various important parts of the research question, and meta-analyses for the quantitative component, which will supplement the qualitative analysis (164). The meta-analyses will measure the quantitative pertaining to types, magnitude and quality of faith-based mental health provision. In addition, the evidence and methods in the studies will be critically appraised using an appropriate mixed-methods tool.

#### Inclusion and exclusion criteria

The inclusion criteria stipulate which studies will be included in the review circumstantial to their linkage to the research question (162, 165). Given the limited information available on this topic, this systematic review will cast a wide net to identify as much relevant literature as possible. This broad inclusivity means that the relevance-checking and quality assessment steps are particularly important. Articles and reports will be included if they provide information on the quality, types and magnitude of FBHP providing mental health

services in any country in Africa. Evidence published between 2007 and 2020 will be included. Qualitative and quantitative studies will be included. “Peer-reviewed and grey literature will be included”, although the review focuses specifically on empirical research (peer reviewed articles, book chapters and reports showing evidence of internal review, and theses and commentaries will also be included) – see Table 7. Therefore, items will be sourced widely from PubMed, Scopus, EBSCOhost and Google Scholar, as well as key organisational websites and databases (such as the WHO database).

<b>Criteria</b>	<b>Justification</b>
Conducted between 2007-2020	Scoping review found most relevant and up to date information was to be found after 2007 (earlier studies give distorted estimates on magnitude)
Types, quality and magnitude of mental health services delivered by FBHPs	Types of MHS include for example are counselling, community mental education, early mental health screening, faith-based home care and alternative types (see Appendix 1)- Figure 1 for more details of types Magnitude will be assessed quantitatively (e.g., number of facilities, footprint, number of services, extent of utilisation). Magnitude will also be discussed in relation to availability (accessibility, affordability and acceptability). Quality will be assessed on standard quality measures (e.g., whether services improved mental health status).
Africa	Studies relating to FBHPs in Africa (empirical studies and grey literature)

**Table 7 Main inclusion and exclusion criterion**

#### *Search strategy*

The scoping review assisted in formulating the search terms that will be used for the systematic review (initial search term table in Appendix 3). It is imperative to make sure the databases and key words are carefully chosen so that all relevant evidence can be identified (166) and to limit databased bias (167). At the start of phase 2, the search terms will be further refined and the search strategy tested with the assistance of a Librarian from University of Cape Town (166). Multiple variations will be included, and clusters developed depending on particular database requirements (for example, utilising Boolean connectors). MeSH terms and key words which are shown in the Appendix section 2 below.

After the search strategy is tested and finalised, the following electronic databases will be searched: Google Scholar, Scopus, PubMed and EBSCOHost (Medline, Cinahl, Africa-wide, Atla (religion) and PsycArticles, PsycInfo). All search processes will be recorded to ensure a transparency and replicability (168). Search results will be collected in Endnote, and processes for screening, checking, and removal of duplicates ensured.

The search strategy will entail relevance checking, then a rapid full text review then a full review and checking of reference lists and decide on included studies. Then finalisation of included studies and then extract relevant data into a data extraction sheet based on types, magnitude and quality of faith-based mental health services and providers.

#### Data Extraction

The identified material will then undergo quality checks (see above). Next data will be extracted from the included material using the data extraction sheet. As noted earlier, the two data types (quantitative and qualitative) will undergo slightly different analytical approaches (see Figure 3), before synthesis occurs.

#### Rigor

All the processes of rigorous systematic review will be adhered to – with rigour achieved if these processes are followed in a thorough manner. These include inclusion/exclusion criteria, quality assessment of evidence,

appropriate search strategy, and the retrieval of the articles. Rigour will be ensured through triangulation between various forms of evidence (169). Multiple databases will be searched which use search terms (listed in Appendices) and then perform data collection and analyses processes. Additionally, the quantitative and qualitative analyses need to be conducted well and suited for the type of data retrieved through the study process. A data extraction sheet will be used in order to ensure transparency and replicability. A secondary reviewer will double review key items (the student's supervisor).

### Ethical Considerations

This is a no-risk study as it is a systematic review of publicly available resources, without any human involvement. For this reason, this review will not require a formal ethical clearance, but departmental approval will be sought prior to the review.

It is, however, acknowledged that this is a sensitive topic, that could raise some concerns or sensitivities. Reflective practice and journaling will ensure reflexivity, and care will be taken to ensure reviewer biases are not influential on the study process.

### Timeline

Date	Task
18 <sup>th</sup> January 2021	Draft 1 of protocol submitted
25 <sup>th</sup> March	Draft 2 of protocol submitted
31 <sup>st</sup> May	Draft 3 of protocol submitted
1 <sup>st</sup> June	Commenced systematic review (4 months)
August 3 <sup>rd</sup>	Submission of final protocol to supervisor
August 10 <sup>th</sup>	Make final edits and submit Protocol for Departmental approval
August 3 <sup>rd</sup>	Continue with Systematic Review
August 20 <sup>th</sup>	Intend to submit
October 10 <sup>th</sup>	Final submission

### Budget

This thesis was initially funded by a bursary award from the health policy and systems department in the Faculty of Public Health and Family medicine through the University of Cape Town. This mini-dissertation was also funded by the National Research Foundation (NRF). This research project is conducted in partial fulfilment of the Masters in Public Health degree at University of Cape Town. Since this is a desk-based review, there will be no direct costs linked to this research.

Item	Total Cost
Notebooks	R150
Pens	R100
Highlighters	R100
Printing	R1500
<b>Total</b>	<b>R1850</b>

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## Appendices

*Appendix 1 Tables on types of FBHPs and the types of faith-based mental health services they provide*

Individual types of FBHPs	Level of health system	Alternative type of mental health service	Definitions
Faith and traditional healers	Community level	Confession (counselling)	This is a type of MHS where patients provide their experiences and receive religious counselling from their traditional or faith healer.
		Prayer	A request for assistance and a form of gratitude to God or other deities.
		Meditation	An umbrella of self-regulation practices which zoom in on training attention and awareness to help get mental processes in control. Meditation fosters general mental health and creates clarity, calm and concentration.
Clergy	Community level	Church/ mosque services	This is a formal type of service of Christian/ Muslim or communal worship which commonly takes place in a mosque or church building.
		Spiritual therapy	This is a type of counselling which tries to treat an individual's body, mind and soul through utilising individual belief systems through faith-based higher power to discover parts of life conflicts.
Herbalists		Exorcism	The eviction or tried eviction of evil spirits derived from a place or person.
		Herbal medicine and fetish practices	Herbal medicine is used through rituals, oils and holy water to improve mental health. Other examples are the ingestion of herbs and washing yourself with herbs also.

**Figure 1 Types of FBHPs and types of faith-based alternative mental health services (definitions)**

Source: Villatoro, Dixon (79), (91, 92, 95, 96, 125, 170-175).

Individual & Organisational types of FBHPs	Level of the health system	Type of religious peril	Definition
Traditional healers	Community level	Beating	The physical beating of a patient when out of control in regards to their mental illness.
Faith healers		Chaining	Chaining a patient so they do not run away or harm themselves as well as others.
		Incarceration	Locking a patient up in isolation or in a cell when they are a harm to themselves or others.
		Long fasting periods	Forcing a patient to not eat for long periods of times in order to get rid of the evil spirits and as a form of sacrifice to God.
		Scarification	The physical burning of a patient resulting in scarring in order to control their mentally ill behaviour.

**Figure 2 Religious perils (those practices which imperil good mental health) at a community level of the health system**

Source: Scoping review. Author adaptation: Atindanbila and Thompson (88), (112).

Types of FBHPs		Types of faith-based biomedical mental health services	Definition
Clergy/Imams	Community level	Counselling	Provided by both Clergy/Imams and FBOs to give advice based on personal, job, relationship, financial and educational issues.
Faith-based organisations (FBOs)	Facility level	Community mental health education	Mental wellness workshops, mental health education to increase mental health literacy and reduce the risk of mental illness
		Early mental health screening	Early onset screening to mental illness at first interaction.

Religious/ faith leaders	faith	Community level	Faith-based home care	Church based programs which aim to cease drug use, help with groceries and daily activities, house cleaning and adherence to faith-based mental health treatment.
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**Figure 3 Types of FBHPs and types of faith-based biomedical types of mental health services at a community and facility level of the health system (definitions)**

Source: Scoping review. Author adaptation from: (16, 79, 94, 96, 126, 127, 176-178).

Organisational types of FBHPs	Level of the health system	Type of biomedical or alternative mental health service	Definition
Faith-based psychiatric or biomedical hospital/ mission hospitals Chaplains	Facility level	Faith-based biomedical care (biomedical)  Chaplaincy spiritual care (alternative lens)	These are faith-based or mission hospitals which provide your 'standard'/ biomedical types of mental health services. Examples are; pharmacotherapy and electroconvulsive therapy or occupational therapy activities.  Spiritual and religious expertise and pastoral counselling. Spiritual care based on faith and spirituality. Conducting spiritual assessment and education groups which utilise spiritual/ religious resources.  Counselling through empathic listening and affirmation practices. Other examples include; rituals and funerals.

**Figure 4 Types of faith-based biomedical services within facility levels of the health system**

Source: Scoping review. Author adaptation: (53, 115, 116, 136, 147, 179, 180).

*Appendix 2 Data Extraction Sheet Template*

- Country
- Name of Study
- Author
- Journal/Source
- Date (of publication)
- Type of study
- Types of FBHPs
  - alternative | biomedical
  - individual religion | mental health
- Individual vs organisational levels of services
  - clergy vs FBO
- Types of MHS (Quantitative or qualitative)
  - Biomedical types of MHS: Counselling, community mental health education, early mental health screening.
  - Alternative types of MHS: Herbal medicine, rituals, oils, prayers.
- Mental health training programs
- Quality of MHS: Did the faith-based mental health services improve mental health
- Types of religious perils
- Inclusion: Quality Assessment using the mixed-methods tool
- Exclusion: Reasons

*Appendix 3 Search terms at end of phase 1, to be developed further*

<b>Search terms</b>	<b>Variations</b>
<b>Mental health</b>	mental health OR mental illness OR mental disorder* OR psychological OR psychology OR psychiatry OR psychiatric OR psychotic OR psychosis OR psychotic disorders OR depression OR anxiety OR bipolar disorder OR schizophrenia OR post-traumatic stress disorder OR trauma OR quality of life OR emotional wellbeing/well being/well-being OR emotional regulation OR self-esteem OR self-perception OR behaviour OR behavioural disorders OR stress OR stress-related disorders OR cognit*
<b>Faith-based</b>	faith-based OR faith based OR relig* OR faith-inspired OR faith-based organi* OR chaplain OR cleric OR clergy OR congregation OR ministry OR Islamic OR Christian OR Pentecost* OR Catholic OR traditional healer OR traditional leader OR faith healer OR herbalist
<b>Health system</b>	non-governmental organi* OR non-state/non state actor OR non-state/non state provider OR hospital OR clinic OR health services

## Part B: Journal Article

### Types, magnitude and quality of faith-based mental health provision in Africa: A Mixed-Methods Systematic Review

Targeted Journal: *International Journal for Mental Health Systems (BioMed Central)*<sup>5</sup>

Nadine Nanji<sup>6</sup>

#### Abstract

**Background:** Mental illness is a highly prevalent issue in Africa, but is under-provisioned, with weak mental health systems and limited available services and anecdotally, it has been suggested that faith-based health providers can fill this gap. Limitations include that there is a dearth of evidence on the magnitude, type, or quality of FBHPs of mental health services and their contributions to broader mental health systems and policies.

**Methods:** A mixed-methods systematic review was conducted in two phases, starting with a scoping review, which informed a mixed methods systematic review to synthesise qualitative and quantitative data. The review sought evidence on faith-based health providers of mental health services in Africa looking at types, magnitude and quality, and included both peer reviewed and grey literature, published between 2007 and 2021, in English. A narrative thematic analysis was used for the qualitative part and meta-analyses was used for the quantitative part to back up the narrative element of this study.

**Results:** This review identified 53 relevant items relating to 13 African countries. The results showed that faith-based mental health providers deliver a range of six types of mental health services which include: alternative types such as prayer, rituals and herbal medicine, counselling, community mental health education, early mental health screening and faith-based home care and faith-based biomedical mental health services which are utilised in the included studies. The magnitude of these faith-based mental health services were proxied according to frequency of use and availability (accessibility, affordability and acceptability), however information was limited on all these aspects especially on the number of beds and facilities. When the quality of these mental health services was assessed, some studies showed positive mental health outcomes from the utilisation of faith-mental health care, but some studies warranted the utilisation of bad quality practices due to human rights abuses.

**Conclusion:** There are limitations regarding these vast array of faith-based health providers and the mental health services they provide which include the harmful practices used in Africa. Faith-based health providers of mental health services are thought to offer culturally appropriate services and are value driven. There were limitations in this study because of the limitation information available on magnitude, so it is recommended that more data on availability of beds and number of facilities is collected in the future. Furthermore, some faith-based provision of mental health services brings with it human rights abuses and better training is needed when dealing with severe mental illness. It also known that there are a lack of human resources in biomedical types of faith-based health provider

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<sup>5</sup> Journal style guide provided in Appendix 5

<sup>6</sup> For the purposes of thesis examination, the student is the first and sole author.

facilities and insufficient funding allocated for these services. Overall, there is also a need for better integration of faith-based health providers into African and LMIC mental health systems and policies.

**Key words:** Faith-based health providers, mental health services, mental health system, religion, Africa

## Background

Health systems contain both state and non-state providers of health services (1). The contribution of non-state providers to broader health systems is often neglected. However, some recent evidence acknowledges the vast range of formal and informal non-state providers and their contribution to universal health coverage (2). Non-state providers include “private for-profit organisations, not-for-profit organizations, pharmacies, civil society organisations, community-based organizations, and individual healthcare providers” (3). As a form of a NSP, faith-based health providers (FBHPs) assist in the delivery of health services and strengthening of health systems and towards achieving universal health coverage. However, their contributions in low- and middle-income countries (LMICs) have been questioned (4). There is a specific research gap pertaining to the magnitude of faith-based health services and providers in Africa (5). In addition, the limited available data in this arena indicates vast disparities and inaccuracies regarding the utilisation of faith-based health provision, and is highly contested (6). There is a necessity for research focusing on mental health services in Africa to fill this gap in the evidence as well as the non-communicable diseases are often neglected in research (7).

Globally, mental illness is thought to affect 7% of the population (8). In Africa, mental illness has been known to contribute to at least 10% of the overall disease burden (9). Accumulated data suggests that 70% of individuals in Africa do not have access to mental health care (Figure 1). Most African countries have less than one psychiatrist per 100,000 population, 16 of these countries have less than 5 psychiatrists per 100,000 population and less than 6 psychologists for their population (Refer to Figure 1). Further, 10 African countries have less than 10 outpatient facilities, and 27 countries have under 10 mental health hospitals (see Figure 1 for more). This clearly illustrates a gap in mental health service provision by biomedical medical practitioners (BMPs). Some literature suggests that, in Africa, FBHPs are often the first point of contact for the mentally ill seeking care (10, 11). However, there are currently no studies that we could find which look at the magnitude, types and quality of faith-based mental health services in Africa (or elsewhere), and therefore, this study will aim these components in relation to faith-based mental provision in Africa.

The Covid-19 pandemic has also created an urgency to address mental illness in Africa given their weak health systems especially among vulnerable and hard-to-reach communities. There is a need for more attention on mental health services to be scaled up so we can ensure equitable and better uptake of mental health services (11).

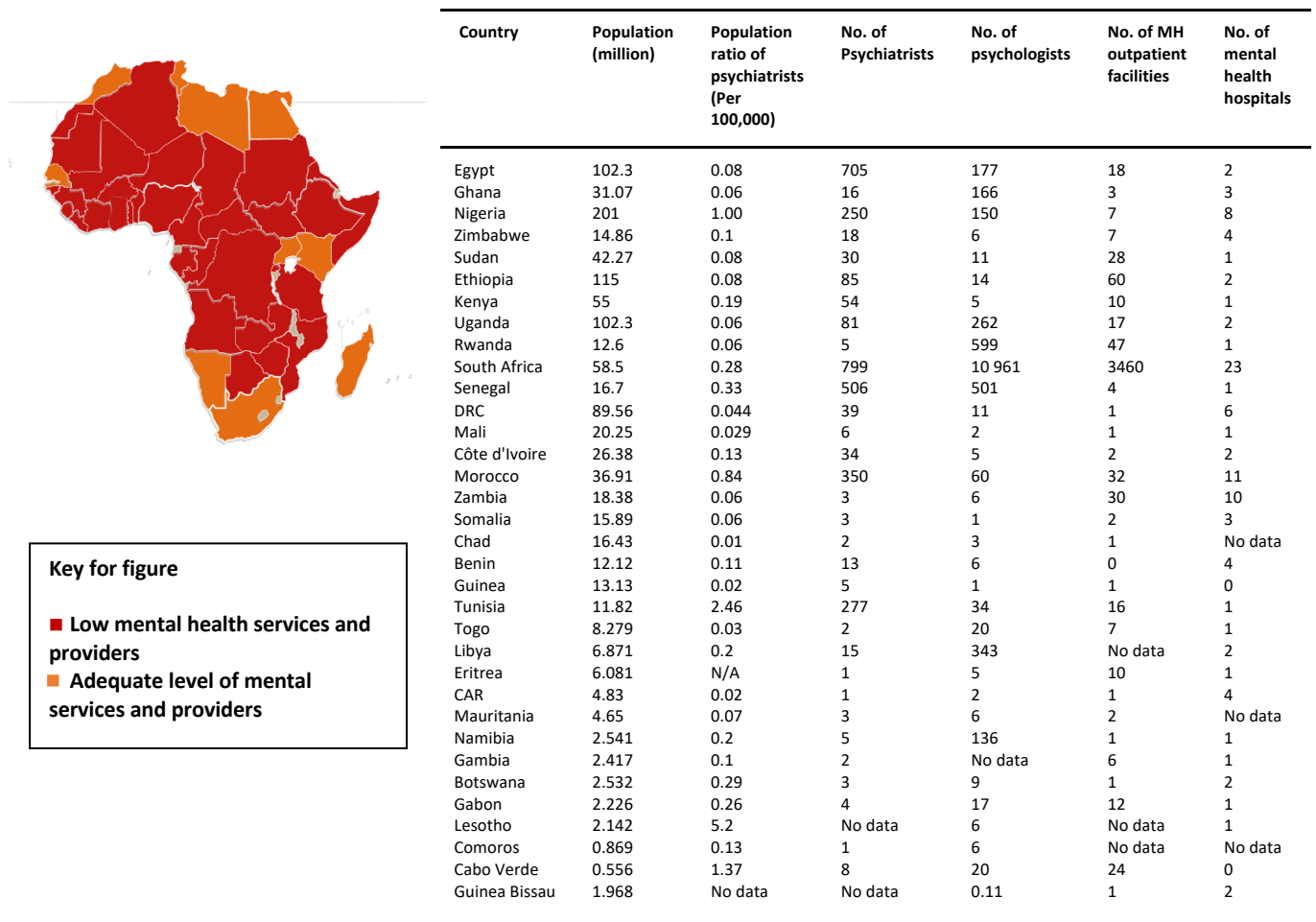
In Africa, faith-based mental health provision is commonly used in humanitarian and crises settings in the form of psychosocial support which is a foot in the door for the identification of faith but using a more inter-sectoral approach as described in the categorisation (12) However, the current framing has been shown to be secular and not integrative of the linkage to the religious experiences of the faith communities which has impacted the involvements of faith-based health providers and organisations expanding their footprint in such humanitarian and emergency settings (11)

African health systems have recently undergone health systems shocks and the lack of access to mental health services has heightened a focus on advancing mental health care using faith-based health providers and mutually integrative biomedical and alternative mental health services. Some of the resources which have assisted the mentally ill in attending religious and faith events as well as utilising prayers and reading scriptures (alternative MHS) (11).

In particular this study explored the vast array of 'biomedical and alternative mental health services' (including six types) provided by FBHPs in Africa. And then, this study will aimed explore and assess what is known about the 'magnitude' of faith-based provision of mental healthcare in Africa – with magnitude being inclusive of an array of related considerations such as 'footprint', the number of beds available, number of facilities, frequency of utilisation, availability (accessibility, affordability and acceptability). However, our initial scoping review indicated that there is little comprehensive information on magnitude available, especially on standard measures such as number of beds and number of facilities – so proxies and inferences may be necessary. Cultural- and social acceptability is considered to be a particularly important factor in mental health services, and there are suggestions that some FBHPs have particular cultural/social acceptability (13-19) In assessing the magnitude of faith-based provision of mental healthcare, it is important to recognise that the available data is rife with inaccuracies and discrepancies, with many reports indicating highly contested statistics (6). There is even less apparent data on the quality of FBHPs engaged in mental health service provision (20). In this study, quality will be considered in relation to standard reports of biomedical quality of care, and also in relation to reports of religiously-linked actions that might have a negative impact on individual mental health (more below).

Finally, this study sought to impose some organisation on the varied types of FBHPs present in Africa. In brief, we were inclusive of all types of FBHPs, including individuals and organisations, those providing alternative or biomedical care - which we have categorised into six types: traditional- and faith-healers, religious leaders (Christian and Muslim clergy such as Mallams as few examples), traditional healing facilities, faith-based organisations (FBOs), and faith-based biomedical health facilities such as hospitals and psychiatric facilities.

The systematic review study aimed to fill this research gap by exploring: *What is known about the types, magnitude and quality of faith-based mental health provision in Africa?*



**Figure 1** Map of Africa indicating (lack of) mental health services in relation to a population ratio [This was calculated through a search of various documents with the most up to date information specifically entailing statistics on low mental health provision in all African countries (Human resources and facilities)] (19-53).

## Methods

This mixed methods systematic review was conducted in two phases to explore the available literature pertaining to the types, magnitude, and quality of faith-based mental health provision in Africa (Figure 2). The first phase consisted of a scoping review (Phase 1) conducted prior to the systematic review to create the framing for this topic as well as validating search terms which cover the full spectrum of the types of FBHPs, and the types of MHSs they provide in the African context. The second phase was a systematic review which extracted data and conducted separate analysis depending on data type (thematic analysis on qualitative data, and meta-analysis on quantitative data) followed by data synthesis. Thus, the study was conducted iteratively, with search terms and categories established in Phase 1, and refined through a further checking process. This was deemed necessary given the exploratory purpose of this research, the diverse data types and sources included, and the fact that this is a new research terrain.

The rigour of the systematic review (Phase 2) was enhanced by minimising bias in the selection and analysis of documents, through the use of a quality appraisal tool for mixed methods studies, and a transparent methodological process (54). The inclusion criteria were as follows: empirical, peer-reviewed studies which includes information on FBHPs of MHSs in Africa and grey literature, as well as commentaries. This included

material relating to all types of faith-based MHSs (Biomedical or alternative), and a variety of FBHP – including faith healers, traditional healers, religious leaders, herbalists, traditional and faith healing facilities (churches, mosques, prayer camps and prayer forests) – as well as FBOs (community-based organisations, non-profit organisations, non-government organisations); faith-based hospitals/facilities and biomedical/psychiatric facilities, delivering services at community or facility level (see Figure 2). We included quantitative, qualitative, and mixed methods studies; journal articles, book chapters, theses, organisational reports, and commentaries (this was due to the lack of studies on faith-based biomedical facilities providing psychiatric care and to provide a view from the perspective of researchers working in the field) showing some form of internal review. Included studies materials were limited to English and published between 2007-2021. Articles were included if they provided information relevant to any of the components of the research question – including evidence on magnitude of FBHPs where frequency of use and availability were used as proxies for magnitude. Availability was also inclusive of affordability, accessibility and acceptability of both the alternative and biomedical types of faith-based mental health services in Africa. Acceptability was included because in faith-based contexts both social and cultural acceptability are related to the access faith-based mental health services given the linkages to religion. Although availability is not the exact same as magnitude, we decided to include this because this is all we could find as we went through the studies. It was decided to include such availability classifications for the magnitude component (although not the exact same as terms) to answer the magnitude component of the research question due to the limited information on number of beds and facilities within the faith-based mental health sector across Africa.

The other articles included in the systematic review were in relation to the types of FBHPs and MHS (including referral), and the quality of services provided (impact of MHS on mental health, religious perils also known as human rights abuses, training and qualifications of FBHPs, and accessibility, availability, and affordability). In full text review, a small cluster of studies which solely focused on collaboration between traditional- or faith-healers and biomedical practitioners were mostly excluded – unless they had other information relating to the above inclusion criteria as well.

The databases that were searched included: PubMed, Scopus, EBSCOhost (Cinahl, AfricaWide, PsycArticles, AtlaReligion and PsycInfo), Google and Google Scholar. The search term clusters and variations are shown in Appendix 1. Since this is a very diverse review terrain, we used Google and Google Scholar to conduct further purposeful searches for material on faith-based health facilities such as hospitals and psychiatric care facilities, as this was not retrievable through standard academic search platforms. To do so we searched names of specific hospitals and the country they came [the results of this are reported below in the Appendix 4: summary of data extraction sheet (results)]. We also scanned the reference lists of included material for further items for inclusion (after the initial phase of exclusion).

The main study characteristics and findings were extracted following Thomas and Harden's approach to data extraction, drawing relevant findings from the studies into the extraction sheet (57). A thematic narrative synthesis (a qualitative analysis approach to identify common themes or ideas across texts) was applied to the extracted qualitative data. For example, the various types of FBHPs were formulated using the categorisation in Figure 2, then these were looked for in the included studies and then inserted into the data extraction sheet in the appropriate section.

For the quantitative data, similar statistics were collated and pooled (in a form of meta-analysis, which was used meta-analyses to synthesize and express the statistics on the various types and magnitude of faith-based mental health provision and faith-based mental health services). A random-effects model was used so that

there could be an observed difference amongst the proportions and the mean, where the mean could not be entirely dependent on sampling error and various other factors. Subsequently, it was known that each study estimated a variant of parameters, and the pool estimate found through the meta-analyses describes the indicates the distribution of the mean. The statistical program “Meta-prop” was used implemented to perform meta-analyses of proportions in STATA through the utilisation of the random effects models with Free-man-Tukey transformation (58). The meta-prop method was used so that the pooled estimation of the frequency of FBHPs and faith-based mental health services could be determined and measured (59). In addition, when confidence intervals are computed it is not attainable when “the statistic is placed on the boundary, since the estimated standard error is set to 0 and then the metan command” will then robotically exclude studies where the “proportion is equal to 0 or 1 from the calculation of the pooled estimate,” (60). The metan command was adapted so that the processes for specifically the binomial data was clear (n and N), and further, the “denoting number of individuals with the characteristic of interest” and the total number of respondents included in the selected studies (56). The studies with zero-standard error were excluded, which could have led to some biases among the results and commonly users computed the standard error in an extemporary method (61). Finally, qualitative and quantitative data was synthesised.

## Results

This systematic review applied Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines for conducting systematic reviews in order to explore the types, quality and magnitude of faith-based mental health provision in Africa (Figure 1 above).

After the search terms were checked and modified, we searched the above-mentioned databases, identifying 2951 relevant items, which were transferred to an EndNote database. Then, Google and Google Scholar were searched for grey literature and faith-based biomedical/ psychiatric facilities (5 studies found). A further 97 studies were found and added to EndNote. Then 117 duplicates were removed, leaving 2834 items. These were checked for relevance through title and abstract screening. In this process we identified 221 studies for full-text review, of which 103 were rejected as not relevant. Two reviewers checked border-line items. We then also conducted a further purposeful search using Google and Google Scholar using names of specific facilities as search terms. In addition, we searched the reference lists of included articles. There were 7 articles were added from citation tracking and google searches. There were 111 articles left which underwent full text review, checking for quality. 65 items were excluded at this stage, comprising material focusing only on individual religiosity and mental health, material focusing on the collaboration between traditional and biomedicine, and material focused only on biomedical MHSs (56).

There were 53 items left and quality checking was done using the Mixed-methods tool (56). After quality checking, 53 remained for full data extraction into the data extraction sheet which had been developed through the initial scoping review (Phase 1 of this study), and provided categorisations of the various types of faith-based MHSs (see summary of populated extraction sheet in Appendix 4). The 53 empirical studies remaining included 45 peer reviewed journal articles and 7 other types of grey literature (theses, books and commentaries). The 53 empirical studies remaining and there were 17 quantitative studies, 24 qualitative studies including theses, 1 book and 2 commentaries included in this study. The reason for inclusion of commentaries outside of the inclusion criteria due to the limitations on grey literature and to include sufficient information on faith-based biomedical/ psychiatric care, specifically looking at magnitude at a facility level from the perspective of researchers and experts in the field. The African countries represented were Ghana (18/53), Nigeria (6/53), Kenya (5/53), Sudan (3/53), South Africa (3/53), Uganda (2/53), Tanzania (2/53), Tunisia (1/53), Somalia (1/53), Egypt (1/53), Ethiopia (1/53), Rwanda (3/53), and Zimbabwe (3/53). The African

countries represented were Ghana (18/53), Nigeria (6/53), Kenya (5/53), Sudan (3/53), South Africa (3/53), Uganda (2/53), Tanzania (2/53), Tunisia (1/53), Somalia (1/53), Egypt (1/53), Ethiopia (1/53), Rwanda (3/53), and Zimbabwe (3/53).

### PRISMA Flow Diagram

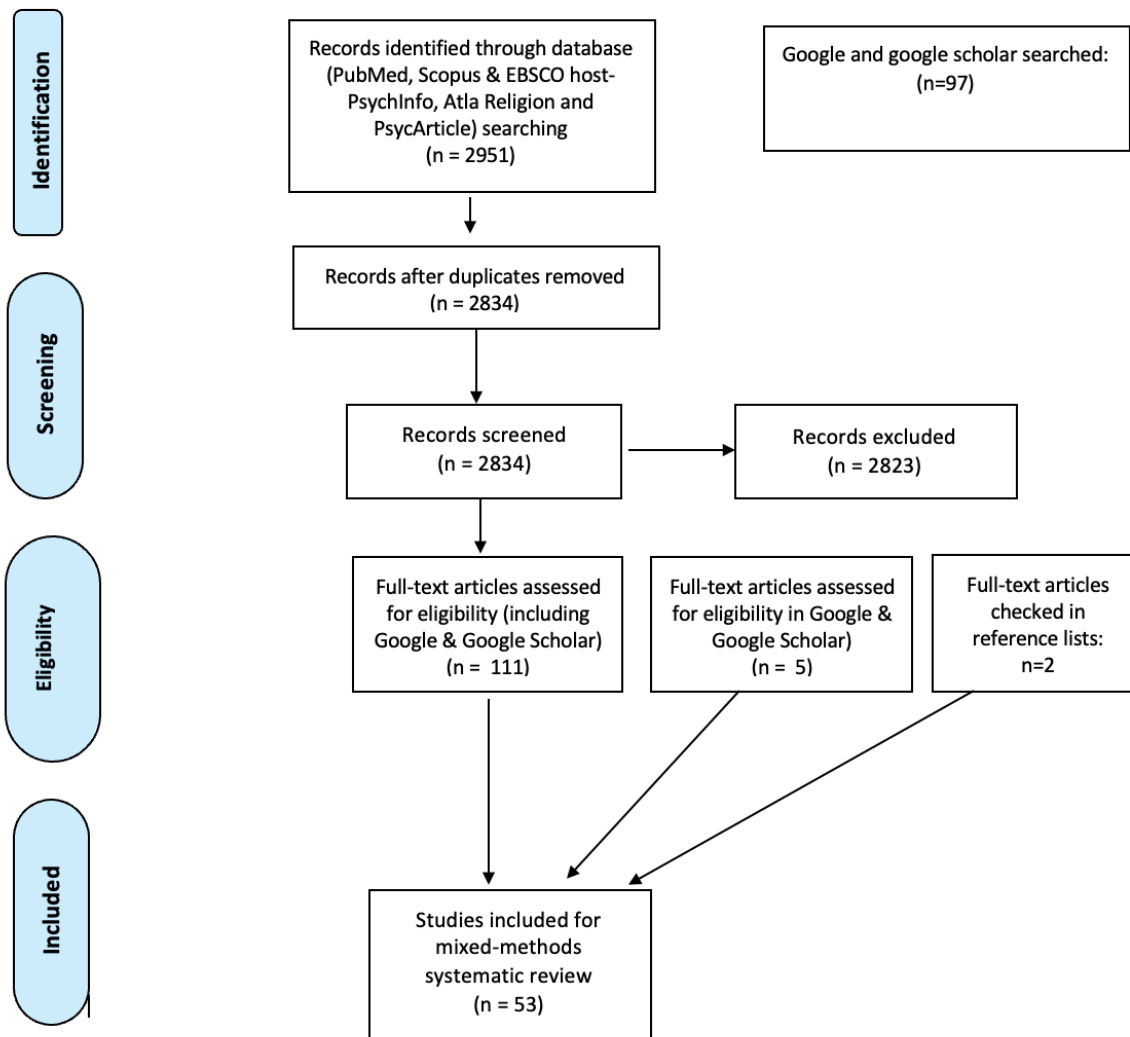
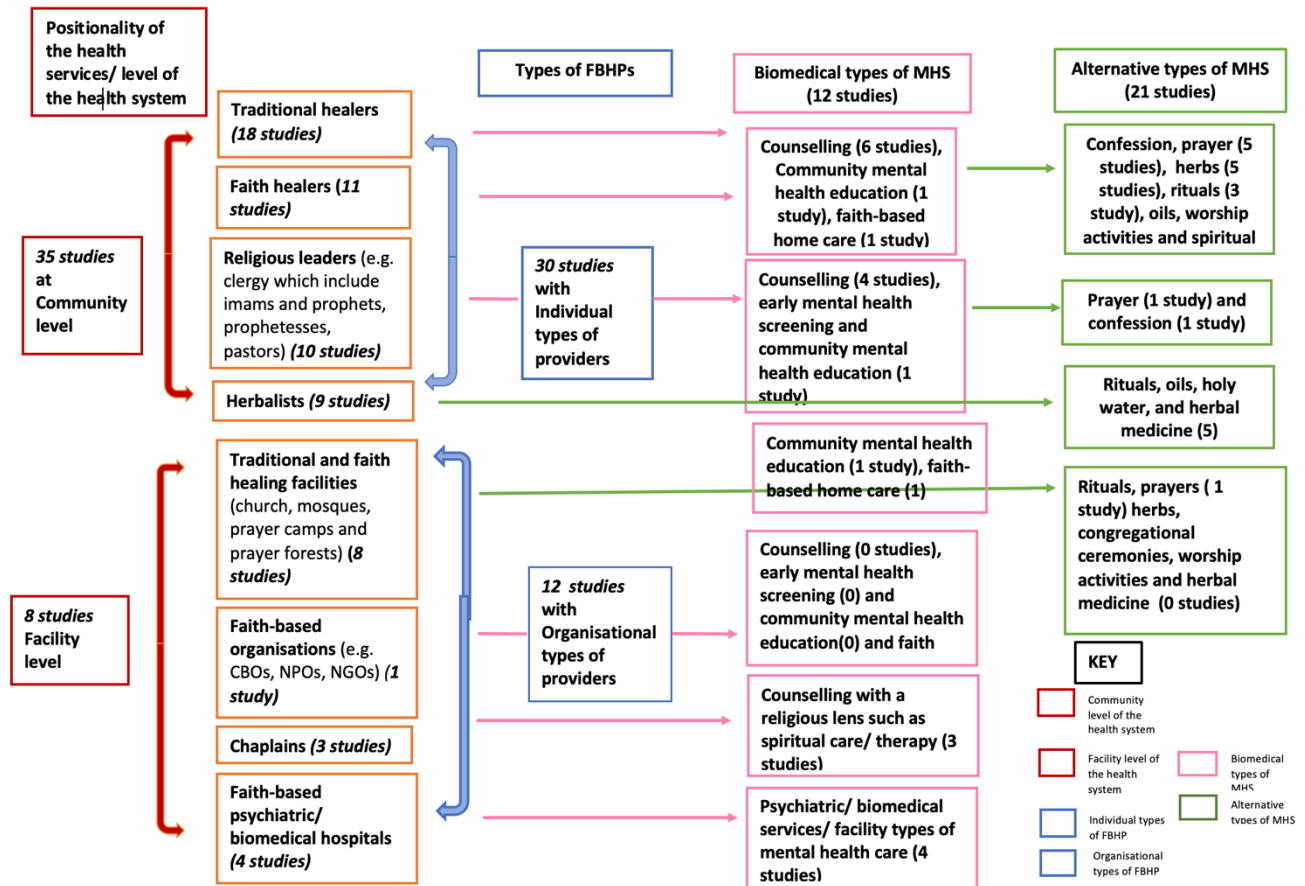


Figure 1 PRISMA flow diagram for systematic review results

#### Types and utilisation of faith-based mental health services provided by FBHPs

There are varied and diverse types of FBHPs mentioned in the included studies – the most prevalent being individual providers (30/53), and the organisational types (12/53). Types included:



**Figure 2** Types of FBHPs (individual and organisational) and mental health services (alternative and biomedical) delivering MHS at the community- and facility-level in the health system (positionality of the service)

We roughly pooled quantitative data on ‘alternative’ types of MHS (described above). There was not quantitative data available on the main types of MHS – the only types being prayer only (3/53 studies), prayer and fasting (4/53), fasting only (2/53), rituals (4/53), herbs and fetish practices (4/53) and sacrifices (4/53) (as shown in table 3) selected from 21/53 studies using STATA to construct a meta-analysis. This specifically entailed an analysis on the frequency of use of these few types of MHS within studies conducted in Ghana, Kenya, Nigeria and Sudan (62-64).<sup>7</sup>

There were qualitative and quantitative studies which were included showing that prayers and rituals are used as alternatives to, or supplements of mental health services (as shown in 16/53 studies) – for example prophets and prophetesses within prayer camps, traditional and faith healers, FBOs and churches across Africa (17, 18, 65-77). Some studies not a distinction between types of FBHPs – for example, in Kenya, study respondents noted that prayer was a commonly used solution for faith healers but not for traditional healers (69).

Prayer is expressed in a myriad of forms in different African contexts. Prayer can take the form of consultations with God (as reported in a study from Kenya (65), a journey of healing (as described in a Ghanaian study (74),

<sup>7</sup> The reader should be aware that this analysis is slightly misleading, as there is a total absence of quantitative data on core MHS types such as biomedical psychiatric care or home-based care, that FBHPs are known to engage in. Furthermore, while there is substantial literature on FBHPs providing HIV/AIDS-related counselling and care, this did not appear substantially in this review, nor provide quantitative measures that could be extrapolated more broadly.

or as bereavement, preaching, and worship (72, 73, 75, 78). Other examples involved traditional and faith healers who provide prayer and Quran recitations which is known to banish evil spirits found in Somalian, South African and Ghanaian studies (13, 77, 78). Prayer only was used in three studies where quantitative data was shown among 8/30 (26.7%) (60), 51/82 (62%) (79) and 34/66 (52%) (63) respondents with mental illness.

Other types of 'alternative' types of mental health services were fasting and prayer where they were used together, as shown in studies within Zimbabwe, Kenya and Ghana as well as other emergency settings (73, 75, 82). In one survey in three sub-Saharan African countries (Ghana, Kenya and Nigeria) by Esan, Appiah-Poku (68) there was a purpose to describe the ways of sharing, practices and profiles of traditional and faith healers in Ghana, Kenya and Nigeria. This study was conducted as part of a series before a randomised control trial based on a "collaborative share care program" performed by traditional and faith healers through a detailed mapping exercise was done in 3 different countries—where different forms of mental health treatments were gathered and substantiated by observations made directly (68). In a study, it was found that 29/30 (96.7%) (62), and in the survey by Esan, Appiah-Poku (66) in three countries, it was found in studies within Ghana 105/205 (51.2%), Kenya 86/406 (21.2%) and Nigeria 46/82 (56.1%) that prayer and fasting was used together as a mental health service (68).

A study by Sorketti, Zainal (64) was conducted in central Sudan aimed to look at "the types of services, interventions and treatments utilised by traditional healers to help patients with psychotic disorders". It was found that fasting was used solely as types of cleansing and getting rid of evil among 120/129 (93%) of patients (64). Traditional and faith-healers were interviewed to comprehend their treatment methods towards mental illness in a study by and it was found that 33/82 (40.2%) used fasting as a MHS (79). According to Fournier (83) traditional healers and herbalists are well trusted and have an influence on patients' emotions through these other types of exorcism practices (83). Other rituals are where 35/82 (42.6%) patients used ritual sacrifice (81).

Country	Title of study (year)	Ratio/ Frequency of use (%)
<b>Counselling</b>		
<b>Nigeria</b>	<b>Agara 2008</b>	<b>27/30 (90%)</b>
<b>Prayer</b>		
<b>Nigeria</b>	Agara 2008	8/30 (26.7%)
<b>Ghana</b>	Lambert 2020	51/82 (62%)
<b>Nigeria</b>	Kaiser 2020	34/66 (52%)
<b>Fasting &amp; prayer</b>		
<b>Nigeria</b>	Agara et al., 2008	29/30 (96.7%)
<b>Ghana</b>	Esan 2019	105/205 (51.2%)
<b>Kenya</b>	Esan 2019	86/406 (21.2%)
<b>Nigeria</b>	Esan 2019	46/82 (56.1%)
<b>Fasting only</b>		
<b>Ghana</b>	Lambert 2020	33/82 (40.2%)
<b>Sudan</b>	Sorketti 2013	120/129 (93%)
<b>Rituals</b>		

<b>Ghana</b>	Lambert 2020	35/82 (42.6%)
<b>Ghana</b>	Esan 2019	118/205 (57.6%)
<b>Kenya</b>	Esan 2019	17/406 (17.5%)
<b>Nigeria</b>	Esan 2019	70/82 (85.4%)
<b>Herbs and fetish practices</b>		
<b>Ghana</b>	Lambert 2020	74/82 (90%)
<b>Ghana</b>	Esan 2019	169/205 (82.4%)
<b>Kenya</b>	Esan 2019	109/406 (26.9%)
<b>Nigeria</b>	Esan 2019	57/82 (69.5%)
<b>Sacrifices</b>		
<b>Nigeria</b>	Agara 2008	3/30 (10%)
<b>Ghana</b>	Esan 2019	35/82 (42.6%)
<b>Kenya</b>	Esan 2019	6/406 (1.5%)
<b>Nigeria</b>	Esan 2019	13/82 (15.9%)

**Table 3 Frequency of use of varied forms of FB MHS (based on meta-analyses of included studies with quantitative data)**

There were various types of rituals such as birthing or death rituals as mentioned by (63) in a South African study, which enhance connections to ancestors and family in order to improve patients' social linkages (82). Other rituals include cleansing rituals and divination (84). It was found that 42.6% of patients used ritual sacrifice in one study (81), and in a survey within 3 countries rituals such as ritualistic dancing were used among 57.6%, 17.5% and 85.4% in Ghana, Kenya and Nigeria respectively (68). Overall, ritual was used very generally and it wasn't clear enough what that entailed in some of studies with very little descriptive nature.

Similarly, herbalists and traditional healers utilise herbal medicine as a treatment for mental illness as described in 9 (of 53) of the included items (68, 80-83, 85-88). Mental health treatments involving herbs identified in the literature include eating herbs, drinking herbal infusions, washing and herbal baths, herbal ointments, decoctions, incense, oils and perfumes (16, 73, 80, 82, 85, 86, 89). One study reported that the choice of herbs by the traditional or faith healer is made by throwing of the bones to ask the ancestors answer what type of medication to use. Lambert (2020) mentioned that 74 out of 82 (90%) of patients used herbs as treatment for mental illness in faith and traditional healing facilities. It was found in a survey within 3 countries that found that 169 out of 205 patients (82.4%) in Ghana, and 109 out of 406 patients (26.9%), in Kenya and 57 out of 82 patients (69.5%) in Nigeria used herbs from traditional and faith healers to treat mental illness (68).

Some FBHPs, such as FBOs, clergy, faith healers and traditional healers, provide more 'biomedical' MHSs (16, 65, 67, 73, 76, 84, 90). The review revealed that traditional and faith healers offered early mental health screening (2/53) (65, 91), counselling (10/53) (13, 14, 17, 61, 65, 67, 71, 74, 82, 90), and faith-based home-based care (4/53) (18, 19, 66, 93). For example, it was noted by a South African study that that traditional healers have the ability to recognise suicidal and traumatic behaviour through early mental health screening (65). A Nigerian mentioned that 90% of faith-healers provided counselling to treat mental illness (60). Similarly, two studies in a Ghanaian report mentioned that clergy playing an advisory role in order to sustain belief in God, and also provided social support with a focus on family and FBOs (76, 94). There was another example which explained that premarital counselling was conducted by Christian and Muslim lay counsellors as shown in a study (95).

The review also identified alternative forms of MHS being provided by FBHPs. These included confessions and simply sitting and listening as a form of counselling, as revealed in studies from South Africa (65, 72, 76, 82, 94). In a South African study it was stated that traditional and faith healers “can easily sit 2 hours and try to trace the problem back to the beginning...counselling, you see the difference between doctors and us is we counsel our patients...” (65). Other examples involve mallams<sup>8</sup> and pastors<sup>9</sup> who provide psychosocial support for their children and families, including, for example, capacity-building for children with disabilities as shown in a Ghanaian study (73, 92).

Community mental health education as a type of mental health service provided by prophets (neo-prophetic ministers), traditional and faith healers, FBOs and churches was found in 4/53 articles (18, 65, 72, 76). A study from Ghana identified churches that were providing MHS through Biblical sermons or professionals that educated communities on abstaining from drugs and exacerbated mental health stigma (72). The abovementioned counselling methods and community mental health education techniques include assistance with jobs, relationships, substance abuse and forms of neglect—which have been shown to improve the mental health status of patients (19, 63, 92).

Faith-based homecare<sup>10</sup> was utilised in 4/53 studies as a type of MHS by FBOs, traditional and faith healers and Christian clergy (18, 19, 66, 93). Faith-based home care generally can take the form of monetary support and gifts from churches as indicated in a Nigerian study (18). In some cases, this type of MHS took the form of monetary or other forms of assistance, such as help with hospital bill payments, help with unemployment, providing accommodation or building homes, or providing clothing or medication (18, 19, 66). However, in some cases this support was seasonal (18). A study from South Africa reported that 86% of traditional healers felt that they had the needed skills and knowledge to cure mental illness, 90% frequently treated patients through residing with them in their homes, and 98% visited their MH patients often (92).

These forms of support have been shown improve mental health and help to counter stigma (18). Stigma was demonstrated in faith-based contexts where – for example, congregants stigmatise the mentally ill, or families and broader social networks abandon or disown the mentally ill (19, 63, 72, 83). In these cases, the literature suggests that traditional healers and clergy can re-establish broken communal ties and provide emotional and material support, as shown, for example, in Ghanaian and Zimbabwean studies (19, 63, 72, 83).

There are also issues related to stigma—for example, where congregants label the mentally ill and where families (social networks) have instances where they have abandoned their own family members (19, 63, 72, 83, 96). A similar phenomenon is suggested in literature from Ghana and South Africa, where mentally ill individuals are often ridiculed and harassed, especially in rural areas with endemic violence (77, 97). Statistics have indicated that 86% of community members with mental illness are subjected to this MH stigma; and 26% of individuals with mental illness became depressed due to being isolated within their communities (96, 97).

The literature also revealed chaplains, mallams, pastors and chaplains located within biomedical health facilities providing MHSs with an alternative or religious lens as shown in 4/53 studies (98-101). We also identified examples of chaplains that visit patients daily, pray for them and promote the use of Holy Books to assist them with their mental illness (98, 99, 101). A chaplain was reported in a study from Zimbabwe stating, “I see myself as an important element in the wellbeing of the clients that I serve. I act as a linkman between

<sup>8</sup> Mallams are a type of Muslim clergy who provide counselling and have learnt to Qur’an.

<sup>9</sup> Pastors are a type of Christian clergy who provide counselling to their congregations.

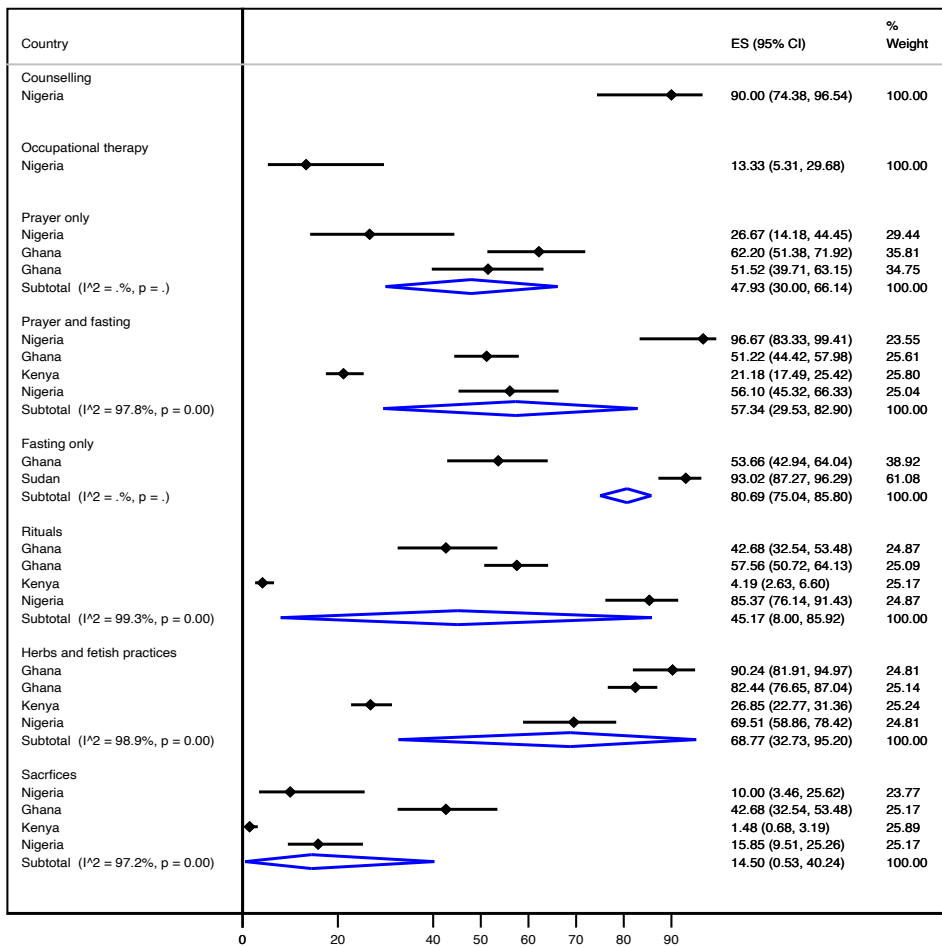
<sup>10</sup> There is a massive faith-based health provider home-based care HIV/Aids footprint which has been vastly reported in literature, but because this review focused on the types of home-based care that focused on mental health care, these articles were not included in this study.

the community and the place where I serve” (101). In a study in Nigeria, indicated that the spiritual care provided by chaplains goes beyond the norm of MHS where chaplains connect with patients and thoroughly understand their religious beliefs as well as establishing trust (99). At the Bowen University Teaching Hospital in Nigeria, chaplains provided a chapel within this hospital that is available all day for alternative MHS, and also do rotational based counselling (100).

Some studies highlighted the sensitive nature of this role (99, 101). For example, two studies (Nigerian and Zimbabwean) reported that chaplains are generally not well equipped to deal with severe cases of mental illness (99, 101). There were 5/53 studies which mentioned the use of psychiatric care at faith-based biomedical facilities (78, 99, 102-104). Another example of a faith-based biomedical facility providing psychiatric care in Uganda is the Ruharo Mission Hospital (a Church of Uganda project) which consists of 12 regional referral hospitals that provide faith-based psychiatric care (102). Similarly, the Kisijzi Hospital (also a Church of Uganda hospital) is proportionally supported by the Uganda government, and contains a psychiatry department (105). In the Benue State, Nigeria, the Christofoel Blind Mission is an NGO facility that provides primary-level and community-based of MHS (103).

Other types of MHSs provided in biomedical facilities include palliative care services (such as grief counselling), as is provided by the Presbyterian Church of East Africa Kikuyu Hospital in Kenya (78). Another example of this sort is the Le Centre Psychothérapeutique Icyizere (The Hope Center) (previously known as the CARAES Ndera Neuropsychiatric Hospital) in Rwanda – a faith-based facility that provides MHS for PTSD and substance abuse (104). A study conducted at this facility found that 77% of patients received outpatient services, 95.3% had psychiatric medications prescribed; 44.7% had either individual or group psychotherapy, and the staff provided mental illness prevention through implementation of community-based programs (104).

During the Covid-19 pandemic, the role of faith-based mental health provision evolved and some individuals and organisations migrated into online recovery groups. For example, Project Exodus which was linked to certain “spiritual pillars of recovery” routed in Christian beliefs. These online recovery groups exemplified examples of interdisciplinary approaches to mental illnesses through collaborations between biomedical and alternative mental health services (105).



**Figure 4 Meta-analyses on frequency (%) of use based on ‘biomedical’ and ‘alternative’ types of faith-based mental health services in Africa**

*Magnitude of faith-based mental health provision*

Magnitude was operationalised in this study as ‘footprint’<sup>11</sup> (number of faith-based facilities, psychiatric beds and any faith-based organisations providing biomedical mental health care), ‘availability of faith-based organisational providers of MHSs (faith-based psychiatric care and faith-based organisations), the utilisation of individuals types of FBHPs and the frequency of use based on faith-based mental health services (mainly ‘alternative’), due to a lack of data on faith-based ‘biomedical’ MHSs.

**Frequency of utilisation**

The review found 11/53 studies which discussed the frequency of utilisation of FBHPs (not all of them, only traditional, faith healers and herbalists as well as faith-based biomedical facilities providing psychiatric care) and the various MHSs in Africa (10, 13, 17, 20, 68, 99, 108-110). Kisiiki Hospital in Uganda is a faith-based facility in an urban area providing biomedical psychiatric care to vulnerable populations (111). The hospital did not have a doctor or a clinical psychologist, and there is limited access to medicines such as antidepressants, anti-psychotic and anxiolytic medications available (106), which can suggest a lack of

<sup>11</sup> This ‘footprint’ was counted and shown in figure 2 expanding on how many studies included each category of providers being used for MHS and organisations/ facilities providing faith-based psychiatric care

available MHS. However, this hospital has 28-beds available for outpatient mental health care, and employs a small team including a psychiatric clinical officer. In addition, there is an occupational therapist on staff, and the psychiatric nurses have been through relevant training (106, 111).<sup>12</sup>

The following operationalisation will be utilised throughout this results section:

**Availability** implies the number of health facilities, access to medicines, resources, and training of FBHPs available for alternative and biomedical types of MHS in a required quantity.

**Accessibility** will be known as the access of faith-based mental health services to vulnerable groups with no discrimination and where faith-based mental health care is economically and geographically accessible in congruency with what the mentally ill need.

**Cultural acceptability** means that these MHS are based on cultural values and are sensitivity to the types of mental health services utilised.

**Social acceptability** means that the faith-based mental health services are accepted by their societies and are supported by social networks from families and other surrounding relationships.

Source: United Committee on Economic Social and Cultural Rights (104).

In another study in Nigeria, in-depth interviews were conducted and there is a community mental health-day centre known as “Christofoel Blind Mission, Health Restoration Centre Agboke and Community Mental Service Day Care Centre and Rehabilitation Centre” (by NKST Mkar, a Christian hospital) (103). These faith-based biomedical-facilities provide information and mental health services at the community-level. However there are no primary care-level activities being provided and there is no official mental healthcare structure at the facility (103). In Rwanda, CARAES-Ndera is a faith-based facility with a focus on neuropsychiatric disorders (child psychiatric specialty), with over 288 beds. This facility provides psychotherapies and medication for patients who have mental illness (112).

This study identified three surveys conducted in Kenya, Ghana and Nigeria by Esan, Appiah-Poku (68). The authors compiled information on the types of alternative providers with a focus on the number of beds for psychiatric admissions (68). The study found that in Ghana, there were 877 spaces for admission for the mentally ill, while in Nigeria there were 677 beds for mentally ill patients within faith-based facilities (68). However, in the Kenyan context where this study was conducted, there were no beds for the mentally ill. This study also found that in Ghana and Nigeria between 60% and 90% of traditional and faith healers had inpatient facilities for the mentally ill (68). However, there was no mechanism for involuntary admissions in these facilities. The authors estimated the ratio of hospital beds to population to be between 0.14 and 0.27 per 1000 people, which is above the norm for biomedical practices which are usually between 0.01 and 0.1 (68).

A review study by Ndeti (113) focused on how often traditional healers are used for MHS, and the types of MHSs they provide in the form of psychotherapy and pharmacotherapy. It was argued in this study that traditional healers are important pathways to MHS including access and utilisation of MHS, especially because they align with traditional belief systems (113). A study in Kenya found that there is sufficient MHS capacity based on the number of traditional healers available; and further suggested that FBHPs have been culturally accepted by individuals suffering from mental illness (107). Similarly, an Ethiopian study used a community resource mapping approach to establish the availability of FBHPs of MHS. The study found that there were

<sup>12</sup> This is the section of the review where two commentaries were used, this was again due to a lack of empirical studies to expand on magnitude in terms of footprint of facilities. The reader should be aware that this was resorted to inclusion in order to gage some perspective from professionals in the research.

150 traditional healers, and 164 mosques and churches where each church and mosque had at least one priest or imam (17).<sup>13</sup>

There are various types of support which are socially accepted which improves magnitude and are associated with faith-based mental health services that are delivered by individual (clergy and traditional/ faith healers) and organisational providers (prayer camps and prayer forests) within African mental health systems (18, 76). Examples are prayer, financial assistance, words of encouragement, emotional care which are socially supported systems of care provided to the mentally ill, and their network of families as shown in Nigeria and Ghana— in terms of both alternative and biomedical types of MHS (18). These socially supported systems have been known to be delivered through community-centric activities as demonstrated in the Nigerian, Ethiopian and Zimbabwean contexts (17-19, 76). A specific example is where churches have partners with health departments and other community linkages using their home-based church groups and implement “collective therapy management” through trusted relationships. Another example is where religious leaders have also been known to increase engagement of mentally ill in religious groups; yet limitations exist among these healers when it comes to handling severe cases of mentally ill patients as shown in Ghana (14, 76, 83)<sup>14</sup>. In South Africa, other types of social support include social cohesion provided by traditional healers which has been shown to utilise the bonds of their communities which have been broken down; and in turn improve suicidal ideation behaviour “usually makes the person see sense” and “as a result they abandon the suicidal behaviours,” (65).

Faith-based health providers and their mental health services they deliver might ideally be recognised as important entities to strengthen mental health systems formed as a basis on the cultural beliefs of communities they work in (65, 74). On the other hand, there are mental health programs and models delivered by these various types of FBHPs— which are not culturally focused or adaptable to certain settings, yet they are effective in primary care based settings (74). In other contexts, such as in emergency and conflict settings, it has been shown that there is an added focal lens on the incorporation of cultural, spiritual and religious practices into mental health services delivered within community as explained in organisational guidelines (75). For example, traditional and faith healing services (at a facility level of the health system) provided in South Africa, Sudan, Malawi and Kenya have been shown to incorporate culturally embedded issues (such as bewitchment, rituals and ancestral connections) into recent spiritual explanatory models delivered by individual providers such as: traditional and faith healers and thereby, strengthening overall mental health systems in the African context (13, 14, 65, 67, 114, 115). Statistics in South Africa have shown that 41% of patients (32 of them) consulted traditional healers due to cultural beliefs being the largest reason (116).

Many studies included in the review suggested that traditional healers are a first point of contact for the mentally ill (10, 13, 20, 110). Four of the included studies offered statistics on the use of traditional healers as a first point of contact for MHS. Synthesising these statistics, we found that between 11% and 62% of mentally ill individuals sought MHS from traditional healers (12, 13, 20, 110) (statistics for these studies are shown in Table 2). However, these statistics show a vast disparity and should not be taken as definite, but rather to

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<sup>13</sup> This magnitude of traditional and faith-healing was found only this study in Ethiopia and is in no ways an estimate of how many actual facilities there are in the whole country. Figure 2 should be referred to to expand where traditional and faith healing facilities were discussed in the other studies in terms of how many studies included these types of facilities providing mental health facilities

<sup>14</sup> This is also a reason to why the quality of faith-based mental health services is reduced, which will be expanded on later in this study and is just a note that should be warranted

provide some indication of the magnitude (specifically utilisation) of faith-based mental health services.<sup>15</sup> The utilisation of traditional healers can be increased through education of individuals and families on the types of mental health treatments available, or the referral severe cases to biomedical types of facilities as recommended by an Ethiopian study (17). When focusing on duration of stay of faith-based mental health facilities, it indicated that 53% of patients spent 1-2 months at these facilities and 10 patients stay over a year (due to its accessibility with a focus on their acceptability) (64).

For the footprint of faith-based mental health services, it was found that in the included literature of this study, there were 4 faith-based biomedical facilities available, 3 studies mentioned the use of chaplains, 18 studies using traditional healers, 11 studies using faith-healers, 8 studies mentioning traditional and faith healing services and 1 study using an FBO for treating the mentally ill in Africa (refer to Figure 2 for more expansion). Nigerian chaplains who work in hospitals settings have been declared as 'primary spiritual caregivers' in hospital settings and chaplains have shown that they are able to perform in-depth investigations (99). In a Malawian study conducted over a month period, 128 mentally ill patients were referred first hand to MHSs in three psychiatric clinics, and were asked what their first point of contact for MHSs were (13). It was found that that 11.7% of patients sought faith-based biomedical services as their first point of contact, where 22.7% were referred from traditional or faith healers (13). In three surveys conducted within Ghana, Kenya and Nigeria, it was found that herbalists constituted of 6.9%, 88% and 28% of all the faith-based health providers were used by at 6.9%, 88% and 28% respectively of the participants (68). In particular, Christian herbalists consisted of 13.7% in Ghana, 3.8% in Kenya and 2.4% in Nigeria and Islamic herbalists comprised of 64% in Ghana, 2.2% in Kenya and 1.2% in Nigeria out of all the herbalists included in a three-country survey (68).

Some of the included studies suggest that traditional and faith healers specifically are more affordable than biomedical MHSs (12, 67, 73). For example, in Kenya, patients could pay traditional healers in gifts and donations, and there is also evidence of cost-sharing mechanisms that allow patients to delay payment such as instalment plans provided by mallams in which further argues for the affordability of faith-based mental health services (67). There is also evidence that the proximity of traditional and faith healers particularly makes them more affordable. This was substantiated by a nurse in a study which stated that, "You see you must understand that there are so many traditional healers, based in all of our communities, so they don't have to travel very far which cuts a lot of costs for people," (73). In Egypt, 24.7% of the patients preferred traditional healing because it was more affordable than biomedical mental health services (19). In another study, it was shown that 75% of patients thought traditional healing was more affordable compared to biomedical psychiatric care (12). Other examples in Ghana and Egypt indicate that at biomedical facilities, mentally ill patients are charged out of pocket for biomedical MHS, so choose traditional healers and religious leaders (as individual providers) as their first point of mental health care due to their affordability (12). In another examples, Muslim healers in Ghana indicated that they were prepared to receive any type of payment, and the traditional healers believed they "served as conduits for the healing process which ultimately comes from God," (80). Other traditional healers believe that they are providing a humanitarian act of service which differs to those which provide biomedical types of MHSs (80). However, a study suggested that healers can be expensive such as in Kenya, but are nonetheless preferred due to their perceived high quality (67). Overall,

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<sup>15</sup> These statistics are in no way accurate and were just found in only 4 included studies, so should not be taken as a definite but this point was just to argue that mentally ill do prefer faith-based health providers over biomedical providers when seeking mental health services

the evidence suggests that traditional healing practices specifically for mental illness are more affordable than biomedical services, thus making FBHPs in Africa more accessible to the mentally ill - in the broadest sense.<sup>16</sup>

Faith-based mental health services are also said to have provided patient-centric care in many rural areas across Africa (where biomedicine is more utilised in urban areas, and traditional more in rural areas) (12, 82). On the other hand, one study reported that limited access to biomedical services resulted in a higher utilisation of harmful faith-based practices that are prevalent in Africa (66). It has been shown that formal biomedical mental health services lack the accessibility which faith-based mental health services provide, with one study indicating that 23.3% of patients preferred seeking MHSs from prayer camps, faith and traditional healing centres particularly as their first point of contact to mental health care (12).

In Rwandan study, it was mentioned through an exploration of facilitators of people with mental disorders, there were prolonged periods of utilising prayers as an MHS example – which then resulted in a delay of seeking biomedical types of MHS from facilities (117). However, this was contradicted in by a study in Egypt which showed that 21.7% of patients preferred to seek MHS from traditional healers and BMPs (12). Other reasons for increased accessibility of faith-based mental health services over biomedical MHS are because of geographical location, and an interest to provide faith-based home care (64). However, two studies of Malawi suggest while half of the patients took one hour to reach the traditional and faith healers in some cases they could as much as take 6 hours (12, 66).

There is a dynamic relationship between affordability, accessibility and availability of faith-based mental health services as argued above (10, 13, 16, 20, 68, 99, 108-110). Adding to this dynamic, is the acceptability of FBHPs – and there is an increased interest in traditional healers as more socially acceptable than biomedical MHS. For example, 30.4% of patients in Egypt found FHMHS to be more acceptable (20). It was also indicated by Ghanaian study that women who suffered from perinatal depression (92.9%) reported that 93% of them preferred mental health treatment from clergy (94).

**Table 5** shows what specific types of FBHPs (only traditional, faith healers and herbalists) were used (according to frequency of use) within the included studies for faith-based mental health services. This was constructed using quantitative data from the included studies and data was used relating to the number of participants who used faith-based health providers. This included the magnitude specifically related to utilisation of the various types of FBHPs. Not all types of FBHPs were included in this table as there was insufficient data relating to clergy, traditional and faith healing facilities, FBOs and faith-based biomedical facilities. However, data was found on the availability of FBHPs delivering MHS within the included studies.

The pooled estimate from the meta-analyses of using the various types of FBHPs as their primary point of mental health care was 1.93-38.1%.

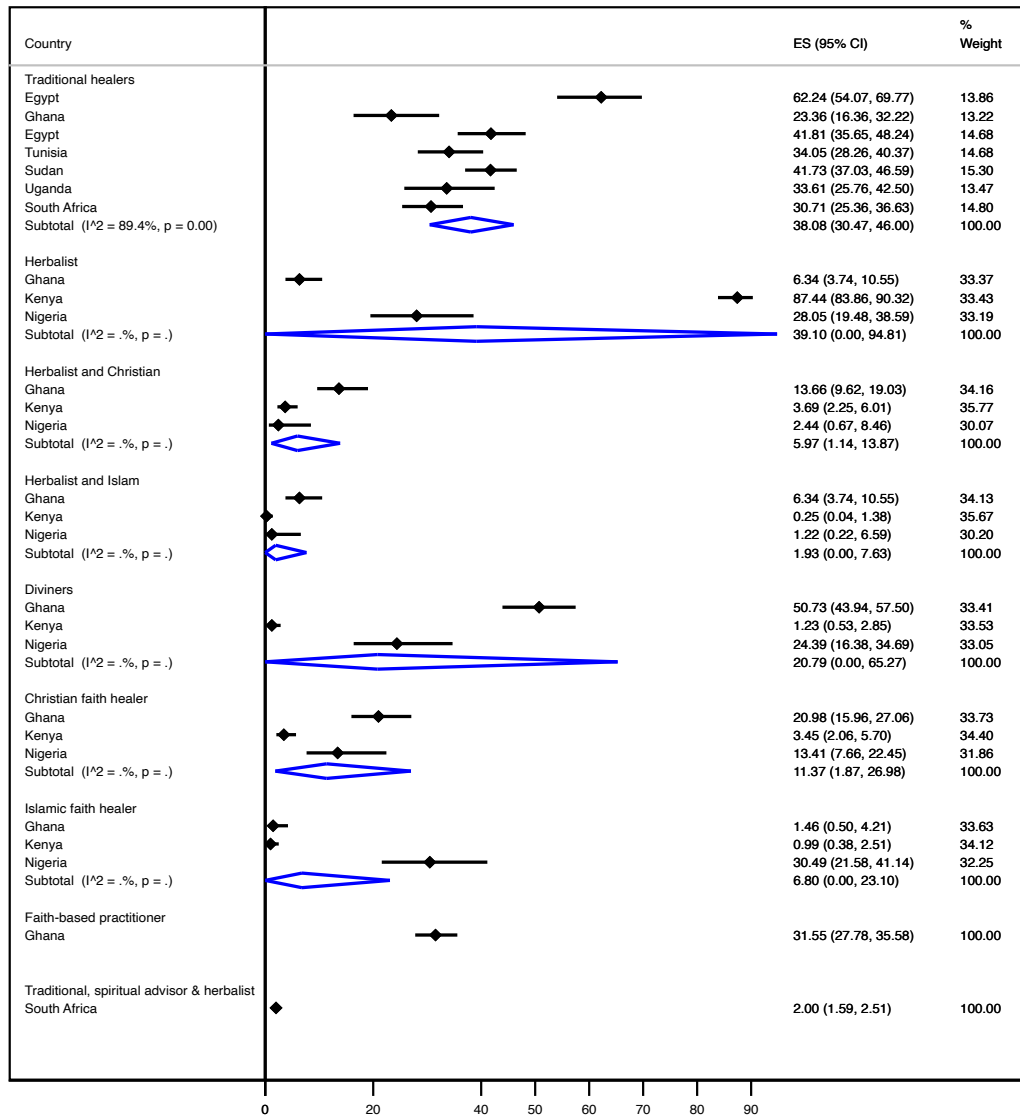
Author (date)	Country	Type of FBHPs sought for MHS	Frequency (%) of use/ ratio
<i>Assad 2015</i>	Egypt	Traditional healers	89/143 (62.2%)
<i>Esan 2019</i>	Ghana	Herbalist	13/205 (6.4%)
		Diviners	104/205 (51%)
		Christian faith healers	43/205 (21.1%)
		Islamic faith healers	3/205 (1.5%)
		Herbalist and Christian	28/205 (13.7%)
		Herbalist and Islam	13/205 (6.4%)
<i>Esan 2019</i>	Kenya	Herbalist	355/406 (88.8%)

<sup>16</sup> However, there was not enough quantitative data to back this statement, it was only what the included studies indicated, more studies are needed in this area in the future

		Diviners	5/406 (1.2%)
		Christian faith healers	14/406 (3.5%)
		Islamic faith healers	4/406 (1%)
		Herbalist and Christian	15/406 (3.8%)
		Herbalist and Islam	1/406 (0.2%)
<b>Esan 2019</b>	Nigeria	Herbalist	23/82 (28%)
		Diviners	20/82 (24.4%)
		Christian faith healers	11/82 (13.4%)
		Islamic faith healers	25/82 (39.5%)
		Herbalist and Christian	2/82 (2.4%)
		Herbalist and Islam	1/82 (1.2%)
<i>Ibrahim 2016</i>		Traditional or religious healers	25/107 (23.3%)
<i>Ibrahim Awaad 2020</i>		Traditional healers	97/232 (41.8%)
<i>Khiari 2019</i>	Tunisia	Traditional or religious healers	79 (34.1%)
<i>Nartey 2019</i>		Faith-based practitioners	171/542 (31.5%)
<i>Ghana</i>			
<i>Shin 2017</i>	Ghana	Individual religion coping	562/703 (80%)
<i>Sorketti 2013</i>	Kenya	Traditional healer centres	68/129 53%
<i>Sorketti 2011</i>	Sudan	Traditional healers	169/405 (41.7%)
<i>Sorsdahl 2010</i>	South Africa	Traditional, spiritual advisor and herbalist	73/3651 (20%)
<i>Van Duijl 2014</i>	Uganda	Traditional healers and churches	40/119 (33.7%)
<i>Zingela 2019</i>	South Africa	Traditional and alternative healers	78/254 (31%)

Source: author

**Table 5 The frequency of use from the limited types of FBHPs found in included studies which were sought for faith-based mental health services in Africa.**



**Figure 10 Meta-analyses of the magnitude of FBHPs (traditional, faith healers and herbalists) use for mental health services in included studies**

*Quality of faith-based mental health services*

Quality of care was discussed that it “entails health service provision by qualified FBHPs who ensure safe and correct treatment for mental illness” (106). In this review, quality of care was mainly operationalised as the quality of faith-based mental health care received in the selected studies, specifically focusing on whether these various types of MHSs improved mental health of the individuals with some information on their help seeking behaviour. With respect to quality of care, we also considered religious perils (chaining, beating, ropes, shackles), which are human rights abuses and are known to be deleterious to mental health. We also considered whether or not there was a clear indication of mental health training of FBHPs, this was classified as an improvement in faith-based mental health care and ultimately, an improvement in mental illness among participants in the selected studies.

*Improvement in mental health outcomes*

Only five of the 53 included studies reported on the effect of faith-based mental health services on mental health outcomes. These studies, however, did not use standardised tools to measure mental health. A study

assessed 350 patients and compared BAD patients with a history of a positive use of traditional healers and a negative history, and found a significant difference in the symptomology profiles for hallucinations (20). However, other clinical correlates like the seriousness of psychotic symptoms and how many manic episodes or depression the patient experienced did not show any significant difference when compared between the two selected study groups (20). Another study in South Africa utilised a cross-sectional quantitative and descriptive methods which entailed consults among 258 patients with traditional healers 12 months prior to study commencements and found that 45 (58%) reported that they had better overall mental health after seeing traditional healers in comparison to 7 who were found to feel worse, as well as 18 (23%) who showed no effect (116). However, only 6% (5) found healers treatment beneficial (116). Another scale used was the “Positive and negative syndrome scale to find out the severity and progress of patients” at admission and at discharge. This study found a decrease overall in the positive and negative syndrome scale scores due to the utilisation of traditional healers at both time intervals with a vast reduction in the positive symptoms in terms of p-scores (64). A Rwandan study by Ng (2016) utilised “descriptive statistics and within group t-tests comparing function impairment and post-traumatic stress disorder symptoms”, and found that there were improvements in functioning of adults diagnosed with psychosis, depression or substance use disorders. There were 20 of these patients which had improved at time of discharge ( $p=0.003$ ) (102). A Kenyan by Musyimi, Mutiso (90) aimed to explore the relationship between “suicidal ideation, depression and other socio-demographic variables with Quality-of-Life indicators” where the participants were seeking MHS from TFHs in Kenya rural areas (88). It found through a regression analyses that suicidal ideation and depression indicated a lower quality of life as a result of being treated for mental illness by traditional healers (90).

It has been mentioned in both a Ugandan and Ghanaian study, that patients found the faith-based mental health treatments made them between 43-58% better, where 57% said they were completely healed, and 9% said they felt worse and 23% showed no effect from the faith-based mental health services (87, 116). Another study in Kenya mentioned that traditional health providers were trained to deliver psychosocial interventions (problem solving and cognitive-behavioural therapy) to patients suffering mild and severe (118). Assessments were conducted at 0,6 and 12 weeks and Analysis of Variance was performed to determine the change in depression scores over the three-time period (118). It was found that 58-78% of patients showed a decrease in depression symptoms at 6 and 12 weeks which suggests the quality of the mental health services was of good standards (118).

Another study in Ghana emphasised that there is value in the spiritual relatability of Muslim traditional healers and that patients’ belief create positive coping mechanisms which then have an effect on their mental health recovery, as well as decreases their chances of relapse (80). It was also found in Sudan that 49% of patients who used traditional healing services saw a reduction in their positive and negative symptom scale scores (62). Findings in this same study has also shown that there have been improvements in the mental health of individuals residing in traditional healing centres (64).

In Africa, religious perils are in 13 out of 53 studies – which have shown to cause human rights abuses in many instances are prevalent among some FBHPs, mainly consisting of traditional and faith healers, and clergy (62, 64, 66-68, 74, 76, 77, 82, 89, 115, 119).<sup>17</sup> These practices can be harmful to mental health and therefore must

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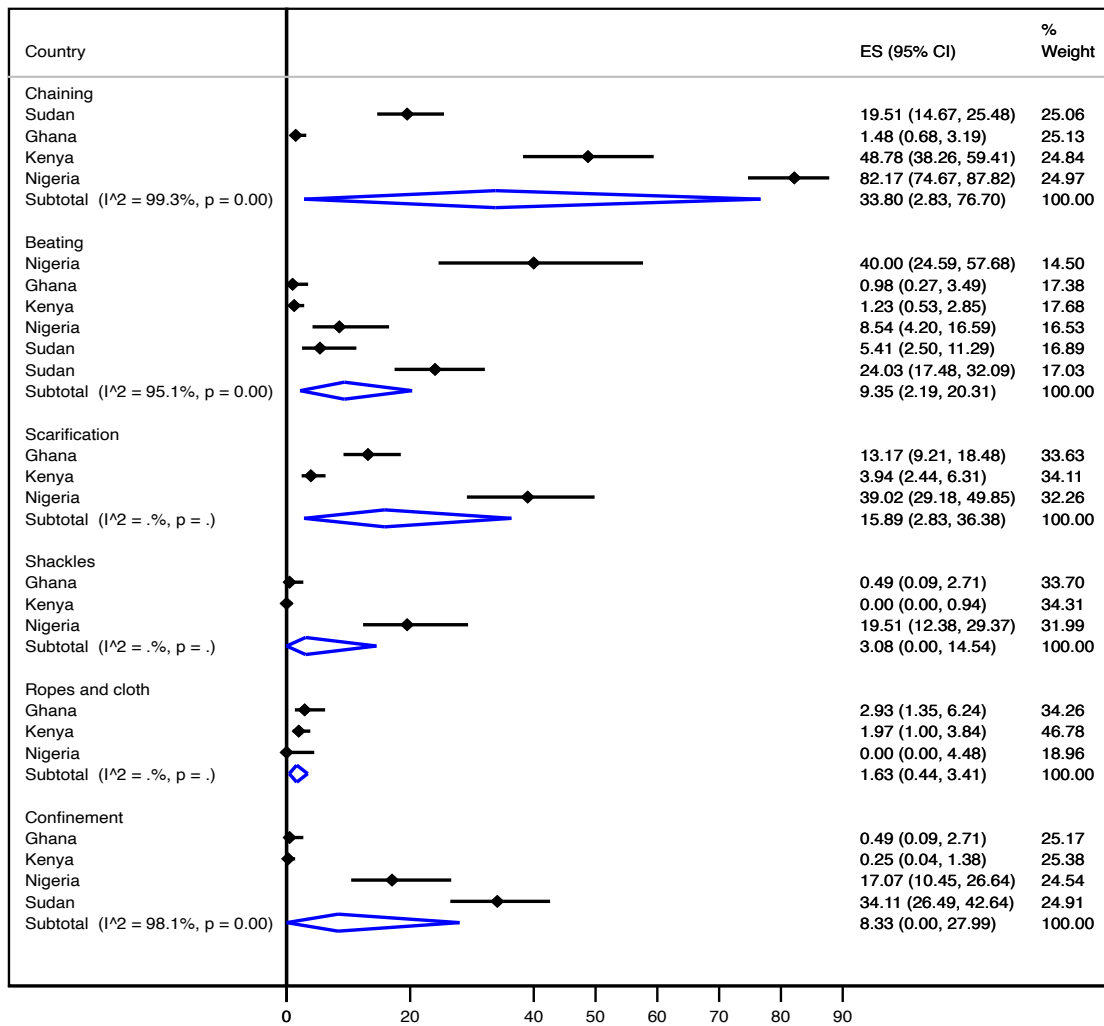
<sup>17</sup> It was mentioned in these studies that religious peril use did in fact decrease the quality of mental health services, but further exploration is needed. There were limitations involved in this analysis because many of the studies included religious perils but there was not enough evidence to indicate clearly what the long-term mental health detriments were of using these what are known as human rights abuses.

be considered in any study on the quality of MHS provided by FBHPs. For example, in Nigeria scarification was utilised by 39% of the traditional and faith healers (68). Studies in South Africa, Ghana, Kenya and Nigeria mentioned that restraint, isolation, fasting, chaining, caning, beating, scarification and incarceration were all utilised in an attempt to help patients who were mentally ill, but ended up causing more harm than good (66, 68, 71, 76, 82, 89). Chaining was used among 192/822 of the respondents in 2/53 studies (one being a survey in three countries) (64, 68), then beating was used by 63/834 (7.6%) respondents in 4/53 studies (60, 62, 66, 112) (again one comprising of a survey by Esan (2019) in three countries), confinement was used by 60/822 studies (0.07%) in 2/53 studies (62, 66) and scarification was used among 79/693 in 1/53 studies (66), shackles were used in 17/822 respondents in 1 study (68) and ropes and cloth used in 14/822 respondents in another single study (68). Among these studies one study where majority of the religious perils were utilised was a survey done in 3 different African countries (68). However, it is important to note that not all faith-based MHS involve human rights abuses as explained in a Tanzanian study (74).

<b>Chaining</b>		
<b>Ghana</b>	Esan 2019	40/205 (19.5%)
<b>Kenya</b>	Esan 2019	6/406 (1.5%)
<b>Nigeria</b>	Esan 2019	40/82 (48.8%)
<b>Sudan</b>	Sorketti 2013	106/129 (82.2%)
<b>Cumulative frequency</b>	All studies	192/ 822 (23.4%)
<b>Beating</b>		
<b>Country</b>	<b>Title of study (year)</b>	<b>Frequency of use (%)</b>
<b>Nigeria</b>	Agara 2008	12/30 (40)
<b>Sudan</b>	Omer 2018	6/111 (5.4%)
<b>Ghana</b>	Esan 2019	2/205 (1%)
<b>Kenya</b>	Esan 2019	5/406 (1.2%)
<b>Nigeria</b>	Esan 2019	7/82 (8.5%)
<b>Sudan</b>	Sorketti 2013	31/129 (24%)
<b>Cumulative frequency</b>	All studies	63/834 (7.6%)
<b>Confinement</b>		
<b>Ghana</b>	Esan 2019	1/205 (0.5%)
<b>Kenya</b>	Esan 2019	1/406 (0.3%)
<b>Nigeria</b>	Esan 2019	14/82 (17.1%)
<b>Sudan</b>	Sorketti 2013	44/129 (34%)
<b>Cumulative frequency</b>	All studies	60/822 (0.07%)
<b>Scarification</b>		
<b>Ghana</b>	Esan 2019	27/205 (13.2%)
<b>Kenya</b>	Esan 2019	16/406 (3.9%)
<b>Nigeria</b>	Esan 2019	32/82 (39%)
<b>Cumulative frequency</b>	All studies	79/693 (10.8%)
<b>Shackles</b>		
<b>Ghana</b>	Esan 2019	1/205 (0.0048%)
<b>Kenya</b>	Esan 2019	0/406 (0%)
<b>Nigeria</b>	Esan 2019	16/82 (0.2%)

<b>Cumulative frequency</b>	All studies	17/ 822 (0.025%)
<b>Ropes and cloth</b>		
<b>Ghana</b>	Esan 2019	6/205 (0.02926%)
<b>Kenya</b>	Esan 2019	8/406 (0.0197%)
<b>Nigeria</b>	Esan 2019	0/82 (0%)
<b>Cumulative frequency</b>	All studies	14/822 (0.75%)

**Table 4 Results on the types of religious perils (harmful practices) in Africa**



**Figure 7 Meta-analyses of religious perils (types of human rights abuses/ harmful practices) in Africa**

In a Ghanaian study, it was mentioned that “At some prayer centres I learnt that, victims are chained and put under all kinds of inhumane treatments such as beatings, long fasting and the like that are unlawful. Some may suffer further damages due to such treatments in the process,”(76) Several studies found that carers were permitted to chain their mentally ill relatives if he or she was aggressive, roaming around or under drug abuse (66, 68, 76). Patients were often chained when they first entered a shrine or prayer camps, and unchained only once they calmed down. In some cases, however, the chains were kept on for months (66, 68, 77). In other studies, shackles were used instead of chains to control the mentally ill. The use of shackles in some cases was justified on the basis that it allowed the traditional, faith healers and herbalists to use other treatments such as herbal medicine, fasting and praying (66, 68). One study suggested that for Christian pastors the use of chains became an integral part of fulfilling a divine mission (77).

Beatings were found to be used among traditional healers, purportedly to get rid of evil spirits, as well as to get a confession for wrongdoing (66, 68). In Ghanaian, Kenyan and Nigerian surveys, it was shown that 60-83% of the traditional, faith healers and herbalists within facilities had training on alternative MHS, and that the quality of the MHS improved as a result of training (68). A survey study by Esan et al conducted in Nigeria and Kenya found that between 61% in Ghana and 85% Nigeria of these same particular types of traditional and faith healers had received some type of training, and that the average duration of training was 4.5 in Kenya and 8 years in Nigeria (68).

In addition, one study reported on the efficacy of mental health education programmes provided by clergy, and demonstrated that these programmes imbue patients with life-skills and coping-mechanisms, and improve their overall mental health (76). On the contrary, other studies suggest some patients experience a decline in their mental health, including negative behavioural changes that they expressed as being a result of being consumed by evil influences – which might suggest questionable quality MHSs (67, 76, 85).

## Discussion

This discussion section will synthesise the evidence presented above on the types, quality and magnitude of FBHPs of MHS in Africa, and discuss these findings in terms of the health systems building blocks in a more generic manner– financing, service delivery, human resources, leadership and governance, and medicines and technology (120).

However, it should be warranted that many of the more generic discussion points have limitations as a result of generalising across very different types of FBHPs (within different religious traditions), and different types of MHSs especially given the limited available literature on the topic. Nevertheless, we

### **Box 1 Summary of results**

1. There are a vast array of FBHPs and both alternative and biomedical MHS being utilised in Africa
2. The frequency of utilisation of FBHPs for MHS in terms of magnitude is relatively high, but there is missing data on all the types of FBHPs and the MHS they provide, specifically more faith-based biomedical types
3. Accessibility and availability of faith-based mental health services is present and they are more accessible than biomedical types of mental health services.
4. There is cultural and social acceptability related to faith-based mental health services
5. The quality of care for faith-based mental health services are adequate but in some cases it can lack quality due to continued use of religious perils
6. Herbal medicine and traditional medicine practices for MHSs are readily available, however they currently are lacking regulation and standardisation. Many side effects have been associated with herbal medicine

do so to lay the foundation for future researchers and policymakers to strengthen mental health systems in Africa, and globally.

#### *Improving financing towards faith-based mental health provision*

With respect to financing, the review suggests that financial constraints can hinder progress with respect to the magnitude and quality of FBHPs and the MHSs they provide in Africa. There were multiple examples of a lack of funding for scans, tests, offices, sufficient quantity of herbal medicine, transport and other technologies (67, 69). Furthermore, funding is often noted as a constraint to achieving better quality of MHS (86). This suggests that one way to strengthen mental health systems would be to devise innovative funding mechanisms for MHSs (see Table 6). A global study suggests that massive investments into traditional medicine are needed in order to ensure high quality care (121).

An improvement in funding mechanisms towards faith-based mental health provision would also assist in strengthening community mental health systems by creating opportunities for religious groups to collect funds to help the mentally ill (17, 67, 69). Studies from Ghana discuss prayer camps that were easily accessible, and had sufficient resources, but could not keep up with demand for services and sometimes accepted donations and gifts in lieu of monetary payments from patients (77). This aligns with evidence from outside of Africa, where for example, it has been proposed that in East and South-East Asian contexts, improved financing for mental health care (community types of services) could be achieved through collaboration between the private and public sector and an increase in availability of facilities and beds (122). It has been shown that traditional healers providing MHSs in Haiti have been found to be pro-poor based and most of the funding for the traditional healers comes from out-of-pocket expenses from the mentally ill who reside in the rural areas (122). It can be proposed that contracting out can be used and the types of contracts proposed for traditional healers need to remain affordable where there is an initial deposit; and final payment is only collected once the treatment is complete and the patient is satisfied with the outcome (10).

However, other types of faith-based MHSs are well-funded. One study found that some clergy and chaplains working within biomedical facilities are sufficiently supported and their expertise are valued as shown in one study (124). This suggests that similar funding mechanisms might be established in the African context (as shown in Figure 8). Additionally, there are ways to improve financing through innovative approaches to human resource management and capacity building of traditional healers (125).

#### *Leveraging training of faith-based health providers of mental health services*

It has been discussed globally that integrating cultural values into mental health services can indicate issues due to a tendency of overreliance and overdependence (126). There are however certain models which can be utilised in the African context through adapting global models of service delivery. These include task-shifting as proposed by the WHO, however this may cause a lower frequency of utilisations of traditional and faith healers when pushing biomedical models into their service provision (127). Therefore, it can be recommended that these models are specifically tailored towards the skills that traditional and faith healers possess through an enhancement of the alternative mental health services they already provide (10). Throughout Africa, this study revealed that in-patient facilities and mental health clinics are under resourced and funding allocated towards improved

quality of mental health services can potentially inform better quality of mental health care (77). However, the fundamental issue is that governments still do not recognise faith-based practices to be of importance, despite high levels of utilisation among vulnerable communities particularly.

There is evidence from this that faith-based biomedical facilities are providing psychiatric care where there are some (but very limited) available mental health services such as beds and biomedical providers providing mental health care in these facilities (103). It is shown in a couple examples that faith-based mental services are also culturally and socially acceptable as found in the African context and discussed in study the findings (86, 94). Faith-based health providers of mental health services hold strong values which are stemmed from the culture of the communities where they provide their services. Therefore, it is important that the training they receive is culturally sensitive, as highlighted in Ghanaian studies (86, 94). In addition, there is some evidence to support capacity-building of FBHPs through knowledge-sharing, where biomedical professionals could train traditional and faith healers to provide better quality MHSs. This is so there can be improved collaboration and partnerships in the future between these two types of mental health provision (83).

In the next section, we shall move away from the health systems building block analysis and focus on other themes that emerge more strongly from the results. Beyond these above discussed building blocks, other themes that emerge that relate to FBHPs in mental health systems – are issues such as the challenges of what we have called ‘religious perils’ and the lack of knowledge and skills for MHS. We will speak to relationships and values as some submergent themes that came out of the results. Cultural values which are part of the faith-based health providers and their mental health services is an important component to the frequency of utilisation and availability of the MHS. The relationships between faith-based health providers and their communities. When proposing training programs for FBHPs, it is important to focus on enhancing their existing skills and knowledge rather than imposing biomedical types of mental health provision.

The literature review suggests that these human rights abuses and other forms of maltreatment undermine the quality of faith-based mental health services as found in faith and traditional healing facilities– such as in Rwanda (149). As such, one approach to strengthening faith-based mental health systems is to introduce requirements for human rights training that eliminates these human rights abuses (86). “Although this is being done, there is still need to directly engage the traditional healers and train them in different aspects of mental health including the rights of patients because some of them still use inhuman practices of tying patients when they are under their care” (13). Traditional and faith healers in traditional and faith healing facilities, and clergy who utilised physical restraints and other possibly harmful treatments are deemed believe that these types of human rights abuses could help patients heal. However, this is not the case and more research is needed into the reasons that these practices still go on, and how they can be altered– such as through mental health training interventions (80).

There is evidence that FBHPs could be utilised more effectively through increased training to improve their knowledge and skills about mental illness (74, 90, 115). Mental health training in the form of ‘task shifting’ as recommended above by the WHO (10) and as discussed above, there is evidence to show that some clergy and traditional and faith healers not have the expertise and training to address mental illness (74, 76). Therefore, policy makers and researchers need to delve into what can be done in terms of health education interventions. This would strengthen the knowledge and skills of FBHPs

of MHS (tangible software) and increase the quality of, and access to, traditional medicine across Africa (17, 109). However, it is important to note that such interventions require very long training periods and are not always feasible (150).<sup>18</sup>

Health system building block and other important emergent themes	Comment/ Reviewed assessment/ issues
<b>Access to medicines</b>	-FBHPs are at the front line of delivery in rural areas so are more easily available and accessible (10, 65, 71, 78). -Are also more affordable because FBHPs can accept payment in gifts or monetary instalments
<b>Cultural appropriation (Values and norms)</b>	-Culturally embedded issues are included such as; rituals and ancestral relations. (11, 63, 65). -Some studies included culturally explanatory models and culturally embedded issues as part of their faith healing services (16). -Validated that reasons for consults were due to FBHPs having cultural beliefs (113). -Cultural symbols and idioms of distress used -Issues of overdependency (13, 14, 62).
<b>Socially supported systems</b>	-Individuals suffering from mental illness are surrounded by networks of families, programs and FBHPs (16). Examples include church programs, social cohesion to help mentally ill to improve bonds through their community linkages (15-17, 74).
<b>Information support</b>	-Churches serve as sites for mental health education and provide programmes (16, 17). -Clergy provide life enhancement activities and mental illness teaching programmes or religious teaching sessions (16, 17). -Issues exist with resources and these activities are not always provided (e.g. during festive seasons) (16)
<b>Human resources/ shortages/ Technology</b>	-Infrastructure shortages exist with chains and to make sure patients do not run away (75) -Other human resource shortages exist with pastors/ traditional healers in prayer camps and prayer forests (75)
<b>Financing mechanisms/ improvements</b>	-There are issues with funding mechanisms towards faith-based mental health provision and this interlinks with the technology they can afford such as office spaces, tests, scans (65, 67) -There is also a lack of finances towards equipment and medicines as well as issues because mentally ill are not paying FBHPs for their mental health services they provide (15).
<b>Skills and knowledge/ training programs</b>	-There is an overall lack of extensive knowledge and skills for mental illness among FBHPs, as well as a lack of qualifications to address serious mental illness (15, 66, 67, 107).
<b>Standardisation and regulation/ qualifications</b>	-There is no proper scientific method to testing herbal medicine, and a trial and error method is used for distribution (11, 83, 91). -No evidence based practices or regulation of herbal medicine, and side effects from the herbal medicine (69, 72, 83). -There is also mistrust from biomedical practitioners towards traditional healers. There are examples in Africa where there are fake healers which ruins the trust in the real healers (67).
<b>Issues with quality</b>	-Quality issues exist because of the use of religious perils which are human rights abuses, however, there has been training in Africa to create an abolition of the human rights abuses within prayer camps (64, 84).

**Table 6 The health systems relevance (Building blocks and other emerged themes) used in the review results section and summary of the relevant studies for purposes of discussion/ recommendations**

Collaborations and partnerships between traditional and biomedical health systems

It can be proposed that there needs to be some form of collaboration between traditional and biomedical systems which entails any potential integration at a systems and policy level (128). There is evidence in Africa where Ghana has managed to integrate traditional medicine into its mental health policies and has been attempting move closer towards universal health coverage (129). In the global sphere, there are examples from Malaysia that demonstrate that it is feasible to integrate traditional and faith healers into primary health care systems. In the case of the Malaysian health system, traditional healers provide a unique cultural perspective which is imperative within religious communities (130). Similarly, India has integrated “Ayurveda, Yoga and Naturopathy, Unani, Siddha,

<sup>18</sup> This is a highly complex idea and would require many resources, but is fundamentally an ideal that could be strived towards

and Homeopathy into their health care system” (131). However, without more conscious efforts on from researchers and policy-makers to integrate these two disparate systems, it can be problematic to overcome resource issues found in traditional health systems. More research and recognition is therefore needed in the field to show the value and importance of integrating traditional and biomedical health systems (132, 133).

Many barriers do still exist to formulating collaborations between traditional and biomedical systems and the integration of traditional medicine into national health systems. A human resource challenge pertaining to this is the strengthening of mental health systems through traditional and faith healers is because “there is a lack of trust between biomedical professionals and traditional and faith healers” (refer to Table 6) (134). This lack of trust is exacerbated because traditional and faith healers’ alternative mental health practices are discouraged by the biomedical field due to their unscientific nature (135). This is apparent in China where biomedical professionals often mistrust traditional healers (136). On the other hand, there are studies globally which show that there is potential when creating formal dialogue between traditional health practitioners and biomedical professionals in the mental health field (8). Therefore, it may be important for biomedical professionals to receive training on the reasons for high frequency of utilisation from traditional medicine and enable partnerships between biomedical professionals and faith-based health providers as well as create referral pathways. There is a need for referral pathways and knowledge exchange between the informal and formal health systems in the African sphere (69, 137).

A recent global study indicated that the use of clinical assessments are needed to evaluate this type of collaboration so that severe mental illness such as psychosis can be addressed and there is evidence to show a reduction in psychotic symptoms after a 6 month period (138).<sup>19</sup> Therefore, this evidence indicates the positive impact of a collaboration between traditional healing and biomedical services. So there is future evidence to show how traditional healing and biomedical services can have an impact on the improvement of mental health outcomes.

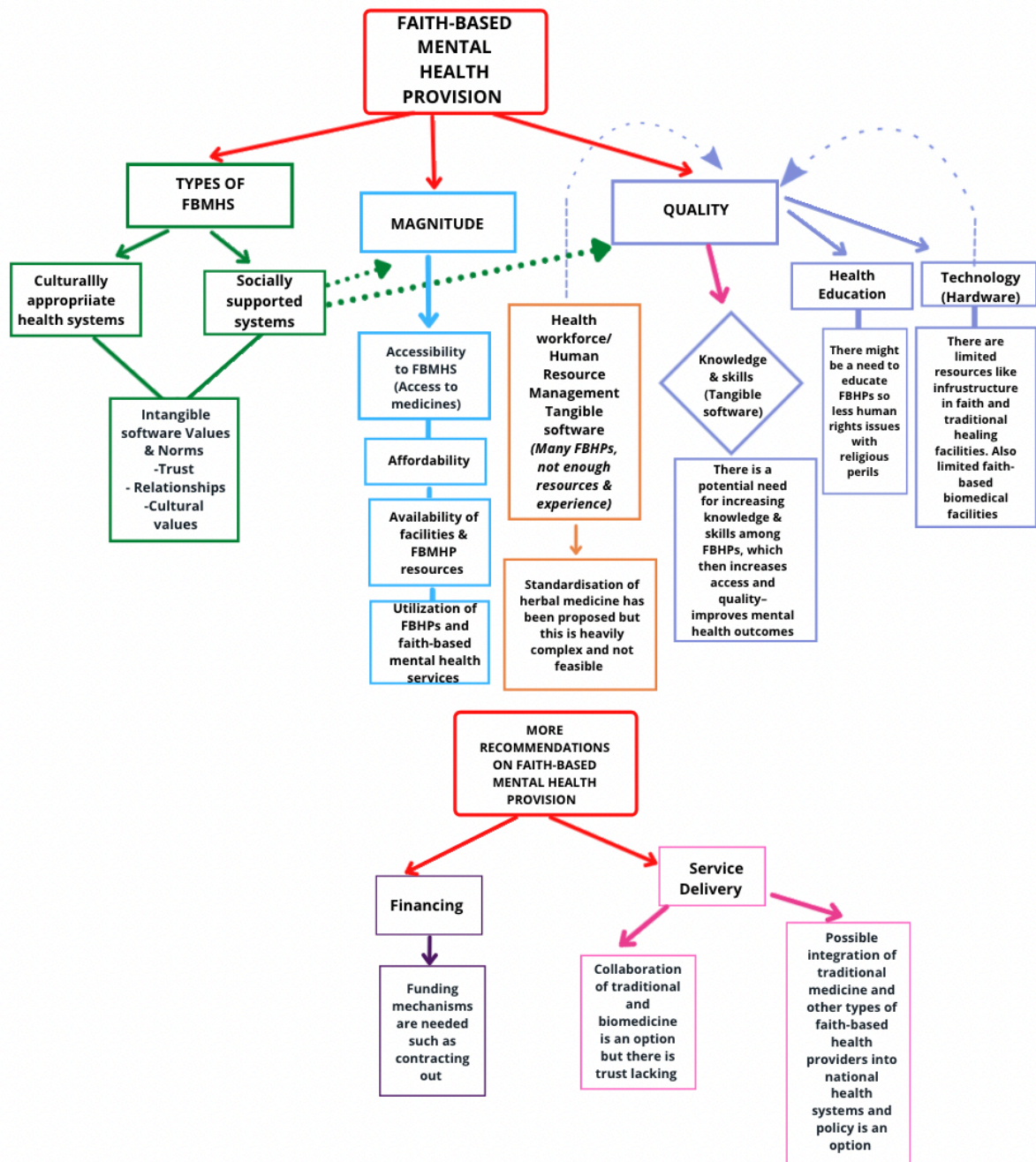
A full integration between traditional and biomedical health systems is an ideal that is often mentioned in the available literature, yet is rarely enacted in policy or implemented because this would require a full restructuring of health systems. It is also important that traditional medicine be kept at a low costs if it is to be integrated it into national health services (139). Overall, there are global examples such as in China where Chinese traditional medicine which has been integrated into their health systems, and in India in terms of Ayurveda medicine where this integration has been done successfully. Therefore, Africa does some ideal global examples of traditional medicine models when addressing mental illness to follow but is heavily idealistic and basically unachievable (133, 140-142). However, there are massive issues in the global literature which mention that problems arise from this vertical approach (143) and that and that there are scarcities in resources (144). A more logical outlook would entail the integration of mental health services into the mainstream of health care at every level of the community and the health system (8). However, this type of approach would need to use family and self-help tools through socially supported systems including primary health services and the inclusion of district level of mental health professionals as explained in Kenyan study (145).

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<sup>19</sup> This is also a recommendation to link to the improvement of the quality of faith-based mental health services

*Policy and governance*

At the policy-development and governance level, African governments can have the potential to support some level of integration particularly in relation to traditional and faith healers into their national mental health systems and their national health services. A Ghanaian study by Osei-tutu (2016) suggests that it is important to include traditional healers in future policies (83). However, there are also massive hinderances and red flags relating to the standardisation, any integration or regulation of herbal and traditional medicine (but not necessarily applicable to all types of faith-based mental health services) (83, 85). There has been a suggestion of increased regulation of traditional healers, and this could be expanded to some other types of FBHPs. It has been mentioned in many cases that herbal medicine could potentially be standardised in order to improve its quality, however due to the complexities of the ingredients and combinations used, this is not entirely feasible (145). The process needed to do this is timeous and there is a need for assurance on technical standards (146). However, the level of experimentation needed would be a tedious process delving into the characteristics within each type of herbal medicine (146, 147). Therefore, while this is an ideal recommendation, it is certainly a massive undertaking and not feasible and also, requires a heavy amount of resources and financial investment in the global and African contexts. There are very few countries which have been able to integrate and create some regulation pertaining to herbal medicine, however currently at an African level, this has not been possible. Examples of countries mentioned earlier that have been able to regulate and standardise herbal medicine to some degree, but not in a full integration sense as yet are India. India has managed to impose some regulations and standards for Ayurvedic medicine, including financing for regulation and oversight of Ayurvedic practitioners, and introducing academic qualifications that are required in order to be able to practice traditional medicine (148).



**Figure 8** Proposed health systems relevance (Health systems building blocks) and other important themes with recommendations.

Source: (117, 118).

**Box 2 Five top Recommendations for mental health systems in Africa**

1. There is a potential need for better funding mechanisms towards faith-based mental health services.
2. Herbal and traditional medicine standardisation and regulation has been advised, however this is not an ideal and is not feasible given the complexities of the type of medicine and variations across contexts— religions and cultures.
3. There is a recommendation for traditional and faith-healers to create referral pathways to biomedical practitioners in order to create some collaboration in the form of partnerships between these vastly different sectors.
4. There is evident mistrust between traditional and faith healers and biomedical professionals, so in the future it can be recommended that perhaps more dialogue and interventions can be centred around this lack of trust, and eventually attempt to break down the barriers that have been created over a very long period of time.
5. Integration of traditional medicine into national mental health systems is a recommendation, but presently there are many barriers which need to be overcome and future research needs to explore exactly how this can be achieved.

**Limitations**

This study had research gaps which included that the faith-based biomedical field was under explored and due to the large complexities of this study, it was extremely difficult to make sure the search terms were as accurate as possible and this took a lot of trial and error. Another limitation is that there is limited literature available on this topic, so the scope of the review is necessarily broad, and can only cover examples and instances where data is available.

Future research might benefit from focusing on only one type of provider or service. Also, given that both faith-based, biomedical and traditional medicine for mental illness is an under-explored field, there is a need for further studies focussing on the policies and policy-making for faith-based mental health services. This was beyond the scope of the present study. This study also only included the main databases in the searches and there are definitely more databases available which relate to this topic. In terms of future empirical and review studies, it can be recommended that there is a need for increased quantitative studies on the types of faith-based mental health providers and the services they deliver. These types of studies can be conducted in the future so that accurate magnitude data on the accessibility of these studies and provide more accurate frequencies of the types of faith-based mental health services and providers utilised. We aimed to assess magnitude (which is inclusive of frequency of utilisation and availability and number of beds and facilities within faith-based health providers and the variety in the types of MHS as a proxy for magnitude), however we found very limited data on the number of bed and number of facilities); as we as limited insights and research on affordability and acceptability (as partial proxies for availability). Therefore, this is a limitation for this study and also indicates an urgent necessity for more research on this other components of 'magnitude' in relation to faith-based mental health provision in Africa.

There is also a need for more grey literature in this arena, because this study identified many gaps on the availability of theses and organisational reports which meant using non-empirical data in some instances such as commentaries which reduced the methodological nature and rigour of this study quite significantly.

**Conclusion**

There are multiple levels, components, and complexities pertaining to faith-based mental health provision both at a facility and community level of the health system delivered by individual and organisational providers. The types of MHSs are either alternative or biomedical, with many intersections and overlaps. This review highlights the importance of incorporating FBHPs and the large array of faith-based mental health services they provide into governance and policy decisions in the future. This is especially pertinent given that the majority of the African population seek services from faith-based mental health providers, especially rural and hard-to-reach populations.

Some the factors mentioned in this article exist in a dynamic relationship with one another and the broader health system. The review highlights the urgent need to recognise faith-based mental health services as an integral part of African (and other low-and-middle income) health systems in the future. An ideal future would be where faith-based are better funded yet still attain their cultural qualities, where providers are able to educate their surrounding communities on mental health and have training in order to improve the magnitude as well as quality of FBHPs.

Finally, faith-based health providers and the mental health services they deliver need to be researched further in order to reduce the major mental health service gap present in Africa. This would help to ensure that the mentally ill in Africa are empowered not only to deal with the religious and spiritual dimensions of mental illness (both alternative and biomedical types of MHS); but also, to ensure that FBHPs are well-equipped to provide MHSs that are of a higher quality– thereby improving mental health outcomes on the continent as a whole.

“The multi-agency nature of mental health-care services requires a strategic posture that invites all into delivering a holistic health care; and in that regard clergy cannot be excluded” (76).

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## Appendices

### *Appendix 1 Search terms for systematic review*

#### **PubMed**

(((((Africa OR African OR Algeria OR Angola OR Benin OR Botswana OR "Burkina Faso"[Text Word] OR Burundi OR "Cabo Verde"[Text Word] OR Cameroon OR Cameroun OR "Canary Islands"[Text Word] OR "Cape Verde"[Text Word] OR "Central African Republic"[Text Word] OR Chad OR Comoros OR Congo OR "Cote d'Ivoire"[Text Word] OR "Democratic Republic of Congo"[Text Word] OR Djibouti OR Egypt OR Eritrea OR eSwatini OR Ethiopia OR Gabon OR Gambia OR Ghana OR Guinea OR Guinea- Bissau OR "Ivory Coast"[Text Word] OR Jamahiriya OR Kenya OR Lesotho OR Liberia OR Libya OR Madagascar OR Malawi OR Mali OR Mauritania OR Mauritius OR Mayotte OR Morocco OR Mozambique OR Namibia OR Niger OR Nigeria OR Principe OR Reunion OR Rwanda OR "Saint Helena"[Text Word] OR "Sao Tome"[Text Word] OR Senegal OR Seychelles OR "Sierra Leone"[Text Word] OR Somalia OR "St Helena"[Text Word] OR Sudan OR Swaziland OR Tanzania OR Togo OR Tunisia

OR Uganda OR "Western Sahara"[Text Word] OR Zaire OR Zambia OR Zimbabwe)) OR ("Africa"[Mesh])) NOT ((African American OR Rural South OR UK OR Asia OR Thailand))) AND (("Mental Health"[Mesh]) OR ((mental health OR mental illness OR mental disorder OR mental disorders OR distress OR psychosis OR mental health systems OR mental health services OR psychosocial OR posttraumatic stress disorder OR counselling OR counselling OR counselling methods OR counselling methods OR counselling services OR counselling services)))) AND (((((((((((faith-based OR faith-based organization OR faith-based organizations OR faith-based organisation OR faith-based organisations OR faith based organization OR faith based organizations OR faith based organisation OR faith based organisations OR faith-based providers OR faith-based health providers)) OR ((mission hospital OR church facility OR mission facility OR mission facilities OR church facilities))) OR ((non-state actors OR non-state providers OR private not-for-profit OR public-private partnerships))) OR ((faith healing OR faith healer OR faith leader OR imam OR imams OR clergy OR clerics OR religious leader OR religious healer OR Christian healer OR Muslim healer OR minister OR minister OR pastor OR pastors OR rabbis OR rabbi OR priest OR priests OR church-based or prayer))) OR ((traditional healer OR traditional healing OR traditional medicine OR African traditional medicine OR traditional health practitioners OR traditional medical practitioners OR indigenous healing OR traditional herbalist OR herbal OR herbal medicine OR witchcraft OR witch doctor OR demon OR demonic OR evil OR evil-eye OR spirit OR spirits OR spiritual therapies OR phytotherapy OR holy spirit OR holy spirits OR diviner OR ministrations of diviners OR medicine men OR sorcerers OR herbalist OR herb OR oils OR Sangoma OR Zulu healer OR Sanusi OR worship OR ritual OR incarceration))) OR ((religious OR religion OR Adventist OR Allah OR Anglican OR Baha'i OR Baptist OR Bible OR Buddhism OR Buddhist OR Caliph OR Catholic OR Christ OR Christian OR Christianity OR Church OR Church of Christ OR Confucianism OR Congregation OR Coptic OR Daoism OR Dutch Reformed OR Ecumenical OR Episcopal OR Evangelical OR Evangelism OR Evangelist OR God OR Hindu OR Hinduism OR Holy OR Interfaith OR Islam OR Jain OR Jainism OR Jehovah's Witness OR Jesus OR Jesus OR Jewish OR Jews OR Judaism OR Koran OR Latter-Day Saint OR Load OR Lutheran OR Mennonite OR Methodist OR Ministries OR Ministry OR Mission OR Missionaries OR Missionary OR Mohammed OR Mormon OR Mosque OR Muhammad OR Mullah OR Muslim OR Orthodox OR Pentecostal OR Presbyterian OR Protestant OR Quaker OR Qur'an OR Religion OR Religious OR Salvation OR Samaritan OR Seventh-Day Adventist OR Shia OR Shi'ite OR Shinto OR Sikh OR Sunni OR Synagogue OR Torah OR Wahhabi OR Zion OR Zionism OR Zionist))) OR ("Clergy"[Mesh])) OR ("Faith Healing"[Mesh] OR "Faith-Based Organizations"[Mesh])) OR ("Medicine, Traditional"[Mesh:NoExp])) OR ("Medicine, African Traditional"[Mesh]))

#### Scopus

(( TITLE-ABS-KEY (( algeria OR angola OR benin OR botswana OR "Burkina Faso" OR burundi OR "cabo AND verde" OR cameroon OR cameroun OR "Canary Islands" OR "Cape Verde" OR "Central African Republic" OR chad OR comoros OR congo OR "Cote d'Ivoire" OR "Democratic Republic of Congo" OR djibouti OR egypt OR eritrea OR eswatini OR ethiopia OR gabon )) OR ( TITLE-ABS-KEY (( gambia OR ghana OR guinea OR "Guinea Bissau" OR "Ivory Coast" OR jamahiriya OR kenya OR lesotho OR liberia OR libya OR madagascar OR malawi OR mali OR mauritania OR mauritius OR mayotte OR morocco OR mozambique OR namibia OR niger OR nigeria OR principe OR reunion OR rwananda ))) OR ( TITLE-ABS-KEY (( "saint AND helena" OR "sao AND tome" OR senegal OR seychelles OR "sierra AND leone" OR somalia OR "st AND helena" OR sudan OR swaziland OR tanzania OR togo OR tunisia OR uganda OR "western AND sahara" OR zaire OR zambia OR zimbabwe ))) OR ( TITLE-ABS-KEY ( africa\* )) AND ( TITLE-ABS-KEY ( ("mental health" OR "mental illness\*" OR "mental disorder\*" OR distress OR psychosis OR "mental health system\*" OR "mental health service\*" OR psychosocial OR "posttraumatic stress disorder" OR counselling OR counseling ))) AND ( ( TITLE-ABS-KEY ( ( religious OR religion OR adventist OR allah OR anglican OR baha'i OR baptist OR bible OR buddhism OR buddhist OR caliph OR catholic OR christ OR christian OR christianity OR church OR "Church of Christ" OR confucianism OR congregation OR coptic OR daoism OR "Dutch Reformed" OR ecumenical OR episcopal OR evangelical OR evangelism OR evangelist OR god OR hindu OR hinduism OR holy OR interfaith OR islam OR jain OR jainism OR "Jehovah's Witness" OR jesuit OR jesus OR jewish OR jews OR judaism OR koran OR "Latter-Day Saint" OR load OR lutheran OR mennonite OR methodist OR ministries OR ministry OR mission OR missionaries OR missionary OR mohammed OR mormon OR mosque OR muhammad OR mullah OR muslim OR orthodox OR pentecostal OR presbyterian OR protestant OR quaker OR qur'an OR religion OR religious OR salvation OR samaritan OR 'seventh-day AND adventist' OR shia OR shi'ite OR shinto OR sikh OR sunni OR synagogue OR torah OR wahhabi OR zion OR zionism OR zionist ))) OR ( TITLE-ABS-KEY ( ("traditional healer\*" OR "traditional healing" OR "traditional medicine" OR "African traditional medicine" OR "traditional health practitioner\*" OR "indigenous healing" OR "traditional herbalist" OR herbal OR "herbal medicine" OR witchcraft OR witch AND doctor OR demon OR demonic OR evil OR "evil-eye" OR spirit\* OR "spiritual therap\*" OR phytotherap\* OR "holy spirit\*" OR diviner OR "ministrations of diviners" OR "medicine men" OR sorcerers OR herbalist OR herb OR oils OR sangoma OR "Zulu healer\*" OR sanusi OR worship OR ritual OR incarceration ))) OR ( TITLE-ABS-KEY ( ("faith healing" OR "faith healer" OR "faith leader" OR imam\* OR clergy OR clerics OR "religious leader\*" OR "religious healer\*" OR "Christian healer\*" OR "Muslim healer\*" OR minister\* OR pastor\* OR rabbi\* OR priest\* OR "church-based" OR prayer ))) OR ( TITLE-ABS-KEY ( ( partnership\* OR collaboration ))) OR ( TITLE-ABS-KEY ( ( "non-state actor\*" OR "non-state provider\*" OR "private not-for-profit" OR "public-private partnership\*" ))) OR ( TITLE-ABS-KEY ( ( "mission hospital\*" OR "church facilit\*" OR "mission facilit\*" ))) OR ( TITLE-ABS-KEY ( ( "faith-based" OR "faith-based organization\*" OR "faith-based organisation\*" OR "faith based organization\*" OR "faith based organisation\*" OR "faith-based provider\*" ))) ))

EBSCOhost (Cinahl, Medline, PsycInfo, Atla Religion and PsycArticles)

( algeria OR angola OR benin OR botswana OR "Burkina Faso" OR burundi OR "cabo AND verde" OR cameroon OR cameroun OR "Canary Islands" OR "Cape Verde" OR "Central African Republic" OR chad OR comoros OR congo OR "Cote d'Ivoire" OR "Democratic Republic of Congo" OR djibouti OR egypt OR eritrea OR eswatini OR ethiopia OR gabon ) ) OR ( ( gambia OR ghana OR guinea OR "Guinea Bissau" OR "Ivory Coast" OR jamahiriya OR kenya OR lesotho OR liberia OR libya OR madagascar OR malawi OR mali OR mauritania OR mauritius OR mayotte OR morocco OR mozambique OR namibia OR niger OR nigeria OR principe OR reunion OR rwanada ) ) OR ( ( "saint AND helena" OR "sao AND tome" OR senegal OR seychelles OR "sierra AND leone" OR somalia OR "st AND helena" OR sudan OR swaziland OR tanzania OR togo OR tunisia OR uganda OR "western AND sahara" OR zaire OR zambia OR zimbabwe ) ) OR ( africa\* ) ) AND ( ( "mental health" OR "mental illness\*" OR "mental disorder\*" OR distress OR psychosis OR "mental health system\*" OR "mental health service\*" OR psychosocial OR "posttraumatic stress disorder" OR counselling OR counseling ) ) AND ( ( religious OR religion OR adventist OR allah OR anglican OR baha'i OR baptist OR bible OR buddhism OR buddhist OR caliph OR catholic OR christ OR christian OR christianity OR church OR "Church of Christ" OR confucianism OR congregation OR coptic OR daoism OR "Dutch Reformed" OR ecumenical OR episcopal OR evangelical OR evangelism OR evangelist OR god OR hindu OR hinduism OR holy OR interfaith OR islam OR jain OR jainism OR "Jehovah's Witness" OR jesuit OR jesus OR jewish OR jews OR judaism OR koran OR "Latter-Day Saint" OR load OR lutheran OR mennonite OR methodist OR ministries OR ministry OR mission OR missionaries OR missionary OR mohammed OR mormon OR mosque OR muhammad OR mullah OR muslim OR orthodox OR pentecostal OR presbyterian OR protestant OR quaker OR qur'an OR religion OR religious OR salvation OR samaritan OR 'seventh-day AND adventist' OR shia OR shi'ite OR shinto OR sikh OR sunni OR synagogue OR torah OR wahhabi OR zion OR zionism OR zionist ) ) OR ( ( "traditional healer\*" OR "traditional healing" OR "traditional medicine" OR "African traditional medicine" OR "traditional health practitioner\*" OR "indigenous healing" OR "traditional herbalist" OR herbal OR "herbal medicine" OR witchcraft OR witch AND doctor OR demon OR demonic OR evil OR "evil-eye" OR spirit\* OR "spiritual therap\*" OR phytotherap\* OR "holy spirit\*" OR diviner OR "ministrations of diviners" OR "medicine men" OR sorcerers OR herbalist OR herb OR oils OR sangoma OR "Zulu healer\*" OR sanusi OR worship OR ritual OR incarceration ) ) OR ( ( "faith healing" OR "faith healer" OR "faith leader" OR imam\* OR clergy OR clerics OR "religious leader\*" OR "religious healer\*" OR "Christian healer\*" OR "Muslim healer\*" OR minister\* OR pastor\* OR rabbi\* OR priest\* OR "church-based" OR prayer ) ) OR ( ( "non-state actor\*" OR "non-state provider\*" OR "private not-for-profit" OR "public-private partnership\*" ) ) ) OR ( ( "mission hospital\*" OR "church facilit\*" OR "mission facilit\*" ) ) ) OR ( ( "faith-based" OR "faith-based organization\*" OR "faith-based organisation\*" OR "faith based organization\*" OR "faith based organisation\*" OR "faith-based provider\*" ) ) ) Published Date: 20060101-20211231 AND Apply equivalent subjects on 2021-06-08 02:38 PM"

#### Added search terms

Psychiatric, faith-based biomedical facilities, faith-based psychiatric service, faith-based psychiatric care.  
Faith-based community mental health education, mental health screening, faith-based home care mental health

#### Appendix 2 Articles included in the systematic review

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## Appendix 3 Summary of data extraction sheet (Methods)

Author/ date	Country	Aim/ study focus	Study design	Data collection tools	Sampling strategy/ representativeness	Types of participants	Data analysis	Overall quality of study
Khiari et al (2019)	Tunisia	This study aimed to look at the pathways to determine what pathways for mental health services were used by individuals in order to look at why there were care delays and examine the relationship for longer consultations.	Quantitative: Cross-sectional design	Face-to-face interviews and hetero questionnaire	Not stated	Patients seeking services from an outpatient clinic	SPSS software, chi-square and t-test	Good
Sorketti (2013)	Sudan	The aim of this study was to discover the outcomes of traditional healing practices in helping mentally ill with treatment and there were recommendations made in order to improve the quality of care within traditional healing facilities.	Quantitative: Prospective cohort design	Questionnaire	Non-probability and no sampling representativeness	Patients	Descriptive statistics	Good
Zingela (2019)	South Africa	This study focused on the investigation of patterns of utilisation among THs.	Quantitative: Cross sectional and descriptive design	Questionnaire	Purposive (non-probability sampling) and no sampling representativeness	Psychiatric patients	Descriptive statistics and logistic regression analyses	Good
Assad (2015)	Egypt	This study aimed to assess at the rates of bipolar disorders among patients who sought care from traditional healers	Quantitative	“Structured Clinical Interview for DSM-IV axis” to validate the bipolar diagnosis and semi-structured interviews	No sampling strategy or representativeness mentioned	Bipolar patients going to a tertiary hospital	Chi-squared test and fishers exact test statistics	Good
Sorsdahl (2009)	South Africa	This was a quantitative descriptive survey type of study which looked at mental illness prevalence.	Quantitative	Questionnaire: World Mental Health Composite International Diagnostic Interview (WMH-CIDI)	Probability multi-stage design and no sampling representativeness	Patients seeking faith-based mental health care	STATA, Pearson chi-square test, t-test	Good
Ibrahim Awaad (2020)	Egypt	This study aimed to measure the pathways schizophrenia patients used to seek help from THs and how MHSs can be made more accessible.	Quantitative	Questionnaire: “Structured Clinical Interview for DSM-IV Axis I Disorder (SCID-I)”	No sampling strategy or representativeness mentioned	Patients at inpatient ward or outpatient clinic of the Institute of Psychiatry,	Chi square test, t-test	Good

Nartey (2019)	Ghana	This study aimed to look at treatment pathways of MHS among consumers and included faith-based practices level of magnitude.	Quantitative	Questionnaire	Non-probability multi-stage sampling, cluster then systematic sampling	Respondents with mental illness seeking mental health services	Descriptive and inferential statistics	Good
Van Duijl (2014)	Uganda	The aim of this study was to explore mental health symptoms while also delving into the steps needed to seek care with an inclusion of explanatory models among respondents with spirit possession.	Mixed-methods	Questionnaire: Semi-structured interviews (using The Spirit Possession Questionnaire- Uganda) and open-ended questions for qualitative component to get narratives	Quant: Cluster sampling	Participants with spirit possession	Qual: content and thematic analysis Quant: SPSS software for basic statistics	Good
Sorketti (2011)	Sudan	The aim of this study was to discover the mentally ill's characteristics at traditional healing centres as well as the types of mental health services used to treat mental illness.	Mixed-methods: Descriptive cross-sectional study	Questionnaire: Specially designed questionnaire	Quant: not mentioned	Inpatients with mental illness in traditional healer centres in Sudan.	Data was analysed using statistical package (SPSS).	Good
Agara (2008)	Nigeria	This study had a purpose to explore the knowledge, attitudes and practices of mental health services among healers within churches, examine their treatment modalities and discover their willingness to partner with biomedical types of mental health professionals.	Mixed-methods	Questionnaire: pre-tested	Quant: not mentioned	15 spiritual healers	The statistical analysis used was Epi Info version 6.02 with frequency and summary statistics generated.	Good
Mbwayo (2013)	Kenya	The main goal of this study was to look at type of mental disorders and how THs treated them.	Mixed-methods	Questionnaires and in-depth interviews to look at psychiatric diagnoses utilising the Mini-Plus	Opportunistic sampling	Mental illness patients and traditional healers	Statistical analyses used were SPSS for quant and thematic analysis for qual	Good
Kaiser (2020)	Nigeria	This mixed-methods study using a sequential exploratory design sought to explore the psychosocial and mental health burden, current resources and coping mechanisms as well as needs among internally displaced people as well as	Mixed-methods	Key Informant and focus group discussions	Random walk protocol (no sampling frame)	Local NGO staff, traditional healers, community/religious leaders	The data analysis method used for the qualitative component were free lists which were analysed using the AnthroPac which	Good

		communities hosted in Bomo State, Nigeria.					looks at the frequency and proportion of participants. Further, FGDs and interviews were analysed to find out themes and then transferred into codes. The data analysis method used for the quantitative component used a descriptive analysis using a Likert scale which was changed into scores.	
Fournier (2012)	Ghana	This paper aimed to focus on two out of three psychiatric hospitals in Ghana and analysed the hospitals resources, available services and the previous annual number of out-patients and in-patients as well as the most frequent diagnoses.	Mixed-methods	The qualitative component used in-depth interviews that addressed the research question. However, the quantitative data was found through logistical and secondary data from the visits to psychiatric hospital records department which were measurement tools that were appropriate to answer the research question.	No mention of sampling	Two psychiatric hospitals in Ghana	No statistical analyses	Lower quality but lacked extensive data on traditional healers, this portrayed itself as more of an opinion piece but of primary data
Iheanacho (2021)	Nigeria	This purpose of this study was to discover the possibility for clergy based intervention among women with depression in south-eastern Nigeria.	Mixed-methods	This study used a 14-item questionnaire for the quantitative part in order to discover the perceptions around depression and preferential treatment among women. The qualitative part used focus group discussions	No mention of sampling	Clergy	The statistical analyses used for the quantitative part of this study were analysed through SPSS post coding and sorting the questionnaire and underwent	Good quality

				for cultural perceptions and knowledge belief of FBHPs.			descriptive statistical analyses and results were portrayed in tables and a frequencies.	
Lambert (2020)	Ghana	Traditional and faith-based healers (20) were selected for this study from each location in in parts of Ghana.	Quantitative	Semi-structured questionnaire	Purposive sampling	Traditional and faith-based healers	It was mostly quantitative and added by open ended descriptive data which were created from chi-square and t-tests and then contrasted to sub samples. This data was analysed by a content analysis and themes found.	<b>Good quality</b>
Olasinde (2020)	Nigeria	It is present services offered at a mission tertiary hospital.	Quantitative	A study proforma was utilised to get needed data	Purposive sampling at a hospital on patients	Chaplains	Data was found entering spreadsheets and using	Good quality
Ng (2016)	Rwanda	This study aimed to give feedback on clinical care used for PTSD and substance use at a faith-based hospital.	Quantitative	Data was collected from Clinical notes and patient charts.	No sampling mentioned	Faith-based hospital	Descriptive statistics, t-tests.	Good quality
Selamu (2015)	Ethiopia	The purpose of this study was to perform community resources mapping so that there is better mental health care utilisation at a primary health level.	Quantitative	A handbook from a community assessment was utilised to collect the quantitative data in this study particularly using a community resource inventory.	Non-probability sampling	Herbalists, traditional and faith-based practitioners, organisations, churches and mosques.	Descriptive analysis	Good quality
Esan (2019)	Ghana, Kenya and Nigeria	This study was part of a primary study before an RCT pertaining to care program partnership and was instituted by THPs and BMPs.	Quantitative	Quantitative descriptive survey	Snowballing sampling (non-probability sampling)	Herbalists, diviners, Christian faith healers, Islamic faith healers, herbalist and Christian,	Descriptive	Good quality

						herbalist and Islam and Witchcraft.		
Omer (2018)	Sudan	This study had aims to look at families attitudes as well as patients related to traditional healing at a hospital.	Quantitative	Questionnaire	No sampling strategy mentioned	Families and patients seeking traditional healers	Chi-squared test and significant variables	Good quality
Aja (2019)	Nigeria	This study aimed to look at personal experiences of chaplains in a faith-based hospital in relation to spirituality	Qualitative	Questionnaires	No sampling	Chaplains	Thematic	Good quality
Dube (2020)	Zimbabwe	This main purpose of this study was to try to comprehend Zimbabwean chaplains expertise when coping with mental disorders, their understanding of diagnostic criteria and what they implement the criteria towards.	Book	In-depth interviews	No sampling mentioned	Chaplains	Book review type with primary data from interviews	Good quality
Dhamani (2011)	Tanzania	The main aim of this study was to explore reason why nurses Tanzania comprehend spirituality and the delivery of spiritual care.	Qualitative	In-depth face to face semi-structured interviews	No sampling mentioned	Religious leaders working in biomedical facilities	Coding profess	Good quality
Osei-tutu (2020)	Ghana	This study investigated premarital counselling practices being provided in Islamic religious and Christian contexts in Ghana.	Qualitative	Interviews (but no specific types mentioned)				
Salifu Yendork (2016)	Ghana	The aim of this study precisely zoomed in on congregants awareness of the definition, types and symptoms of mental disorders as well as church's education on mental disorders and the thereafter impact on the knowledge on congregants mental health.	Qualitative	In-depth interviews and focus group discussions as well as observations of church activities were utilised for collecting data.	Convenient, snowball and purposive sampling (non-probability sampling)	Religious leaders such as pastors and imams	Phenomenological Analyses	Good quality
Yaro (2020)	Ghana	The study aimed to discuss the training within prayer camps and referral services that took place between FBHPs and	Qualitative	In-depth and face-to-face interviews	Purposive sampling	Spiritual healers and traditional health practitioners	No in-depth analysis mentioned extensively but thematic and	Lower quality

		formal mental health services. training of informal providers					narrative analysis briefly stated	
Asamoah (2014)	Ghana	This study aimed to analyse the perceptions of Pentecostal clergy and their role of their churches in mental health-care provision within a Ghanaian context.	Qualitative	Semi-structured interviews	Purposive sampling	Clergy	Thematic analysis	Good quality
Ebimbo (2018)	Nigeria	The main aim of this study was to provide church support to older adults in Nigeria and find out more about the types of mental health care they provide.	Qualitative	Focus group discussions and in-depth interviews	No sampling mentioned	Church-based organisations	Thematic analysis	Good quality
Bantjes (2018)	South Africa	The aim of this study was to look at suicide and how traditional healers can recognise symptoms as well as how they work on the front lines to deal with suicidal behaviour.	Qualitative	In-depth semi-structured interviews.	Purposive and snowball sampling	Traditional healers	Brief thematic analysis	Good quality
Im (2017)	Somalia	This study aims to explore cultural idioms of distress among Somali displaced refugees in Kenya in order to understand the contextual culture in a sensitive yet responsive manner.	Qualitative	Key-informant and focus group interviews	Purposive sampling	Traditional healers	Template analysis method-a form for thematic analysis to organise themes	Good quality
Knettel (2018)	Tanzania	The aim of this study was to discover how mental health providers are treating the mentally ill through looking at various frameworks, views of patients and what causes their mental illness. Also the impact of alternative types of MHS utilised by patients in traditional and faith healing facilities.	Qualitative	Open-ended, semi-structured interviews	Snowball sampling	Traditional and faith healers	Consensual qualitative research and the constant comparative method with line-by-line coding	Good quality
Kpobi (2019) 'Ghanaian traditional and faith healers'	Ghana	The aim of this research was to explain possession from the angle of TFHs as well as the reasons why TFHs are more	Qualitative	Semi-structured interviews	Case-vignette	Faith healers	Thematic analysis through ATLAS software	Good quality

explanatory models..”		accessible in comparison to BMPs with increased rates of utilisation.						
Musyimi (2018)	Kenya	The aim of this study was to provide data in a foundational sense in order to find the perceptions of TFHs within Kenyan rural areas using FGDs.	Qualitative	Focus group discussions	Random sampling	Traditional and faith healers	Thematic analysis then open coding	High quality (used random sampling)
Ae-Ngibise (2010)	Ghana	The aim of this study was to find out the justifications around why TFHs are widely used as well as a focus on the facilitators and barriers to collaboration between THPs and BMPs.	Qualitative	Semi-structured interviews and focus group discussions	Purposive sampling	Traditional and faith healers	Situational analysis among the status of mental health policy, services and legislation in Ghana. "An a priori analytical framework" was used, which was created according to the thematic areas.	Good quality
Ally (2008)	South Africa	The aim of this study was to look at Muslim Faith Healers views of mental illness and spiritually caused illness across the two different modes of treatments.	Qualitative	Semi-structured interviews	Non-probability convenience sampling	Muslim faith healers	Thematic context analysis	Good quality
Arias (2016)	Ghana	The aim of this study was to explore practices and beliefs within prayer camps as well as find out insights into potential partnerships between prayer.	Qualitative	Semi-structured interviews	Purposive sampling	Prophets and prophetesses in prayer camps	Constant comparative methods and thematic coding	Good quality
Kpobi (2018) ‘That is how the real mad people behave’:	Ghana	The aim of this study was to determine the reasons and beliefs for mental illness among traditional medicine men.	Qualitative	Semi-structured interviews	Purposive and convenience sampling	Herbalists and traditional healers	Thematic analysis	Good quality
Kpobi (2019)	Ghana	The aim of this study was to find out beliefs on mental	Qualitative	Semi-structured interviews	Purposive and convenience sampling	Traditional medicine men	Thematic analysis	Good quality

“Muslim traditional healers”		illness from the perception of Muslim faith healers.						
Read (2009)	Ghana	The goal is to research the methods utilised for mental disorders by traditional healers in Ghana of which a qualitative description is well suited for this research aim.	Qualitative	Semi-structured interviews	Purposive sampling	Traditional healers	Thematic coding using a 6-step model	Good quality
Asasira (2018)	Uganda	The overall aim of this research was to find out the impact of public-private partnerships on mental health outcomes of the population targeted as well as issues of how these faith-based biomedical providers can improve these outcomes.	Qualitative	Semi-structured interviews	Purposive sampling	Mission hospital	No mention of analysis	Lower quality
Anyebe (2019)	Nigeria	This study aimed to report current status on the availability of mental health services at various faith-based biomedical providers.	Qualitative	Semi-structured interviews	Purposive sampling	Faith-based biomedical providers: hospitals	Thematic clustering data analysis	Good quality
Kajawu (2016)	Zimbabwe	This study aimed to explore THs and the perceptions on the various types of faith-based mental health services	Qualitative	Semi-structured interviews	No mention	Herbalists and traditional healers	Thematic analysis	Good quality
Rukambe (2019) Thesis	South Africa	The purpose of this study was to create guidelines for social workers to attain spiritual sensitivity in their mental health practices.	Qualitative	One-day workshops to create guidelines	Purposive sampling	Social workers using spirituality	Thematic analysis	Good quality
Maina (2017) Thesis	Zimbabwe	The purpose of this study was to get data on “PCEA Milimani south presbytery supports bereaved families.”	Mixed-methods	Questionnaires and interview	Purposive sampling	Presbytery	Deductions were made and inferential analysis.	Good quality
Murambidzi (2016) Thesis	Zimbabwe	This study aimed to look at clergy’s responses and how mental illness is recognised.	Qualitative	Face-to-face interviews	Purposive sampling	Clergy	Framework type and using in-depth analysis	
Mashamaite (2015)	South Africa	The purpose of this study was to discover what types of	Qualitative	Semi-structured interviews	Purposive sampling	Traditional healers	Content analysis	

		mental health treatment traditional healers use.						
Martin (2019)			Commentary					
McAdam (2016)			Commentary					
Rusengamihigo (2021)	Rwanda	This study aimed to measure the linkage between mental health or parents and their offspring.	Quantitative					
Rugema (2015)	Rwanda	This study aimed to find out experiences of health care professionals specifically looking at facilitators and barriers for mentally ill who seek mental health care.	Qualitative	Interview guide	Convenience sampling		Content analysis	
Assad (2015)	Egypt	The aim of this study was to examine the rate of bipolar disorder patients who use traditional healers and the clinical characteristics of those patients.	Quantitative	"Structured Clinical Interview for DSM-IV Axis I Disorder (SCID-I)"	No sampling mentioned	Traditional healers	Statistical analysis using SPSS	
Kaiser (2019)	Nigeria	This study discovered the "mental health and psychosocial (MHPs) burden" and present resources, coping strategies and the needs among host communities and internally displaced persons (IDPs).	Mixed-methods	Surveys, interviews, free lists, focus group discussions	Random walk sampling	Internally displaced people	Descriptive analysis, Anthropic and audio-recordings and transcript that were modified	Good quality
Ng (2016)	Rwanda	This program was done in order to identify, gather, summarise and evaluate certain patient-types of indicators pertaining to treatment for "PTSD in the Rwanda health care system	Quantitative	Patient clinical charts	Chart reviews	Patients with PTSD	t-tests and descriptive statistics	
Musyimi (2017)	Kenya	The aim of this study was to find out the "relationship between depression, suicidal ideation and socio-demographic variables with Quality of Life (QOL) variables	Quantitative	Beck Depression Inventory II (BDI-II), Beck Scale for Suicide Ideation (BSS) and WHO Quality of Life Survey-BREF (WHOQOL-BREF),	No mentioned sample	Cross sectional epidemiological surveys	Parametric tests, regression analyses and correlation analyses	

		in people using MHS from traditional and faith healers.						
Sorsdahl (2010) Traditional healer attitudes	South Africa	The purpose of this study was to use “use the constructs of the Theory of Planned Behaviour (TPB)” to find out how referral practices among traditional healers with mentally ill patients.	Qualitative	Focus groups	Convenience sampling	Framework approach		

## Appendix 4 Summary of data extraction sheet (Results)

Author/ date	Country	Individual/ Organisational providers	Level of the health system	Types of FBHPs	Types of MHS (6 types)	Other health systems building blocks across all types of MHS	Magnitude findings (access, avail, afford)	Quality (MHS) findings/ religious perils/ outcomes on mental health
Khiari et al (2019)	Tunisia	Individual	Community level	Traditional and faith healers			34% of the population sought help from traditional or faith healers as their source of contact	
Sorketti (2013)	Sudan	Individual and Organisational	Community level/ facility level	Traditional healers and traditional healing centres			53% spent 1-2 months in traditional or faith healing facilities	Fasting was used by 93%, confinement used by 34%, chaining used by 82% and beating used by 24%.
Zingela (2019)	South Africa	Individual	Community level	Traditional healers			Overall, 78 (31%) of respondents had consulted a healer in the past year where reasons consisted of cultural and religious beliefs or families influence.	It was found that 58% of patient said they felt better after the healer's treatment in comparison to 9% who said they felt worse and 23% who mentioned they had no difference in their mental health.
Sorsdahl (2009)	South Africa	Individual	Community level	Traditional healers and religious leaders, faith healers, herbalists			Indicated magnitude of patients seeking alternative types of services from THs; 6% sought services from THs, 7% from spiritual or religious leaders and 2% from other types of healers (FHs and herbalists as examples).	
Ibrahim Awaad (2020)	Egypt	Individual	Community level	Traditional healers			An amount of 41.8% sought mental health treatment from THs as their primary source of contact. Reasons for preferred treatment were affordability where 72.3% of the patients preferred to consult a TH for that reason.	Little effectiveness shown by interventions for reducing mental illness
Nartey (2019)	Ghana	Individual	Community level	Faith-based practitioners			FBHPs had 171 participants (31.5%) as their first point of contact. Affordability- financed through family, self-funded, national health insurance scheme. Over half faced financial strains.	
Van Duijl (2014)	Uganda	Individual and organisational	Community level	Traditional healers, barangi healers. Healing places were church, church healing places using the force of Holy spirit.	Alternative types of services; traditional healers use divination in a more or less conventional methods. Types at Charismatic and Pentecostal churches, exorcist practices using singing,		The magnitude of patients using religious healing at churches were 17%.	

					praying, dancing and herbs provided orally.			
Sorketti (2011)	Sudan	Individual and organisational	Community level	Traditional healers and traditional healing centres			It was found that 41.7% of patients who went to traditional healing centres 55.3% mentioned they went to a traditional healer frequently. These patients stayed at the traditional healing centres for 5 months and the average duration of mental illness left untreated was 13 months.	<b>INCLUDE THE RELIGIOUS PERILS STATS</b>
Esan (2019)	Kenya, Nigeria and Ghana	Individual	Community level	Herbalists, diviners, Christian faith healers, Islamic faith healers, herbalist and Christian, herbalist and Islam and Witchcraft	The types of mental health services they provided were; herbs and fetish practices, prayer and fasting, scarification, orthodox medications and rituals.			Religious perils involve; starvation, beating, confinement/ incarceration, overcrowding, sleeping on the bare floor, inappropriate bodily exposure.
Agara (2008)	Nigeria	Individual types	Community level	Spiritual healers	Alternative types such as; holy water, amulets, fasting, sacrifices (examples are fruits, candles and clothing). Biomedical types: Counselling (90%). Fasting and prayer used by 96.7%.			Physical restraint was used such as beating (40%) and sacrifice.
Mbwayo (2013)	Kenya	Individual types	Community level	Traditional healers	Some biomedical and alternative types of mental health services; Counselling and various types of herbs, sometimes used together. Ancestor consultations were also used.			
Kaiser (2020)	Nigeria	Individual and organisational types of providers	Community level	Traditional healers and religious leaders and local NGO staff	Types of mental health services/ strategies include spiritual/moral support, financial, material such as,			

					praying, getting advice and seeking help from traditional healers or from mallams as well as food provision. In order to help MH stigma, mentally ill distanced themselves.			
Fournier (2012)	Ghana	Individual types of providers	Community and facility level	Traditional and faith healers	Counselling. Also mentions alternative types of MHS such as herbs, exorcism and prayers			
Iheanacho (2021)	Ghana	Individual types	Community level	Clergy	Counselling was used as type of MH. Mentioned a need for culturally sensitive training.		Acceptability- the clergy who were trained for counselling were at 92.9%, whereas the traditional healers who were trained were only at 10.7%.	
Lambert (2020)	Ghana	Individual and Organisational providers	Community level	Traditional healing centres and faith-based healing centres (Traditional and faith healers )	Alternative MHS: Faith-based and traditional healing centres "frequently used herbs (90%), prayer (62.5%), and ritual sacrifice (42.5%)."			Most healers who used religious perils such as physical restraint using chains and rope (55% reported use of such).
Olasinde (2020)	Nigeria	Organisational provider	Facility level	Faith-based hospital	Chaplains provide a chapel for all day MHS, and also do rotational based counselling.			
Ng (2016)	Rwanda	Organisational provider	Facility level	Faith-based biomedical	Biomedical types: Outpatient (77.3% used) and inpatient care, most patients had medication prescribed, as well as therapy and community outreach prevention programs. Individual psychotherapy used by 67.9% and group therapy used by 25.6%.			
Selamu (2015)	Ethiopia	Individual and organisational providers	Community level	Herbalists, traditional and faith-healers, organisations,	Alternative types of mental health services used such as holy water and were first point of	Financial support was provided during funeral services through microfinance groups and social systems used for		

				churches and mosques.	contact for family members.	attendance of mosques and churches.		
Esan (2019)	Ghana, Kenya & Nigeria	Individual providers	Community level	Herbalists, diviners, Christian faith healers, Islamic faith healers, herbalist and Christian, herbalist and Islam and Witchcraft.	Alternative types: The types of mental health services they provided were; herbs and fetish practices, prayer and fasting, scarification, orthodox medications and rituals.			Religious perils involve; starvation, beating, confinement/ incarceration, overcrowding, sleeping on the bare floor, inappropriate bodily exposure but there were quality checks of the alternative MHS provided.
Omer (2018)	Sudan	Individual providers	Community level	Traditional healers	Types of MHS include incantation and erasure which took up 43.2% of all the treatment methods.	Information support: health education was highlighted as an important factor in order to improve utilisation of faith-based mental health services.		Beating was used.
Aja (2019)	Nigeria	Organisational providers	Facility level	Faith-based biomedical providers working in formal facility settings	Biomedical types of MHS with a religious lens: emotional and spiritual support.		Acceptability: effective spiritual care in Africa needs to have cultural underpinnings.	
Dube (2020)	Zimbabwe	Individuals	Facility level	Chaplains	Spiritual care is a method that will assist dually the chaplains and mental health professionals and patients.			
Dhamani (2011)	Tanzania				Alternative types such as prayers and readings. Biomedical types of MHS include, counselling and reassurance.			
Osei-tutu (2020)	Ghana	Individuals	Community level	Muslim and Christian Lay Counsellors (clergy and Islamic clerics and laity)	<b>Counselling</b> Types of mental health services; premarital counselling. Assistance with financial and household management.			Mentioned training

Salifu Yendork (2016)	Ghana	Organisational and Individual providers	Community level	Churches and Congregants	Community mental health education Stigma types Alternative types of mental health services such as healing schools using bible teachings for the mentally ill.		Acceptability: socially supported systems Overdependence issues known as 'faith crisis'. There are also issues around an overdependence of individuals with mental illnesses on congregations which has been known to cause an over dependence and cause a "faith crisis."	
Yaro (2020)	Ghana	Individual	Community level	Traditional and spiritual healers	Biomedical types and training was used for knowledge and understanding, as well as human rights issues. Alternative types were used like herbs.	It was stated that some individuals may have financial issues such as poverty which causes mental illness and pastors from the church have been shown to help.		
Asamoah (2014)	Ghana	Individual	Community level	Christian clergy or Pentecostal/charismatic groups.	Alternative types include exorcism (can be potentially harmful). Biomedical types include emotional care and counselling is provided by the churches. These are more as an advisory role for belief in God. Mental health education used. Alternative in terms of spiritual care where clergy deliver education on religion from the Bible.	Human resource issues: Lack of pastors (human resources) to provide mental health services. Financial support: There are cases where patients go to pastors for monetary support but they cannot always provide this and also, governments do not allocate enough funding for this in Ghana.	Socially supported system: It is the social support systems that help faith-based mental health providers with their services, these include community linkages through faith-based home care as well as the surrounding relationships of the patients.	Religious perils exist where patients are beaten and chained as well as long periods of fasting. Issues with clergy mental health practices not being legal. In this setting, it was mentioned that the mentally ill underwent ill treatment in the form of human rights abuses in some Pentecostal prayer camps and churches which worsened the mental health status of patients despite their unique nature.
Ebingbo (2018)	Nigeria	Organisational providers	Facility level	Church-based organisations	Biomedical types of MHS: FBOs provide counselling. Faith-based home-care is also another type of mental health service but is in the form of monetary support and gifts from the churches, however is found to be seasonal. Community mental			

					health education is delivered through teaching programmes especially for the older adults. Examples are Holy Communions. Church visitations provided by clergy combined with emotional support.			
Bantjes (2018)	South Africa	Individual providers	Community level	Traditional healers and herbalists	Alternative MHS used such as herbal medicine, rituals, ancestral relations to mental illness. Biomedical types provided by THs such as counselling (sitting and listening), financial management. It was found that THs can recognise suicidal and traumatic behaviour. emotions/ feelings. Issues around social cohesion.	Issues arise based on social cohesion because the patients' surrounding communities lack moral guidance as well as experience a breakdown of bonds especially when they experience 'madness.'		There were no religious perils but no regulation of the herbal medicine can be harmful to their mental and also since it is not scientific.
Im (2017)	Somalia	Individual providers	Community level	Traditional healers	Counselling used and job creation assistance. Alternative practices used were "religious practices such as prayer and Qur'an recital."			Chaining at residences was used.
Knettel (2018)	Tanzania	Individuals	Community level	Traditional and faith healers	Alternative methods include traditional healers using herbs and prayers.		Mental health training- Improvement in the mental health services would need to include models of care which are inclusive of task-shifting and school counselling which are culturally sensitive.	
Kpobi (2019) "Ghanaian traditional and faith healers' explanatory models."	Ghana	Individuals	Community level	Herbalists, pastors and mallams (religious leaders).	Alternative types were used such as herbal tonics and help with children's intellectual disabilities. Counselling: the pastors and shrine priests provided psychosocial support.			Traditional healers' lack the knowledge and skills especially in situations where there were extreme cases of mental illness. Mental health training programs were suggested in order to improve the healer's expertise. Knowledge exchange was suggested among FBHPs.

					Financial assistance provided.			
Musyimi (2018) Exploring	Kenya	Individuals	Community level	Traditional health practitioners	Counselling was used. Counselling and prayer were used together. Other methods used included exorcisms and home visits (faith-based home care). There were issues around fake healers especially herbalists which sold their herbs at cheaper rates and this caused a mistrust from families and patients and among healers.	THs mentioned issues around financial resources.		
Ae-Ngibise (2010)	Ghana	Individuals	Community level	Christian and Islamic religious healers	Counselling methods like confession is an example. Prayers, fasting and anointing oils or holy water.		Respondents in this study mentioned that the widespread use of traditional health practitioners are due to their affordability.	
Ally (2008)	South Africa	Individual	Community level	Muslim faith healers	Alternative types of services; focus was on recital of the Qu-ran.			
Arias (2016)	Ghana	Individuals	Community level	Prophets and prophetesses in prayer camps. There were also biomedical types as these camps involved a collaboration.	Alternative types of methods; prayers. Biomedical types included referrals to hospitals and some camps allowed patients to take medication.			There are issues of human rights violations especially in prayers camps in Ghana. Beating/ caning and long fasting periods are examples.
Kpobi (2018) 'That is how the real mad people behave':	Ghana	Individuals	Community level	Herbalists and traditional healers	Type of MHS provided was herbal medicine which involves baths, ointments, incense and infusions. Fasting entailing dietary restrictions and activities were used.			Mentioned that herbal medicine should be standardised. It also said that herbal medicine is difficult to regulate and changes from case to case. This are also issues on how effective the methods can be where there are risks of potential severe side effects and abnormal behaviours which reduced quality.

Kpobi (2019) Muslim traditional healers	Ghana	Individuals	Community level	Traditional healers and mallam	The types of mental health services were; recitation of the Qur'an, bathing in water or drinking it and other rituals. The processes these mallams used were unstandardised and a matter of trial and error as well as possibly ineffective and risky.		"Some of the participants reported that the patients did not have to pay" if they did not have the money and the healers were able to accept any forms of payments and were also satisfied with no payment at all in some cases.	Issues of toxicity were apparent in cases of having to drink herbs and ink and is not guided from Islamic holy books or regulated and standardised which creates huge compromise on the quality of these mental health treatments.
Kpobi (2019)	Ghana	Individuals	Community level	Traditional herbalists	Types of mental health services/treatment include herbal remedies and use of ritual objects as well as use of prayer. Traditional herbalists can serve as conduits to God.		Treatments had a self-limiting nature and no fixed timelines and relied on obsessed changes to determine recovery as well as a false outcome. Even though faith-based mental health services are accessible and affordable, it does determine the effectiveness of these treatments.	Religious perils were used as treatment method, which included; restraint, isolation and dietary restrictions such as fasting.
Read (2009)	Ghana	Individuals	Community level	Prayer camps and shrines as well as churches	Faith-based home care Extra measures which assisted with mental health from the pastors; these were food, clothing and accommodation in regions with high amount of unemployment. Informants in the church and shrines used social and material support and escape from stigma within the home community.			Beatings were specifically used among traditional healers to get rid of evil spirits as well as to get a confession for wrongdoing. In terms of the Christian pastors, chains were used.
Asasira (2018)	Ghana	Organisatio nal	Facility	Faith-based psychiatric care-: Mission hospital	Biomedical types: The Ruharo Mission Hospital at the regional referral hospitals (12 of them) provides faith-based psychiatric/ biomedical care which offer mental health services			

Anyebe (2019)	Nigeria	Organisational	Facility	Faith-based biomedical provider	The Christoffel Blind Mission is an NGO that provides community types of "mental health services at a primary health care level". A church exists in Benue State in Mkar which integrates MHSs at a facility level.			
Kajawu (2016)	Zimbabwe	Individuals	Facility	Traditional medical practitioners	Herbal medicine used	Culturally tailored mental health services		Religious perils were used
Rukambe (2019) Thesis	Namibia		Alternative types of FBHPs: traditional and faith healers		Alternative types: Herbs and biomedical types; counselling through seeing and naming. Rituals were mentioned also where traditional healers expel spirits that cause mental illness. Dream interpretations also and social ancestral linkages.	Traditional healers incorporate spiritual sensitivity into their practices where they involve healers and cultural competency.	Acceptability: Traditional healers incorporate spiritual sensitivity into their practices where they involve healers and cultural competency.	
Maina (2017) Thesis	Kenya	Organisational	Facility	Biomedical types: faith-based hospitals and alternative types: churches	Biomedical types were counselling. Alternative types; prayers were offered during bereavement in order to deal with loss. Biomedical types such as counselling.			
Murambidzi (2016) Thesis	Zimbabwe	Individual	Community level	Alternative types of FBHPs: traditional and faith healers	Biomedical types; counselling on bereavement, poverty, jobs, family, substance abuse and food and health issue assistance.			
Mashamaite (2015)	South Africa	Individual	Community level	Alternative types: faith and indigenous healers	Alternative types; herbs, divination of bones, animal sacrifice.			
Martin (2019)	Uganda	Organisational	Facility level	Biomedical types: faith-based hospitals	Biomedical types: Kisiiji Hospital (Church of Uganda hospital) which			

					is partly supported by the Ugandan Government and provides out-patient and in-patient psychiatric facilities.			
McAdam (2016) Commentary			Facility level	Faith-based biomedical	Kisiiki Hospital in Uganda is a faith-based facility in an urban area providing biomedical psychiatric care to vulnerable populations			
Rusengamihigo (2021)	Rwanda	Organisational	Facility level	Faith-based biomedical	CARAES-Ndera is a faith-based facility with a focus on neuropsychiatric disorders (child psychiatric specialty), with over 288 beds.			
Rugema	Rwanda	Organisational	Facility level	Traditional healers	Alternative types such as exorcism was used to help mentally ill which was routed from beliefs by the community in evil spirits. Prayer was used which created a delay in seeking counselling.			
Musyimi (2018)	Kenya	Community level	Facility level	Traditional healers				It found through a regression analyses that suicidal ideation and depression indicated a lower quality of life as a result of being treated for mental illness by traditional healers.

*Appendix 5 International Journal of Mental Health Systems Journal Guidelines (BiomedCentral)***Preparing figures**

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