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'We are all working toward one goal. We want people to become well': A visual exploration of what promotes successful collaboration between community mental health workers and healers in Ghana

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Abstract

The practices of traditional and faith-based healers in low- and middle-income countries in Africa and elsewhere have come under intense scrutiny in recent years owing to allegations of human rights abuses. To mitigate these, there have been calls to develop collaborations between healers and formal health services to optimise available mental health interventions in poorly resourced contexts. For various reasons, attempts to establish such partnerships in a sustainable manner in different countries have not always been successful. In this article, we present findings from the Together for Mental Health visual research project to showcase examples of healer–health worker collaborations in Ghana that have been largely successful and discuss the barriers and facilitators to establishing these partnerships. Data reported in this article were collected using visual ethnography and filmed individual interviews with eight community mental health workers, six traditional and faith-based healers and two local philanthropists in the Bono East Region. The findings suggest that successful collaborations were built through mutually respectful interpersonal relationships, support from the health system and access to community resources. Although these facilitated collaboration, resource constraints, distrust and ethical dilemmas had to be overcome to build stronger partnerships. These findings highlight the importance of dedicated institutional and logistic support for ensuring the successful integration of the different health systems in pluralistic settings.

Keywords

Ghana, mental health, human rights, traditional healing, collaboration, visual ethnography

Background

The use of psychiatric services remains relatively low in many low- and middle-income countries (LMICs) where traditional and faith-based healing systems tend to dominate health-seeking pathways (Rathod et al., 2017). It has often been suggested that in such contexts, particularly in Africa, a major reason for the popularity of non-biomedical interventions is related to health beliefs that lean more toward supernatural explanations for mental illness (Gureje et al., 2015; Musyimi et al., 2016; Opare-Henaku & Utsey, 2017; Read, 2012). Although beliefs in spiritual and animist factors related to ill-health are common in Africa, as in many other countries (Green & Colucci, 2020), several studies have identified that additional context-related factors such as limited availability of biomedical facilities and health professionals, as well as systemic issues such as cost and accessibility, also play an important role in determining the under-utilisation of biomedical mental health

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services (Ae-Ngibise et al., 2010; Badu et al., 2018; Esan et al., 2019). There is, in fact, evidence to suggest that spiritual beliefs do not prevent help-seekers from making use of several healthcare streams, operating within a pluralistic approach in which the perceived benefits of different approaches to care are considered to be mutually enhancing (Badu et al., 2019; de-Graft Aikins, 2005; van der Watt et al., 2017; Read, 2012).

The practices of traditional and faith-based healers in Africa and other LMICs have, however, come under intense criticism in recent years owing to allegations of human rights abuses including the use of mechanical restraints, forced fasts, corporal punishment and social exclusion (Human Rights Watch, 2020). In addition, it has been argued that limited knowledge about specific treatment approaches does not allow a systematic evaluation of their efficacy (Arias et al., 2016). Thus, evidence-based best practice based on scientific rigour has been difficult to establish with traditional and faith-based healing systems, resulting in disdain and suspicion between systems (Nortje et al., 2016). Furthermore, in a postcolonial African context, biomedicine retains a hegemonic position of perceived efficacy and modernity, and receives more structural support in the health systems of most states. Traditional healing is, therefore, poorly understood (Kong et al., 2021; Kwame, 2021) and mostly unsupported by state funding and investment. Yet, it is estimated that traditional and faith-based systems are used exclusively by approximately 80% of people requiring mental health support in Africa (WHO, 2019).

With this in mind, there have been longstanding calls to develop sustainable collaborations between traditional and faith-based healers and formal health services in order to optimise the mental health interventions available in poorly resourced contexts (Campbell-Hall et al., 2010; Petersen et al., 2011). There have been attempts to establish such partnerships in various ways in different countries. However, these have not always been successful. In a review of mental health practitioners' perceptions about collaboration in LMICs, Green and Colucci (2020) identified that traditional healers and biomedical professionals were both cognisant of the benefits of collaborating; however, there was mutual distrust of each other's motives and practices. This notwithstanding, in recent years a few projects have explored ways in which collaborations between biomedicine and traditional or faith-based healing systems can be strengthened (Baheretibeb et al., 2021; Gureje et al. 2020; Ofori-Atta et al., 2018).

Mental healthcare in Ghana

Until recently, formalised mental health services in Ghana were provided mainly through three specialist psychiatric hospitals located in two southern coastal regions of the country. Community mental health services were limited in scope and concentrated in urban areas. Many communities, particularly in rural areas, were underserved, leading to significant unmet need and a treatment gap of over 90% (M. Roberts et al., 2014; WHO, 2019). Families and communities commonly seek help from practitioners such as traditional healers and herbalists who use plant-based medicines. Furthermore, with the upsurge of neo-Pentecostalism, there is widespread use of Christian faith-healing in residential centres called 'prayer camps', operated by syncretic and neo-prophetic churches (Osafo, 2016). There are also several Islamic healers. These so-called alternative health providers use practices and approaches to distress and healing that are often shared with the communities in which they operate. Such healers occupy positions of power and influence, and their interventions, such as animal sacrifice, prayers, fasting and deliverance from evil spirits, may be considered by those who use them as more desirable than biomedical treatments (Kpobi & Swartz, 2018a; Ojagbemi & Gureje, 2021; Read, 2017).

In 2012, Ghana passed a new Mental Health Law (Act 846) that established a Mental Health Authority (MHA) with the aim of improving access to and provision of biomedical mental health services. One primary focus of the MHA has been to integrate mental health into primary care in order to deinstitutionalise mental healthcare. Small psychiatric units have been established at regional, district and community hospitals and clinics in previously underserved regions of the country, including in the predominantly rural central and northern belt. This has resulted in an expansion of community mental health with the deployment of hundreds of community mental health workers to health facilities across the country.

With the increased number of mental health workers in primary care facilities, a further goal of the MHA is to encourage partnerships between mental health professionals and traditional and faith-based healers to enable greater monitoring of their practices to minimise, and ultimately prevent, human rights abuses. Such collaborations also allow for training of healers and foster dialogues about best practice. The MHA developed guidelines for use by health workers on negotiating care and building partnerships with healers. They also provided 'registers' given to each healer to allow health workers to collect sociodemographic information about the people who seek their help.

There is, however, limited research that examines the ways in which such collaborations between healers and health workers are built in particular settings, the challenges encountered, and the factors that might promote their success. To understand this, the Together for Mental Health research project used visual ethnographic methods to examine how healer–mental health worker collaborations in Ghana and Indonesia are established, and how these partnerships have facilitated the provision of mental healthcare within traditional and faith-healing spaces. It also explored whether working together helps to minimise human rights abuses

such as coercion and restraint. In this article, we report on findings from Ghana to discuss what helps to promote successful collaboration between mental health workers and healers and some of the challenges encountered. We draw on these findings to suggest ways in which these collaborations could be established in other contexts.

Methods

Research design

The Together for Mental Health project employed visual ethnography to examine the ways in which community mental health workers and healers work together in rural communities in Ghana and Indonesia. Filmed observations and audiovisual interviews documented and highlighted interactions between healers, mental health workers, caregivers, people with lived experience of mental health conditions and other actors in the community. This approach built on methodology developed for research on human rights and mental health in Indonesia (Colucci, 2016), as well as previous ethnographic and qualitative research on traditional and faith-based healing and mental health in Ghana conducted by the other authors (Kpobi & Swartz, 2018b; Read, 2017, 2019). In this article, we present findings from thematic analysis of interviews, fieldnotes and visual data from the Ghana fieldwork and filming. Findings from the Indonesia fieldwork have been compiled into a companion article that has been submitted for publication (Setiyawati et al., under review). Papers are in preparation reporting further on the ethnographic findings and visual methods employed. In addition, two ethnographic documentaries, one from each country, have been produced[1] alongside other short films planned for future release.

Research setting

In Ghana, the project was carried out in three rural districts in the Bono East Region: Nkoranza South, Techiman and Tuobodom. The region is made up of small, predominantly agrarian communities. The dominant languages are Twi and Bono (a derivative of Twi). The majority religion is Christian (72%), with a smaller Islamic population (17%) and approximately 3% identifying with indigenous religions (Ghana Statistical Service, 2022). Primary health services are provided through district and community-based health centres and clinics. In the past few years, small mental health units have been established within these primary health centres to provide mental health and psychosocial support to the surrounding communities. With a regional population of over two million (Ghana Statistical Services, 2022), there were no psychiatrists and psychologists practising in any of the three districts at the time of data collection. Formal mental health services were provided by medical assistants with additional training in psychiatry (called clinical psychiatry officers), community mental health officers and mental health nurses.

As described above, a variety of ritual and spiritual practitioners operate in the Bono East Region and many are used to address mental illness and its perceived causes, such as witchcraft, possession by evil spirits or curses. This includes *akɔmfoɔ* (singular *ɔkɔmfo*) loosely translated in English as 'traditional healers'. They are addressed as 'Nana' (grandfather), a term also used to address chiefs and elders. *Akɔmfoɔ* serve the *abosom* (usually translated as 'small gods') particular to each shrine and when possessed by them attain powers that are used to divine the cause of problems (such as illness) and take action to address them. This usually includes rituals such as animal sacrifice and other acts of propitiation, as well as administration of plant-based medicines. In addition, a wide variety of neo-Pentecostal prophets and pastors run 'prayer camps' or healing churches, many located in rural areas. Some practice a form of syncretic Christianity known in Twi as *sunsum sore*, or spiritual churches. Pastors of whatever denomination are usually addressed as *(o)sofo* or *(o)diifo*. Most conduct deliverance services to remove evil spirits, and 'strong' prayers and fasting to address perceived causes of mental illness, as well as using substances such as olive oil or 'holy water'. Some also use plant medicines. There are a much smaller number of Islamic healers operating in Bono East, particularly serving the Muslim communities who have settled in the area, but we were unfortunately unable to recruit an Islamic healer to take part in the study within the research timeline. Families who bring their sick relatives to the shrines or prayer camps often stay for weeks, months or even years receiving treatment and joining in the daily life of the facility. A caregiver, often the mother, is usually required to stay with the patient to tend to their daily needs, such as bathing and cooking.

Data collection

Fieldwork was conducted between April and June 2019. Before commencing fieldwork, an in-country advisory group made up of various stakeholders was constituted to provide guidance on issues such as potential filming sites, community entry, as well as the types of questions to ask and from whom. The 17-member advisory group included people with lived experience of mental health difficulties, relatives/caregivers, psychiatrists, mental health nurses, traditional healers, faith healers, representatives from non-governmental organisations (NGOs) working in mental health, artists and human rights advocates.

Selection of the research sites and participants was purposive, using existing research networks and visits to local mental health teams to identify examples of collaborations with traditional and faith healers. Some mental health workers and healers had been participants in earlier ethnographic research by Ursula Read (2012, 2019). Mental health workers introduced the research team to other

healers with whom they had existing collaborations or with whom they were seeking to collaborate and to patients/caregivers who were using or had used healers.

During fieldwork, we conducted filmed observations of interactions between community mental health workers, families and caregivers, people with mental health difficulties and traditional or faith-based healers. We also filmed healing sessions, festivals and other rituals at two traditional shrines; healing, prayer and worship services at four neo-Pentecostal churches; interactions between health workers and families in three homes; and daily routines of community mental health nurses at four clinics/health centres.

In addition to the filmed observations, we also conducted filmed interviews with eight mental health workers, six traditional/faith-based healers, eleven relatives/caregivers, ten people with lived experience of mental health conditions, two entrepreneurs who conducted philanthropic activities in the community to support people living with mental illness, and one social worker. In this article, we report on findings from the health workers, healers and philanthropists. The majority of interviews were conducted in Twi/Bono, with a few in English. In addition to the filmed activities, fieldnotes were kept to record observations.

The fieldwork was carried out by a team of social science researchers who all identify as female. LK is a Ghanaian with a background in clinical psychology and has done research on traditional and faith-healing in Ghana. She conducted most of the interviews and supported the development of the research approach in the field. She also conducted observations and analysis of data. EC is Italian based at a UK university and was the principal investigator for the project. She has a background in cultural psychiatry, clinical and community psychology and visual anthropology, and led the technical and conceptual aspects of the filming and observations. UR is a British medical anthropologist and occupational therapist who has conducted longstanding research on mental health in Ghana, primarily in the Bono East Region. She led the conceptual development of the study with EC, facilitated site selection, community entry and data collection through her existing research networks, and conducted ethnographic observations and data analysis. RS is a Ghanaian with a background in clinical psychology. She translated the research materials and provided interpretation when necessary. She was responsible for consenting participants as well as conducting some interviews and participated in preliminary analysis of the data.

Ethical considerations

The study received ethics approval from Ghana Health Service Ethics Review Committee and Middlesex University's Psychology Research Ethics Committee. We also sought permission for the research fieldwork from the MHA in Ghana, Nkoranza South traditional council, as well as the district and municipal health directorates.

Careful consideration was given to the informed consent process because of the deep stigma that is associated with mental health issues in Ghana, and previous sensationalist reportage of healing practices and human rights concerns (Read, 2021). We were also mindful of our positionality in relation to the research setting. Although the team included Ghanaian researchers (LK and RS), two of the researchers, UR and EC, are White Europeans. In addition, the Ghanaian members of the team were not from the research communities and had received higher levels of formal education than most of the participants. Thus, we were mindful of the potential influence of colonial histories, issues of power and privilege, and initial suspicions about our intentions, particularly in relation to participants' sensitivities around being filmed and concerns about how the footage would be used. We consulted closely with local nursing teams and health managers regarding protocols for engaging with healers and local communities and appropriate forms of remuneration. All participants in the film and interviews gave written informed consent or, if unable to write, provided a thumb print witnessed by a family member who provided written consent. We employed a staged consent process in which all participants were asked to provide consent at each stage of the research. They were asked to decide the extent of their participation and level of anonymity in the filmed aspects of the study by, for instance, being filmed from the back. This consent was reviewed if the participant was filmed on more than one occasion.

In cases in which participants preferred to remain anonymous, we assigned pseudonyms in the transcriptions and censored their footage so they could not be visibly identified; for example, through blurring the face or editing out footage where the participant was visible.

Data analysis

All filmed interviews and observations were time-coded and transcribed verbatim in the original language. These were subsequently translated into English by RS and checked by LK and UR. Discussions around the most appropriate translation were held with the team. Fieldnotes were also typed and included for analysis.

Thematic analysis (Braun & Clarke, 2006) was conducted in an iterative and comparative process triangulating film transcripts with visual data from the film footage, photographs and fieldnotes of observations. An initial process of manual coding of the observational and interview data was used alongside repeated viewing of the film footage to identify emerging themes. These themes were then used to inform the editing of the filmed footage for the ethnographic documentary, *Nkabom: A Little Medicine, A Little Prayer* (available at https://movie-ment.org/together4mh/). A second process used NVivo 2020 software to code the interview transcripts, building on this initial analysis. The analysis involved familiarisation with the interview transcripts through the translation process and repeated reading,

followed by initial independent coding of three sample transcripts to develop a tentative coding framework through discussion and review of codes. Deductive codes were developed based on the research literature and research questions alongside inductive codes developed from the data. With this tentative framework, the remaining interview transcripts were split among three members of the team for initial analysis, with each transcript given to at least two coders. Subsequently, themes were developed based on inter-coder agreements and discussion of differences and triangulation with observational data from the film footage and fieldnotes. In this article, we present data on the themes relating to factors that were identified as facilitating collaborative partnerships between the healers and mental health workers, as well as some of the challenges.

Findings

We identified several factors that facilitated collaborations between healers and mental health workers, as well as factors that served as barriers to collaboration.

Facilitating factors included four broad themes, namely: (1) interpersonal relationships between healers and health workers; (2) intrapersonal characteristics; (3) health systems support; and (4) community resources. Each of these had various sub-themes as shown in Figure 1 below.

Barriers to successful collaboration included: (1) legacies of distrust; (2) competition for inadequate resources; and (3) ethical dilemmas. Figure 2 outlines the themes and sub-themes of barriers to collaboration.

Each of the themes and sub-themes are discussed in the sections below and are illustrated with quotes, ethnographic observations and photographs where appropriate.

Factors that facilitated successful collaboration

Interpersonal relationships between healers and health workers

Establishing good interpersonal relationships was key to the success of the collaborations. This was achieved through

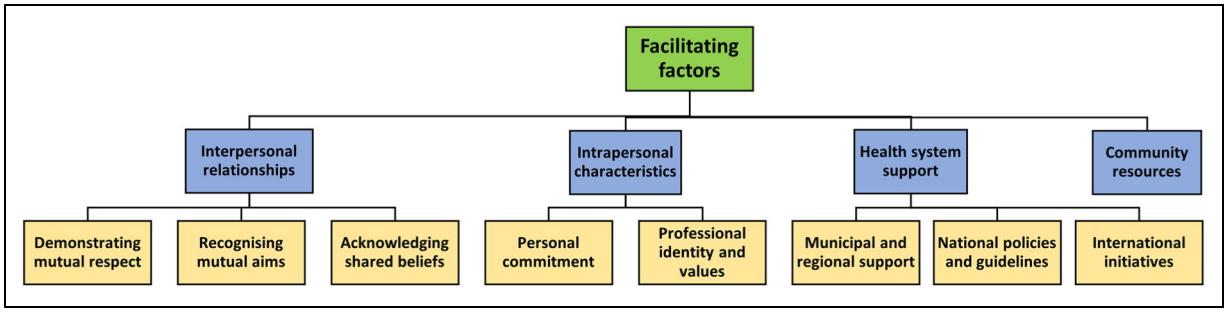

Figure 1. Thematic map of facilitators for collaboration between healers and health workers.

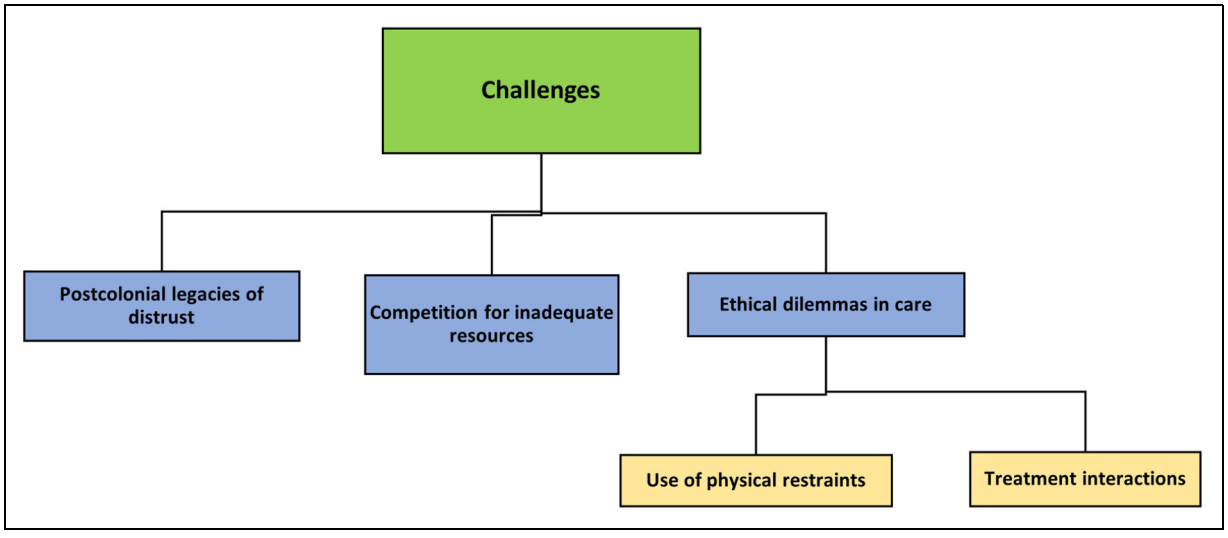

Figure 2. Thematic map of challenges to collaboration between healers and health workers.

several key factors – demonstrating mutual respect, recognising mutual goals, and acknowledging shared beliefs.

'Respect is the key attitude': demonstrating mutual respect. An important interpersonal factor that health workers discussed as imperative for building successful collaborations involved recognition of the healers' positions of authority and expertise within the communities in which they worked and an avoidance of explicit criticism which might lead to confrontation. George, a mental health nurse in Nkoranza explained:

> You cannot go to someone's house and tell the person, 'Do this, do [that]'. I am not going there to condemn what he is doing there. I am going there with a purpose, so I must respect him as a person and respect what he is doing. Respect is the key attitude.

Traditional healers are considered cultural leaders within their communities owing to their perceived connections to the spirit world. The authority and power of traditional healers have historically been ridiculed or dismissed by colonial administrations (J. Roberts, 2021) and these attitudes have persisted among many health service providers who often criticise such practices as 'backward' and 'superstitious' (Read, 2017). In order not to perpetuate these historical tensions, the mental health workers consistently and explicitly emphasised their respect for the healers. When visiting with members of the nursing teams we witnessed the ways in which they interacted with the healers, visibly demonstrating deference and remaining non-confrontational – both of which are culturally expected behaviours when interacting with people in authority. Health workers followed accepted protocols in forms of address and gestures. For example, when visiting Nana Duodu, an *ɔkɔmfo* with whom George and the team worked, at his shrine, we observed how George approached him in a deferential manner, bowing in greeting (Figure 3).

Health workers were careful to acknowledge the healers' expertise, recognising that they each approached healing from different perspectives. They explicitly acknowledged to the healers with whom they sought to partner that they had no expertise in spiritual matters and were coming in a spirit of collaboration rather than competition. They emphasised that professional training in mental health could complement the healers' spiritual insight. Sister Regina[2], a pioneering community mental health worker in the region who mentored the younger novice nurses, stated it this way:

> I will always tell them, 'Nana [lit. grandfather, honorific term used to address traditional healers], I can't see

Figure 3. Nurse George bows to greet traditional healer Nana Duodu as a sign of respect for his cultural position.

> beyond my nose so I am always after the physical[3]. But you know the spirit, so you will also do your spiritual part'. We talk this out with them and they are calm. They know you have given them respect.

Similarly, some Christian healers recognised that there may be some things that were not spiritual in nature and required biomedical intervention. In such cases, they expressed appreciation for the expert intervention of the health workers. An elder at a prayer camp in the market town of Techiman where mental health nurses conducted regular visits explained:

> …when it happens to be spiritual, the prophet is able to deal with it very well. For the physical ones we call the experts, the doctors, to come. We call the doctors to check their blood, their strength, how they are faring, their appetite, to aid in taking medication. We realised that we couldn't treat them with our knowledge; it gets to a point where the doctor's knowledge is above ours. So while we take care of the spiritual aspect, we call them to take care of the physical part.

With this mutual respect for differing expertise, healers and health workers were able to separate out their respective domains to avoid conflict and acknowledge the potential for their respective complementary roles.

'Working towards one goal': recognising mutual aims. Another supporting factor for promoting collaborative interpersonal relationships was a recognition that both parties were working toward a mutual goal. In their engagements with healers, health workers sought to show the healers that it could be in the interest of both parties if they worked together. As Abu, a mental health nurse in Techiman, emphasised, the important aspect was not the method but the result:

> We are all working towards one goal. We all want people to be getting well. So whether you are using orthodox [medicine] or you are using traditional [medicine], the important thing is for them to get well.

In these instances this pragmatic approach appeared to be effective because the healers were receptive to the health workers, in most cases welcoming them warmly when they came to visit. Sofo Ketewa, who led the prayer camp in Techiman, acknowledged the potential for faster recovery when the two methods of healthcare were combined:

> We have a lot of knowledge, but it is also right that we learn from your knowledge. That will be helpful. Because healing is not only spiritual, there is also the physical. So if the spiritual and the physical treatment join together, it works better.

A church elder corroborated this, saying 'When it is beyond our abilities, we call them'.

This dual approach was particularly evident when patients[4] brought to healers were behaving in ways which could be perceived as dangerous or disruptive. On visits to Sofo Ketewa's prayer camp we interacted with several men who were very agitated, angry and argumentative, shouting at their mothers and sometimes threatening them. On one visit, a patient accused his mother of putting something in his food (this is commonly believed to be a way of enacting witchcraft) and so he refused to eat when she cooked for him. Another young man was moving around, restlessly, giggling and behaving in sexually suggestive ways. The camp attendants usually responded to these behaviours by putting the person in chains or shackles. In these difficult situations, nurses took an important role negotiating with the healers and family caregivers to administer sedatives and remove the chains (see Figure 4). Sister Regina echoes the elder in describing their methods as complementary in these situations. After medication is administered then the pastor's interventions such as prayers can continue: 'maybe we'll give a sedative before you [the healer] also continue from where we stopped'. In this case, as Read reports elsewhere (2019), chains and sedating medication are often viewed as achieving similar ends, to calm and 'cool' the patient and enable them to resume spiritual treatment as well as fulfil social roles.

'We also believe in the spiritual aspect': acknowledging shared beliefs. Although community mental health workers had received training in biomedicine and a scientific approach to mental illness, they occupied a liminal space in their identification with their professional training on the one hand, and cultural beliefs and values similar to those of the healers on the other. Despite their medical training, health workers acknowledged the co-existence of their own belief in the potential for spiritual forces to influence health. As Sister Regina put it: 'I am a Christian, I believe in God. I believe God created human beings and he cures illnesses'. Although there is a great deal of variation in what Christian nurses believe is acceptable, dependent on their particular form of Christian practice, nurses were adept in emphasising shared beliefs and minimising points of difference, whatever their personal misgivings. Abigail, a mental health nurse, described this process in relation to a prophet with whom she was attempting to establish a collaboration and who practised a form of syncretic Christianity which many other Christians tend to view with suspicion:

> I sat there with him and all he could tell me is that he has seen a vision about me and some stars. That I had a brightening star covered with some darkness and he knows that there are some spiritual forces behind it and so he will

Figure 4. Nurse Kingsford speaks to healer Sofo Ketewa about a patient's care.

> pray for me and I should also pray. And I said 'Ooh, he shouldn't worry, I am also a Christian and I pray a lot so that won't be much of a problem' […] in fact, I had to take all that, just so that he wouldn't … I had my plans for going there. I just wanted to nail it. I wanted to just … establish that rapport with him.

Attending church services with the nurses, we saw how they actively took part in prayers and other aspects of the services and how their faith informed much of their approach to their work as a service, not only to the people of Ghana, but to God. The goal of collaboration was therefore not to change causal beliefs about mental illness, but to advocate for the inclusion of biomedical interventions alongside spiritual treatment. George described this as follows:

> … the mental health officers who are giving treatment, we are Christians, one way or the other, [or] Muslims. Meaning that we also believe in the spiritual aspect. But we want to give the physical treatment. Maybe you are thinking that your condition is spiritual, but [for all] you know, it is physical. And maybe we are thinking that it is physical, [for all] you know, it is a spiritual [condition]. So we are not against [the spiritual].

Such statements highlight how successful collaboration was built by identifying shared beliefs and values between healers and health workers and using these as a bridge to find joint pathways for providing care.

Intrapersonal characteristics

'You need to be selfless': personal commitment. Other facilitating factors that helped to sustain the collaborative relationship between the healers and health workers were reflected in the personal characteristics of the nurses and the healers. It was clear that the particular commitment and drive of the

mental health workers in this study contributed to the success of the collaborations[5]. They demonstrated a focused dedication to seeing community mental healthcare thrive in their respective districts. We saw evidence of their passion to ensure that as many people as possible who required help were reached, such as working long hours and responding to late night phone calls on their personal mobiles from families needing help. As Eric, another mental health nurse, described: 'Patients have my number so they can call me at any time they want'. One Sunday for example, a day which was officially his day off, George described how he had been called to administer sedative medication to someone who had become psychotic. This drive pushed them to persist despite the low status of mental health within the health system, as George explained:

> As soon as you become a [community mental health worker], if you want to do the work to touch the lives of people, then you need to be [selfless] because it is a part of the profession that has been neglected.

The healers in turn were impressed by the hard work and patience that the health workers demonstrated. This made them more willing to work with them. Nana Duodu remarked:

> When I met George, I could see he was very serious about the work he was doing. He was focused on his work. Someone who works hard and pushes himself to see the growth of the nation, I always want to partner with you. […] He rides his motorcycle and comes here, and we talk. Some days, when I go to town, I meet with him and we talk.

These quotes illustrate the personal commitments of both healers and mental health workers to building and sustaining collaborative partnerships.

'My work is important to me': professional identity and values. Both healers and health workers took pride in their professional role, and this was reflected in their personal ethos of care. The collaboration, therefore, worked because it was mutually beneficial for building or sustaining their respective professional identities. Nana Duodu stated:

> …my work is important to me. I am not a lazy person. My work is very important to me. So when I see that the work is also important to you, then we can work together … it will benefit all of us.

The mental health workers' attitudes also demonstrated personal moral principles, which influenced their professional behaviour. We witnessed how they often went 'beyond their mandate' to meet the needs of people under their care, such as using their own funds to purchase medicines or help patients set up small businesses. During the course of fieldwork, for example, the nurses used a public holiday to donate a mattress, clothing and other items to a young woman who was formerly homeless, in an attempt to reintegrate her into her family and set her up with a livelihood.

Stigma towards mental health within the wider health sector is widespread as the nurses reported. Abigail was told by the health workers in her clinic that she had to keep her 'mad' patients away from other patients, and nurses were commonly referred to as *abodamfo* (mad people's) nurse. This spurred them to develop their own professional networks, both formal and informal, to sustain their morale and gain support. WhatsApp groups and in-person meetings were important means of strengthening their professional identity and mutual learning. Mental health teams supported each other through periodic debriefing meetings, making decisions about care or family interventions together, and pooling their resources to purchase medication and fuel to visit healers and families. As George described:

> Richard has been handling more than ten patients. He buys them medication every month. Abigail and I have been doing the same here. We have been buying for the patients. Liberty, the same thing. The issue is, sometimes you'll see them, and the little [money] that you are getting, you need to use some to support these people, because you are afraid otherwise they will relapse.

In this way, they sought to strengthen their morale and pride in their professional identity, which was particularly important in a widely stigmatised field of healthcare.

Health system support

A further crucial factor that supports collaborations between healers and mental health workers in Ghana is the support from local, national and international health policy and systems. This system-level support was highly valued by mental health workers in this study as lending credibility and reinforcing their efforts to establish partnerships with healers.

Municipal and regional support. Nurses in Nkoranza South and Techiman emphasised the value of support from the municipal health directors in enabling their work. As George put it, the director of health was 'another collaborator' because of the assistance he gave in many ways, from promoting their work in the municipality, to making resources available and even making a substantial personal donation. This contrasted with other districts where health managers could be less supportive and indeed obstructive; for example, withholding resources that mental health workers needed to do their work or deploying them in

other areas of health such as disease control. However, George emphasised that as more mental health workers are posted to primary healthcare, health managers are starting to see 'massive improvements' and so realise 'that we too have something [to offer]'.

In addition, new regional mental health co-ordinators, appointed as part of the implementation of the Mental Health Act, provide a focal point for mental health workers across the region and organise training and supervision. Through this and other informal mechanisms, nurses developed networks with other mental health teams by which they gained practical and emotional support, peer learning, and assistance with fundraising activities. Training workshops, often offered by NGOs active in mental health and organised through the regional mental health co-ordinators, enabled nurses to share experiences and reinforced a rights-based approach to their work.

National policies and guidelines. As described above, collaborative relationships are explicitly promoted by the Mental Health Authority (MHA) to meet the mental health needs of the country and prevent human rights abuses. The mental health workers in this study are part of a shift to community-based mental healthcare in Ghana, which followed the passage of the Mental Health Act in 2012. To meet the requirements of the Act, mental health workers are advised to establish working relationships with traditional and faith-based healers in their community. To help fulfil this mandate, the MHA has developed policies and guidelines and trained mental health workers in building and sustaining relationships with healers and monitoring for potential human rights abuses.

As part of the implementation of this policy, the MHA now provides patient registers which mental health workers are tasked to give to healers to record sociodemographic information about the people who use their services. In practice, the registers are also useful for helping the mental health workers keep track of the people who visit healers in their community, particularly as many of these people may have come from elsewhere. By supporting the healers to use the registers, the mental health workers were able to follow up and, if necessary, refer people for further care once they left the healers to return home, as George describes:

> So [when] the Mental Health Authority gave us the register, we were happy. I gave the register to [the healers], and [told them], 'Any patient who will come to the […] prayer camp or to the facility, make sure you register the person. [Write] the one who is responsible [for them], take their contacts'. So, as soon as the people are discharged … we [try to] trace them with the information that has been written in the register and try to call them to follow up. Because most of them are not [from]here. Most of them are coming from other parts of Ghana.

Through the data recorded in the registers, the health workers could identify nearby health facilities in the service users' local community and provide referrals if needed. In this way, even when the spiritual care provided by the healers had been completed, biomedical treatment could continue.

International initiatives. Mental health workers were also able to tap into wider global initiatives through the activities of international organisations in Ghana. This included training on human rights and collaborative ways of working such as WHO QualityRights (Moro et al., 2021), which was being rolled out across the country during the time of the research. All of the nurses were undergoing or had completed training in human rights as part of this initiative, with Abu and George additionally trained to be trainers. George explained how this had helped to transform his approach to care and treatment, particularly in relation to reducing coercive practices:

> I was fortunate because I was among those who went for the national training. One thing I have seen about QualityRights is that it is very, very good, very helpful. The aspect I like most is the human rights. […] the day we started the training, I felt sad because I realised that we think we are helping the patients, not knowing that we are causing more harm forcing treatment on these patients against their will, especially when they are aggressive. And sometimes, when the patients say something, we doubt it.

Community resources

Aside from this institutional level support, mental health workers also drew on resources available in the local community to support their attempts to build collaboration with healers. Although the government gave policy support, this was not always backed up with resources, such as transport and fuel, and so mobilising support from civil society such as NGOs and local philanthropists was crucial. The activities of national and international NGOs operating in the field of mental health in Ghana have increased significantly over the past decade, specifically in relation to livelihood support and protecting human rights (Cohen et al., 2012; Yaro et al., 2020). As part of this, they have run training workshops for healers and mental health workers, including in the Bono East Region, as well as establishing livelihood support initiatives such as mushroom farming. They frequently work in partnership with local community mental health workers who engage in training and refer their patients to livelihood programmes and are thus aware of the resource challenges. Indeed, NGOs invariably need to address these before they can implement their projects. It is therefore not uncommon for NGOs to purchase logistics

such as motorcycles or medication, and some nurses are active in lobbying for these.

The extent of this patchwork of support was evident when we visited Eric in his dilapidated office in the local health clinic. Notes were stacked haphazardly on a bench because he had no cupboard or filing cabinet and, he told us, the bench and even his desk had been donated. A number of tubs of fluoxetine, an anti-depressant, had been provided by another NGO, as had his motorbike. Thus, by making mental healthcare possible, albeit limited by the sporadic and short-term nature of NGO projects, these donations directly and indirectly supported mental health workers to fulfil their mandate to collaborate with healers.

The mental health workers also actively sought partnerships with influential people within their communities. These included entrepreneurs and a journalist at the local commercial radio station who could assist with fundraising and awareness-raising activities. For instance, mental health workers in Nkoranza periodically received donations to support with buying medication for patients staying at healing centres or to pay for fuel costs for visits to healers. AskGod, a prominent local philanthropist in Nkoranza, loaned his vehicle to the team to visit distant communities and provided work opportunities in his construction business to support the recovery and rehabilitation of people who had been treated by the mental health team (see Figure 5). He described how this helped to challenge stigma and support social inclusion:

> Sometimes I use my pick-up [truck] and then we all go. When we do that, it helps the community to see that they are working beyond what they are required to do. There are many in the community who treat people with mental illnesses as outcasts, they are not useful to anyone. But when they see us drawing close to such people, it makes them realize that they are also worthy.

Challenges to effective collaboration

We have identified factors that helped to strengthen collaborations between healers and health workers in this setting but there were also several challenges to initiating and sustaining these relationships.

Postcolonial legacies of distrust

As mentioned earlier, traditional healing was banned during the colonial era as it was considered primitive and harmful. By contrast, biomedicine was promoted as progressive, scientific and more efficacious (J. Roberts, 2021). As a result, there was much disdain for indigenous healing within elite educated circles in Ghanaian society, and people who used their services were considered unenlightened (J. Roberts, 2021). Such sentiments regarding the two health systems have remained in postcolonial times. Sensationalist reports of chaining or beating by traditional healers reinforce a view of healers as primitive and barbaric and many are widely viewed as 'charlatans' or 'quacks' who are focused solely on making money (Read, 2017). This suspicion extends to Christian pastors who may fear losing their livelihoods and reputation for healing power (Kpobi & Swartz, 2018a). As a result of this negative

Figure 5. Local philanthropist AskGod employs people with mental health problems in his construction business.

regard, mental health workers reported that many healers were initially suspicious of their intentions for seeking partnerships with them. Kingsford, a mental health nurse in Techiman, recalled:

> The pastors … initially they wanted to refuse us, they did not want us here. But when we came here, we sat the pastor down and explained that this is the situation on the ground, we wanted to work with them, we want us to come together so that we will do our part and he will do his part.

Against this backdrop, the health workers needed to work carefully at overcoming the healers' suspicions in order to gain their trust and build working relationships. As Sister Regina explained, some healers feared that health workers would take their patients, and thus their livelihoods, away:

> Initially when you go, they think you want to hijack their patients. So we tell them, 'We are not here to hijack but to collaborate with you. If you will permit us, we would like to know what you do, then you also know what we can do. We are not here to challenge your powers'.

What is evident in these responses is that mental healthcare operated within a political economy (Kong et al., 2021) where healers often felt short-changed by the dominant biomedical healthcare system. There were concerns that the presence of biomedical interventions within their healing spaces could potentially damage their client base. To overcome these fears, as we have described above, the health workers (who initiated most of these relationships) had to cultivate trust in the healers by proving their desire for partnership, not dominance.

Competition for inadequate resources

Although community mental healthcare is being promoted through legislation and policy in Ghana, as described above, there is a general low priority of mental health in the national health discourse and financing. As a result, to date there is no provision of ring-fenced funding to support community mental health activities and very limited support at a primary care level. Consequently, the mental health workers have to grapple with an absence of resources to facilitate their work, including inadequate infrastructure and logistics, as Eric's situation described above illustrates. Furthermore, although mental healthcare is meant to be freely available at public community-based health facilities, there is usually an inadequate medication supply. Thus, the community health workers often have to purchase medication and bear transport costs from their own pockets, as Sister Regina explained:

> We needed a motorbike to go out [but there were] no means. Then MIHOSO [a local NGO] gave us a motorbike. And when that motorbike came, [there was] nobody to fuel [it]. I will have to buy fuel, George will have to buy [medication] and then, we were on the field. And on the days that I don't have [money], George will buy fuel and we will go.

This quote highlights the absence of logistic support and the community health workers' use of their own meagre resources to visit healers and provide treatment. With the absence of ring-fenced support for mental healthcare in the community, the nurses often have to compete for limited resources with other public health programmes. Occasionally, they joined other better-funded and more highly prioritised public health activities, such as neonatal care, to be able to conduct community visits.

Ethical dilemmas in care

Alongside these logistical challenges, mental health workers encountered ethical dilemmas, which impeded the progress of the collaboration.

Use of physical restraints. The use of chains to restrain people in healing centres in Ghana has been heavily criticised by human rights organisations (HRW, 2020). Although chaining is banned in Ghana, both in the constitution and more explicitly in the 2012 Mental Health Act, as described above we witnessed chains and shackles in use in traditional healing centres and prayer camps where the nurses were conducting visits. This was used to control disruptive and aggressive behaviour or to prevent people leaving and potentially getting lost or using drugs. Although mental health workers are tasked to ensure that chaining is stopped completely, this has been difficult to accomplish in practice as they find themselves in a conflicting role when visiting healers – acting as a form of state-sponsored surveillance while also requesting partnership. This reinforces the hierarchical relationships between biomedicine and healing described above and thus creates distrust, which can threaten hard-won relationships, as Abu describes:

> The first time we came here, […] we met patients in chains and shackles … It wasn't easy. We faced some challenges and rejections and other difficulties, but we kept pushing and then at long last, they came to understand that we have to work together … They felt we wanted to monitor their activities and then report on them.

As discussed earlier, although mental health has begun to be provided within primary care clinics, there are very limited facilities to provide acute inpatient care in the region. Conversely, traditional healing shrines are numerous and can provide a means of confining people who may be perceived to be a threat to the community, as described in the case of Sofo Ketewa's prayer camp. Faced with this reality, some mental health workers described feeling helpless, unable to

provide a humane alternative if chains were removed and highly agitated people from shrines or prayer camps were brought to their clinic. To overcome this challenge, the nurses negotiated with the healers to allow them to commence pharmaceutical treatment while the person remained restrained at the healing centre. Once the person was calmer, they could use this as an argument for the healer to permit them to unlock the chains. Abu described the difficulties of this situation when he met a person in chains at Sofo Ketewa's prayer camp:

> I couldn't stand it but there was nothing I could have done at the time. It was a very difficult situation. I couldn't have intervened in any way. We normally argue or advise that they remove the chains before we give medication. But in his case, we cannot argue that much. We do it gradually.

Treatment interactions. Another dilemma faced by mental health workers was in relation to the danger of drug interactions. In several healing centres, including some healing churches, plant-based herbal medication is given to patients. These herbal treatments could potentially have dangerous interactions when taken together with psychotropic medication. Although the mental health workers request that patients staying with healers only take pharmaceuticals provided by the nurses, this is not always accepted by the healers. As explained by Kingsford:

> Sometimes we will prescribe drugs for them to take. But [the healer] will also instruct them not to take it, or to start with [herbal medication] then later continue with ours. So it became […] a bit of confusion. We sat [the healer] down and tried to let him know that […] their medication and our medication cannot … we can't combine both of them for the client [because of] the side effects.

In addition, in the early days of their collaboration, the nurses noticed that there were instances when the healers would buy psychotropic medications themselves to give to their patients. This was usually for people who were disruptive or aggressive as they desired the rapid sedating effect of psychotropics. In such cases, the nurses lost control over the administration of drugs that can have highly dangerous effects, particularly if given in too high a dose. The nurses reported that they had to explain the dangers to the healers and negotiate to retain their control in dispensing psychotropic medication.

It is important to highlight that the above barriers were related by the mental health workers and not the healers. This is likely because it was the mental health workers who were required to seek out healers to initiate partnerships as part of their work. In this study we found that it was only after being approached by the nurses in the first instance that some healers then went on to call them of their own volition. As explained above, many of the healers were initially sceptical of the biomedical system and therefore rarely sought to work with them. However, once the initial relationship had been established, the healers contacted the health workers whenever they received new patients who appeared to need psychiatric interventions.

Discussion

In this article, we have discussed facilitating factors and barriers in developing collaborative care between mental health workers and healers, drawing on a visual ethnography of examples in Ghana. The findings of this study highlight that successful collaboration between healers and health workers is dependent on several multi-layered conditions being consistently provided and reinforced.

As others have identified, collaborations have not been sustainable because of deep distrust and suspicion between practitioners of different healing paradigms (Abdullahi, 2011; Green & Colucci, 2020; Krah et al., 2018). The mental health workers in this study recognised this problem. By purposefully emphasising mutual recognition of and respect for the authority and expertise of traditional and faith-based healers, they were able to cooperate and work toward mutual goals for the benefit of people in their care. This was also facilitated by the fact that the mental health workers shared at least some aspects of their cultural and spiritual beliefs with the healers. Intrapersonal characteristics were also fundamental, as without the flexibility, commitment and dedication of the mental health workers and the healers, the partnerships could not have been initiated or sustained. Identification with a professional role and its attendant obligations, whether as a healer or a health worker, was also crucial in motivating individuals to establish and maintain successful collaborations.

However, individual motivations and interpersonal relationships are seldom sufficient on their own. These findings reflect the importance of structural support from local and national level health systems and policies (Gureje et al., 2015). By making room for traditional healing within the formal mental health system, a process of equal regard and mutual capacity can be cultivated. This is a crucial difference from attempts at collaboration which emphasise task-shifting, where the healers' roles are typically limited to providing support for psychiatric interventions (Mendenhall et al., 2014; Musyimi et al., 2017). The approach adopted by participants in this study allowed the expression of cultural norms and not merely co-opting healers' cultural authority for the purposes of handing over their patients to psychiatric treatment (Gureje et al., 2015). Alongside health system support, informal support harnessed from community level actors, such as NGOs and philanthropists, helped overcome chronic resource challenges that could prevent collaborations being established and sustained.

Challenges to collaboration discussed by the participants reflect the low priority of mental health in Ghana. Inadequate facilities, few mental health professionals and shortages of psychotropic medication are factors that have been identified as problematic in the delivery of mental healthcare in Ghana and other LMICs for several years (M. Roberts et al., 2014; Saxena et al., 2007). Despite the recent advances made in community mental health services in Ghana, there is clearly still a need for dedicated and sustained funding and resources to support mental health at the community level. Although community-based support has been helpful, this is often piecemeal and short-term. Without dedicated and sustained funding, progress in building collaborations and their long-term viability is threatened. Furthermore, the absence of adequate logistics also affects those facing an acute mental health crisis, as there are very few alternative inpatient facilities, especially outside the major urban centres (Nyame et al., 2021). Rather than focusing on transforming traditional healing practices alone, changes are also needed on the part of the formal health system.

Given these challenges, the real driving force for successful collaboration was in the interpersonal relationships between healers and health workers and the mutual respect for their domains of expertise (Read, 2019). Because of shared cultural beliefs, mental health workers did not feel threatened by the healers' worldview but recognised the value of spiritual connectedness as important for healing. They did not find this to be in conflict with their biomedical training, but instead identified a complementary role for religious faith and spiritual belief in their approach to collaboration. As Mathauer and Imhoff (2006) suggest, religious identities foster cognitive and motivational responses, including those based on how values and norms are expressed in other areas of the individual's life. We saw this in the acceptance of the place of spiritual interventions by the health workers, and in the personal ethos of care displayed by both healers and mental health workers.

Although our study identified important factors for building sustainable collaborations, there were some limitations. The first is that the experiences of successful collaboration that we observed are not necessarily a reflection of what collaborative care is like in other contexts, including in other parts of Ghana. Indeed, there were particular factors that made these collaborations successful, such as the personalities and motivations of the nurses, which may not be present in other attempts. We also recognise that the factors that facilitated success in these communities may be different elsewhere, and that success is a product of positive engagement from all parties involved. Our aim in this project was, however, to show that collaboration is indeed possible and can be mutually beneficial. The second limitation is the fact that, although LK and UR have longstanding fieldwork experience in this context and maintain contact with participants in the field sites, the data for this visual research project were collected over a relatively short period. Further planned visits to the field site could not be conducted within the funding timeline owing to the outbreak of COVID-19. Therefore, it was not possible to consistently follow participants over time to determine the success of the partnerships in the longer term, particularly from the perspective of caregivers and patients who often came from outside the communities where the healers were based. Third, because of the time limitations and the reluctance of some participants to be filmed, we were not able to speak to many people with lived experience of mental health conditions to determine their experiences with and views on collaborative care.

Conclusion

This study is one of few that illustrates how collaborations between mental health workers and healers are working in everyday practice, rather than within the restricted context of a research intervention. The findings suggest how collaborations can be successfully established not only in Ghana, but also in other contexts. The factors that contributed to the success of these collaborations included individual and relational characteristics as well as support from communities and the health system. However, inadequate resources resulted in ethical dilemmas that had to be carefully navigated. By strengthening the facilitating factors and mitigating against identified barriers, these partnerships show promise for developing community mental healthcare in Ghana and other settings into a more holistic system with benefits for enhancing care and protecting human rights.

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Notes

1. See https://movie-ment.org/together4mh/
2. Regina Ayishatu Ali sadly passed away in 2020 before editing of the ethnographic documentary was completed. A short video of the film footage featuring Sister Regina was made in her memory and can be found at https://movie-ment.org/together4mh/
3. Healers are believed to be able to see into the spiritual realm which is invisible to the ordinary person. Sister Regina is referring to the fact that as a health worker she does not possess this insight but is limited to what is physically visible to the human eye.
4. We recognise the importance of avoiding stigmatising language when referring to people with lived experience of mental illness and have consulted with people with lived experience in Ghana regarding preferred terminology in English and Ghanaian languages. In this article we refer to people who were believed to be experiencing or to have experienced mental illness as 'patients', in recognition of the fact that most were receiving treatment at the time from healers or health workers. 'Patient' is also used to translate the Twi term *yarefo* [literally 'sick person'] which is widely used by healers and families.
5. We acknowledge that we selected nursing teams for our research that were generally highly motivated and engaged and that the examples we give here cannot be taken as illustrative of mental health workers' practices in Ghana as a whole. We are aware that difficult working conditions, lack of resources and stigma towards mental health workers can also be demoralising and disincentivising. However, we have witnessed nurses taking similar proactive approaches in other parts of Ghana such as Tamale and Kintampo and Cecilia Draicchio reports similar findings from her fieldwork in Western Ghana (Draicchio, 2020).

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