"Ghana has played a pioneering role in promoting the value of traditional healers in mental health."

Pluralistic Approaches to Mental Health Care in Ghana

URSULA READ AND LILY KPOBI

On the roadside just outside the market town of Kintampo, around 400 kilometers from Accra, the capital of Ghana, a large billboard advertises the services of a traditional healer. The sign is similar to many that line the highways, promoting a variety of healers, from purveyors of herbal medicines to Christian pastors offering miracle cures and deliverance from demonic forces. But this particular sign stands out for those with an interest in mental illness, since it advertises services offered at a local shrine specifically for the treatment of *ɛdam*—"madness." The *nana* (chief or "grandfather") who is the shrine's custodian has a reputation for expertise in healing madness, drawing clients not only from the local area, but also from villages, towns, and cities across Ghana, and even beyond.

The shrine is surrounded by a forest and adjacent to a small village, accessible from the highway along a narrow, unpaved road. Though somewhat hidden away, it is far from remote. The shrine has attracted attention at the highest level of the Ghanaian mental health system. In 2011, Akwasi Osei, then serving as chief psychiatrist in charge of the country's mental health services, paid a visit to the shrine. Evidence of the visit is visible in a large water tank and borehole, which were funded through the mental health administration to supply water to the shrine's inhabitants.

At the time, the Ghana Health Service was establishing a program in community mental health at the nearby Kintampo College of Health and Wellbeing, one of the country's premier sites for training primary health workers. The shrine hosts annual visits by lecturers and students from the college. They come to learn about the healer's methods for the treatment of mental illness as part of their training as community mental health practitioners.

The healer welcomes these visits as evidence of his recognition by the mental health system and his reputation as an expert in treating mental illness, yet in fundamental ways his practice has remained unchanged. Nana's shrine is typical of many in this part of Ghana. In the Akan tradition, Nana is an *ɔkɔmfo* (literally, a person who is possessed [by the gods]) whose role is to serve the *abosomfoɔ* (gods) who possess him. Possession is brought about through prolonged ritual dancing accompanied by drumming and singing. In this state, Nana acts as the gods' mouthpiece. They will diagnose the problem and what is needed for a resolution—usually confession and sacrifice for a wrong committed, either by the person who is afflicted or by those around them.

People who are brought for treatment of "madness" form the majority of those staying at the shrine. They sleep on soiled and worn mattresses on a raised concrete platform. Apart from a corrugated iron roof, the platform is open to the elements, with mosquito nets providing some protection.

Many people staying at the shrine are shackled to one of the metal posts holding up the roof. Family members, most often mothers, stay with them in the compound to prepare meals and help with bathing and other personal care. These relatives also help to administer Nana's medicine, which may be drunk as a liquid or inhaled as a vapor or used for bathing. The medicine has highly sedative effects, and often the clients are in a deep sleep.

Every Sunday and during festivals, the families must be in attendance at the shrine when Nana consults with the gods. Sometimes they must bring required offerings, such as sheep. When the time is

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right and the family has propitiated the gods and paid the needed sum as a mark of appreciation, the afflicted person will be permitted to return home.

Many of those who visit the shrines complain bitterly about the high cost of the treatment. Besides the money they must give to the healer and pay for the offerings, there is also the loss of earnings due to many weeks or months spent at the shrine. Those who have been kept in chains are often highly critical of their treatment and express resentment toward both the healer and their families, who, in their view, have inflicted it on them.

Yet shrines like Nana's are also sociable places, despite the chains and evident suffering. Caregivers come together to share stories and advice, drawing on their experiences of providing care for an adult child, who often does not recognize that there is any problem or may have been hostile and even violent toward them. For some, the shrine provides a resolution and a respite after many years of struggle. For others, the shrine is one stop in an ongoing search for a cure.

Many observers of Africa predicted that with time, "old traditions" and "superstitious beliefs" would be replaced by "modern" medical or psychological approaches to the treatment of mental illness. But Ghana has continued to embrace a pluralistic system of health care, even as mental health services have expanded. This pluralistic approach is supported by influential international actors, such as the World Health Organization (WHO). In this model, traditional and faith healers are considered a potentially valuable resource to plug the gaps where resources are scarce, as well as to address specific cultural or spiritual needs.

Many saw traditional healing as congruent with deeply held cultural beliefs.

But there have also been widespread concerns about human rights abuses associated with such healers. Human rights organizations have published damning reports detailing the use of chains, enforced fasting, and beatings in healing churches and shrines. As part of the effort to protect the human rights of people with mental illness and prevent such abuses, Ghana's Mental Health Authority has actively promoted collaboration between traditional and faith healers and mental health practitioners. Such collaboration is expected to include checking for any harmful practices and supporting access to medical treatment for mental illness.

This raises the question of how effective such efforts have been, both in developing mutually respectful relationships between medical and traditional or faith-based practitioners and in the protection of human rights. In shrines like Nana's, chaining and shackling of people with mental health conditions continues. In his shrine's case, this is despite the proximity of the shrine to the training college and to a highly respected international health research center, and visits by instructors and students from the college and international researchers (including the authors of this essay).

Historical Views of Traditional Healers

Under the colonial mission to "civilize" Africa, traditional healers were often denigrated as "backward" and "superstitious," labeled as "witch doctors" and "fetish priests." Modern medicine was promoted as the scientific alternative. Training medical personnel and establishing clinics and hospitals was a prominent part of colonial and missionary activity. In the field of psychiatry, however, colonial authorities were rather more ambivalent.

Until chlorpromazine began to be used for treating psychosis in the 1950s, there was no clear "scientific" alternative for the treatment of mental illness. Mental illness was presented as a social as much as a medical problem: "roaming vagrants" were a common concern, particularly in the growing urban centers. And doubts were already being expressed, on both humanitarian and economic grounds, about the treatment of patients confined for many years in asylums in Europe. Replicating such a system in Africa seemed both costly and of dubious benefit, particularly in the postwar period, as the colonial project itself was increasingly contested both in Africa and in the metropoles.

Psychiatrists conducting research into the "problem" of mental illness in the Gold Coast and other British colonies in Africa generally favored family care and "native doctors" over psychiatric asylums. The common perception was that "traditional" societies were more accepting and tolerant of people with mental health conditions, despite the use of various forms of restraint. Robert Cunyngham-Brown, a British psychiatrist who in 1936 conducted an inquiry into the care of "lunatics" in British West Africa, concluded that "family care of the insane" not only made patients happier

and healthier than care in "closed institutions," but also was much more economical.

British psychiatrist Geoffrey Tooth, who later played a role in implementing community mental health in the UK, argued that care within the family or in the compound of a "native doctor" was preferable to being confined in an asylum, even if patients were chained or "logged," another method of confinement that involved placing someone's leg through a hole in a log. In his report, published in 1950, Tooth wrote:

> A person who develops a mental illness in his own home, or who is returned to his home while insane, may, according to circumstances, be logged in the family compound and attended by the local herbalist; he may be boarded in the compound of a native doctor; or he may be allowed to roam at will. Some of these persons, though probably not many, are kept under mechanical restraint for many years. Their lot, though far from ideal, compares favourably with an asylum patient under similar conditions.

He recommended building on these existing practices rather than replacing them with an "imported system."

The potential of traditional and faith healers in mental health care was also a favorite subject of transcultural psychiatry, which emerged in the 1950s. Proponents of transcultural psychiatry questioned the universality of mental disorders such as schizophrenia, exploring alternative approaches to treatment. Raymond Prince, a Canadian who worked as a government psychiatrist in Nigeria from 1957 to 1959, was one of a number of medics and psychiatrists who studied the practices of traditional and faith healers, staying for two weeks with Chief Jimo Adetona, whom he referred to as "my friend, the witchdoctor." He published papers on the use of *rauwolfia*, a plant-based medicine employed as a sedative by healers, as well as psychological interpretations of witchcraft and curses.

In the 1930s Margaret Field, a government anthropologist in the Gold Coast, began to study the rapidly multiplying shrines for protection from witchcraft. Finding that many supplicants appeared to be mentally ill, Field returned to the UK and completed her training in psychiatry at the age of 52. In 1955, she returned to Ghana and conducted a detailed study of shrines in the Ashanti region. This became her magnum opus, *Search for Security: An Ethno-Psychiatric Study of Rural Ghana*, published in 1960, which details over 100 cases, as well as describing the social and cultural context that she believed might lead to mental illness. She concluded: "The rural patient is never taken to [a] mental hospital, not because of any associated stigma, but because the illness is regarded as supernaturally determined and hence outside the province of hospitals."

Like Field, many saw traditional healing as congruent with deeply held cultural beliefs, as well as offering an effective form of "African psychotherapy," as the Ghanaian sociologist Patrick Twumasi argued. In 1954–55, Gustav Jahoda, an Austrian-born psychologist then living in Ghana, also conducted a study on what led people to seek help from traditional healers, a healing church, or the mental hospital. He concluded that "the support and reassurance [traditional healers] provide probably often prevents the occurrence of serious breakdowns."

Nonetheless, the Gold Coast authorities, like other British colonial administrations, had adopted a process through which "troublesome lunatics" could be sent for confinement in government institutions. Initially they were confined in prisons; in 1888, following the passage of the Lunatic Asylum Ordinance, the old high court building in central Accra was converted into an asylum. Eventually, in 1906, a purpose-built asylum opened to admit patients. Despite its premise as a medical rather than penal institution, the Accra asylum retained a prison-like architecture with "airing courts," heavy metal doors, and barbed wire. Handcuffs, leg irons, and seclusion cells were used to restrain "restless" or violent patients.

Following independence from British colonial rule in 1957 and the introduction of chlorpromazine around the same time, E. B. Forster, a Gambian who was the first African psychiatrist to work in Ghana, was able to report in 1962: "Restraint is now purely by chemical means." Despite the advent of pharmaceutical treatment and an increase in "voluntary patients," Forster noted that "the function of the fetish priests continues to exist, for after the patient has been discharged from the hospital improved, this is regarded as only partial improvement that becomes complete only after the performance of certain rites." In his view, although "native doctors have a definite place in the management of those emotional reactions which have a strong cultural overtone," such as hysterical reactions, obsessions, and phobias, they were "quite ineffective in dealing with the psychotic patient."

He also noted, "Their patients are usually subjected to inhuman treatment such as beatings, starvation, and indiscriminate purgation."

Forster's attitude was generally dismissive of those he referred to as "fetish priests, native doctors and other charlatans." But for some Africans, reclaiming the value of traditional African knowledge was an important part of restoring national pride. This included establishing Afrocentric approaches to health care. In 1963, Ghana established the Ghana Psychic and Traditional Healing Association under the administration of the independent country's first president, Kwame Nkrumah. In Nigeria in the 1950s, the renowned psychiatrist Adeoye Lambo, as part of his vision for an "African psychiatry," established a system of "village psychiatry," where patients could consult with healers while receiving treatment from the Aro psychiatric hospital. Henri Collomb, a French psychiatrist who headed the Fann clinic from 1959 to 1978 in Dakar, Senegal, invited healers to run sessions in the clinic.

This interest in traditional healing did not substitute for innovations in psychiatry in the region. Africans studied psychiatry in Europe and actively participated in international and regional debates on the future of the profession, including as members of the World Psychiatric Association. Following independence, a new psychiatric hospital was constructed near Cape Coast as part of Nkrumah's plan to modernize Ghana's health system. Further plans for a "Pan-African Mental Health Village" on the outskirts of Accra were not realized after Nkrumah was deposed in 1966. But a third psychiatric hospital was constructed on the site and opened in 1975.

Starting in the 1960s, the WHO promoted a shift from asylums to community care. There were tentative steps toward developing community mental health in Ghana. Training of community psychiatric nurses began in 1972. These nurses deliver mental health services at community health facilities and provide follow-up care after patients are discharged from hospitals, including home visits. But the initiative had very limited reach, particularly beyond the capital, amid economic and political crises during the 1980s as well as structural adjustment policies that imposed budgetary austerity in countries receiving donor funding. This restricted investment in public services such as health care.

Healers and 'global mental health'

The turn of the millennium witnessed a shift in attention to mental health by international agencies, accompanied by new sources of research funding. As researchers called for a "scaling up" of services to treat mental illness, traditional healers were again proposed as a complementary resource with which to fill the "treatment gap" between those believed to be suffering from mental disorder and those receiving treatment. Vikram Patel, a leading figure in the new field of "global mental health," described the traditional healer as "a key player in the mental health system."

In recent guidance on person-centered and human rights–based approaches to community mental health, the WHO advises countries to "ensure due consideration for the role and support provided by traditional and faith-based healers and organizations." It recommends "capitalizing on the positive aspects of the care and support they provide while at the same time working to stop the use of coercive practices." In other words, according to the WHO, the notion of "collaboration" contains a dual purpose: on the one hand, tapping healers' contributions as a source of accessible, culturally valued care; on the other hand, preventing human rights abuses.

Healers whose practices are most harmful may be least likely to collaborate.

The 2006 United Nations Convention on the Rights of Persons with Disabilities, together with the growing involvement of people with lived experience of mental illness in advocacy and activism, turned a new spotlight on the human rights of people with mental illnesses or "psychosocial disabilities." Investigations by human rights groups and nongovernmental organizations exposed the widespread use of chains by healers and others, describing in vivid terms the impact on people subjected to such restraints.

As a result, approaches to "collaboration" tend to reinforce a hierarchy in which medical authorities inspect and regulate traditional healers, whereas healers do not have a concomitant role in overseeing "formal" mental health services. Yet human rights observers and those receiving services have also documented the continuing use of coercion and restraint within psychiatric facilities. The push to promote patients' human rights

has come with limited attention to the necessary resources. Medical facilities receive government or donor funding, whereas healers operate as private enterprises and must cover the costs of meeting the required standard. The requirements include providing high-quality, secure accommodation and upgrading sanitation facilities.

Regulating Healers

Consistent with earlier efforts to integrate traditional healing into primary health care, Ghana has played a pioneering role in promoting the value of traditional healers in mental health. Meanwhile, over the past decade, Ghanaian medical schools have trained increasing numbers of psychiatrists, and the ranks of mental health nurses and community mental health workers have significantly expanded. Most towns and villages now host at least one community mental health worker—a vivid contrast to other African countries where community mental health care is virtually absent.

The 2012 Mental Health Act, which was supported by the WHO, sought to bring legislation in line with human rights principles. Along with governing procedures for involuntary hospital admission, the law also calls for the Mental Health Authority to "collaborate with the Traditional and Alternative Medicine Council and other providers of unorthodox mental health care to ensure the best interest of persons with mental disorder."

The law permits involuntary seclusion or "minimal mechanical restraints" only "when there is imminent danger to the patient or others and tranquilisation is not appropriate or readily available." But such involuntary confinement is not permitted in nonaccredited "unorthodox" facilities, such as shrines or churches. Visiting committees are tasked with carrying out inspections of both psychiatric and "unorthodox" healing facilities.

Notably, in the preamble to the Mental Health Authority's 2018 Guidelines for Traditional and Faith Healers, the 2012 law's requirement to "collaborate" was rephrased as a mandate to "regulate" the practices of traditional and faith-based healers. As stated in the foreword to the guidelines, the primary emphasis is on the authority's role in regulation, framing collaboration as a means to prevent harm and ensure that treatment is provided in an "acceptable way that does not compromise the dignity and human rights of clients." Healing facilities must provide roofed and walled accommodation, potable water, "safe, hygienic toilets," "nutritious meals," and "locks and doors for safety and security." The guidelines also declare that "chaining, shackling and caging are abolished."

As part of the implementation of the 2012 law, the Mental Health Authority embarked on a nationwide training program for traditional and faith healers, with support from international donors and NGOs. In the course of their duties, community mental health workers are also mandated to visit local traditional and faith healers to build partnerships and monitor their activities. They negotiate the removal of restraints and offer psychotropic medication to patients at shrines and churches.

The increase in community mental health workers has brought care to many who previously struggled to access medical treatment. Some healers are open to visits from community mental health workers, and many healers and families welcome the effects of sedating medicines in calming aggression and agitation. Some healers have also reduced their use of restraints, except when clients are first admitted. As we witnessed at the shrine, however, the terms on which collaboration is established, and the degree of success in reducing harmful treatment of people with mental illness, can vary widely.

In 2023, Human Rights Watch researchers returned to Ghana and visited two leading churches where people were being treated for mental illness. They reported that the visiting committees were only partially operational, concluding, "The government has not adequately resourced the enforcement mechanisms to monitor compliance by faith-based centers where people are being held in chains and assist those currently being unlawfully detained." One of the churches they inspected had been the site of an earlier experiment with collaboration in which medication was provided for people with mental illness who were staying at the church.

Varied Practices

For Nana, psychotropic medications with their sedating effects offer little benefit compared with his own herbal remedy, a recipe handed down from the former custodian of the shrine. From his perspective, his medicine has a considerable advantage, since its power is not only biological but also spiritual. According to Nana, in selecting the plants for the recipe, he is guided by the gods, imbuing the plants with spiritual potency. In order for his clients to receive his treatment, he must make sure that they remain at the shrine and take part in the necessary rituals. From Nana's point of view, the

shackles and chains are an essential tool to this end, until his clients recover sufficiently to remain of their own accord. Nana's commitment to collaboration is thus strictly on his own terms.

This reflects a tension within approaches to collaboration that tend to gloss over wide variation in healing practices and orientations. Innovation has been central to the dynamism of the healing landscape in Africa for centuries. Arguably, this is what made Africa fertile ground for the introduction of Islam and Christianity.

Today, Pentecostal Christian churches are particularly prominent in the healing landscape across Africa. Their popularity is such that they probably draw more supplicants than so-called traditional healers. Some Christian healers denigrate the practices of traditional healers as backward and demonic, much in the vein of earlier Christian missionaries.

Whereas healers such as Nana draw on Akan traditions and the power of herbal plants, Christian healers rely primarily on prayers or deliverance from evil spirits. For such healers, collaboration may be more straightforward, since "medicine and prayers" can be more easily combined than plant-based medicines and pharmaceuticals. Christian healers may also incorporate Christian practices into the administration of pharmaceuticals—for example, by praying over them.

To complicate things further, some Christian healers also incorporate healing plants into their repertoire. Others insist on the importance of long periods of fasting—a practice which is often enforced against the supplicant's will. Some Christian healers may also resist collaboration, since it may challenge their own claims to miraculous healing powers.

Faced with this diversity, mental health workers can find it difficult to establish collaboration. They have little choice but to work with those who are most open to developing partnerships. This may mean that healers whose practices are most harmful may be least likely to collaborate.

Despite the legal backing of the Mental Health Act, mental health workers have little cultural or social authority to intervene, and most would be reluctant to openly challenge healers who are respected and sometimes feared in their communities. To date, despite external pressure for stronger enforcement of the law, there have been no prosecutions or forced closures of healing centers. A "softly, softly" approach—building trust and working for gradual change—seems to be preferred to outright confrontation.

Scarce resources

In addition to the challenges presented by this diversity of healing practices and differing claims to healing power, scarcity of resources has severely hampered efforts to improve mental health care in Ghana. From the outset, the growth in the numbers of community mental health care personnel has not been accompanied by an increase in resources with which to carry out their role, such as access to appropriate modes of transportation and adequate medical supplies.

Community mental health care is dependent on suitable vehicles to visit patients and their families, both those at home and those staying with healers. Often, as with Nana's shrine, such locations are not easily accessible on public transport. Many are in more remote locations, along rough, unpaved roads, requiring motorbikes or other off-road vehicles to reach them.

The provision of pharmaceuticals to community health facilities is insufficient and inconsistent. Families are often impressed with the sedative effects of "hospital medicine," but ensuring a regular and affordable supply is difficult. The government often reports shortages in essential medications.

As a consequence, many nurses are forced to improvise to meet demand. This may involve buying medicines wholesale and then selling them to families at a cheaper price. But doing so can expose them to suspicions of profiteering. Nurses may also purchase medications for patients by pooling their personal funds or seek support from community philanthropists. But families often must find a way to buy the medicines themselves.

The absence of institutional support creates ethical dilemmas for mental health workers and families. When chains are removed from someone staying in a shrine or church who is in a mental health crisis, they can be at risk of running away and becoming lost, or causing harm to him/herself or others. Yet there may not be sufficient nearby facilities to provide a safer and more humane alternative.

The dilapidation of the Accra psychiatric hospital and its outdated architecture have been a long-standing concern. Promises to replace it with a "modern facility" designed by the renowned Ghanaian British architect David Adjaye, and to build a new psychiatric hospital in every region of the country, look unlikely to be achieved since the economy has weakened. The country's three existing psychiatric hospitals are all in the south; the

rest of the country is served only by a small number of inpatient units in general hospitals.

For families struggling to care for a relative experiencing a mental health crisis, the numerous shrines and healing churches offer a convenient space for support and containment. Some have accused the government of abdicating its responsibility by outsourcing this role to traditional and faith healers. Facing chronic funding shortfalls, the psychiatric hospitals now require upfront payments for admission. Previously overcrowded wards are emptied out, while healing churches and shrines like those near Kintampo continue to thrive. But containing a mental health crisis while respecting human rights is difficult even within the hospital environment, let alone in healing facilities, where buildings are often poorly maintained and sanitation is limited. Neither the hospitals nor the shrines have met the standards set out in the Mental Health Authority's guidelines.

These challenges have resulted in a mass exodus of Ghanaian mental health professionals in recent years. Record numbers have been recruited by countries in the global North to fill the gaps in their own struggling health systems. This "brain drain" has further weakened the already precarious community mental health system, which has lost many of the workers who were trained since the passage of Ghana's Mental Health Act. Less experienced, overstretched mental health workers therefore may be the only available resources in community clinics and hospitals. Such conditions can make their services less effective and appealing, driving families back to the promises of traditional and faith healers.

THE SEARCH FOR A CURE

Ghanaians experiencing mental illness and the families who care for them approach hospitals, shrines, and churches with the same goal: to find a cure. The impact of serious mental illness can be devastating, disrupting dreams and plans for education, employment, and family life.

When mental health practitioners encourage families to make use of medical treatment, they may overpromise on the effectiveness of what is on offer. After all, taking medicines indefinitely, especially since doing so comes with a cost, does not represent a cure as most people would conceive it. The common comparison of such a regimen with medication for diabetes does not engage with the unpleasant side effects of psychotropic medication, or with enduring uncertainties surrounding the causes and outcomes of mental health conditions.

As the science of mental illness continues to be questioned and people with lived experience of mental health conditions demand better services and greater inclusion, a pluralistic approach leaves open possibilities for healing that might otherwise be foreclosed. As one Ghanaian advocate living with a mental health condition put it, "We are Africans, so we can't leave spirituality out." ■