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Providing mental healthcare through faith-based entities in Africa: a systematic review

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Abstract

Background: Psychological disturbances and mental illnesses are prevalent on the continent of Africa. There are shortages of mental health services and a lack of quality providers with limited training and supervision. It is perceived that faith-based entities for psycho-emotional health and wellbeing are filling the gap with positive impact. However, the risks associated with unconventional or extreme spiritual practices will be evaluated. The contributions of these entities, their roles in the global and African health system, and their implications for community development and policy making are highlighted.

Methods: A mixed-methods systematic review was conducted in two phases to synthesise qualitative and quantitative data. The review sought evidence on faith-based health providers of mental health services in Africa looking at types, magnitude, and quality and included both peer-reviewed and grey literature published between 2007 and 2024 in English. A narrative thematic analysis was used for the qualitative part and meta-analyses was used for the quantitative part to back up the narrative element of this study.

Results: This review identified 55 relevant items from 13 African countries. The results showed that faith-based, mental-health providers deliver a range of six types of alternative mental healthcare, faith-based, home care, and faith-based, biomedical, mental healthcare. The magnitude of these faith-based, mental health services were considered according to frequency of use and availability (accessibility, affordability, and acceptability), however evidence was limited. When the quality of the mental healthcare was assessed, some studies showed positive mental health outcomes from the utilisation of faith-based, mental healthcare, but some studies revealed bad quality practices due to harmful treatment.

Conclusion: There are limitations regarding the vast array of faith-based, health providers and the mental healthcare they provide which include harmful practices used in Africa. Training interventions are needed to avoid harmful treatment. Faith-based, mental healthcare offers culturally influenced practices for mental-health which should be leveraged. Integration of faith-based, mental healthcare into any primary, health system is advised in order to attain universal health coverage. Finally, possible regulation of traditional and faith healing methods for emotional struggles could be implemented at a policy level.

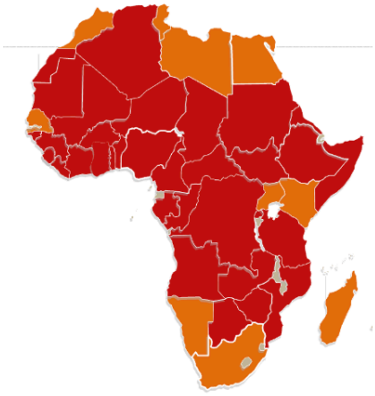
Keywords: Faith-based, health providers, mental healthcare, mental health, emotional struggles, psychological well-being; harmful treatments, mental-health system, religion, culture, Africa

Background

Health systems contain both state and non-state providers (NSPs) delivering health services.[1] NSPs such as faith-based, health providers (FBHPs) deliver health services, strengthen health systems, and contribute towards universal health coverage (UHC), but the significance of their contributions in low-and middle-income countries have been questioned.[2,3,4] A research gap is linked to the magnitude of faith-based health provision in Africa with limited data and inaccuracies around their utilisation.[5,6] There is a need to focus on mental-health services in Africa to fill this evidence gap which is often neglected.[7]

Mental illness (in all forms from mild to severe) affects 7% to 10% of the global and African population.[8,9] Data accumulated suggest that 70% of individuals in Africa do not have access to mental healthcare (MHC). Most African countries in terms of providing biomedical MHC have a low availability of mental-health hospitals and outpatient facilities and have about 5 psychiatrists and 6 psychologists per 100, 000 population (Figure 1).[10] There is a research gap in MHC in LMICs in regards to the state's provision, and NSPs have the ability to fill this gap.[151] African health systems have undergone shocks with a lack of providing MHC.[11] Faith-based, health providers are often a first point of contact for providing both biomedical and alternative MHC.[10,11] However, there are currently no systematic reviews which assess magnitude, types, and quality of faith-based, mental healthcare in Africa, so this study will aim to include these various components and fill the research gap.

Figure 1. Map of Africa indicating (lack of) mental-health services in relation to a population ratio



Note. These were calculated through a search of various documents and not from papers in the findings with the most up to date information specifically entailing statistics on low, mental-health provision in all African countries (human resources and facilities). [19-53]

Country	Population (million)	Population ratio of psychiatrists (Per 100,000)	No. of Psychiatrists	No. of psychologists	No. of MH outpatient facilities
Egypt	102.3	0.08	705	177	18
Ghana	31.07	0.06	16	166	3
Nigeria	201	1.00	250	150	7
Zimbabwe	14.86	0.1	18	6	7
Sudan	42.27	0.08	30	11	28
Ethiopia	115	0.08	85	14	60
Kenya	55	0.19	54	5	10
Uganda	102.3	0.06	81	262	17
Rwanda	12.6	0.06	5	599	47
South Africa	58.5	0.28	799	10 961	3460
Senegal	16.7	0.33	506	501	4
DRC	89.56	0.044	39	11	1
Mali	20.25	0.029	6	2	1
Côte d'Ivoire	26.38	0.13	34	5	2
Morocco	36.91	0.84	350	60	32
Zambia	18.38	0.06	3	6	30
Somalia	15.89	0.06	3	1	2
Chad	16.43	0.01	2	3	1
Benin	12.12	0.11	13	6	0
Guinea	13.13	0.02	5	1	1
Tunisia	11.82	2.46	277	34	16
Togo	8.279	0.03	2	20	7
Libya	6.871	0.2	15	343	No data
Eritrea	6.081	N/A	1	5	10
CAR	4.83	0.02	1	2	1
Mauritania	4.65	0.07	3	6	2
Namibia	2.541	0.2	5	136	1
Gambia	2.417	0.1	2	No data	6
Botswana	2.532	0.29	3	9	1
Gabon	2.226	0.26	4	17	12
Lesotho	2.142	5.2	No data	6	No data
Comoros	0.869	0.13	1	6	No data
Cabo Verde	0.556	1.37	8	20	24
Guinea Bissau	1.968	No data	No data	0.11	1

Key for figure:

- **Low mental health services & providers**
- **Adequate level of mental health services & providers**

Africa has various ethnic nationalities with different languages and cultures, but some countries do share similarities across their belief systems. For example, Nigerian culture can resemble Ghanaian culture, yet, culture can be universal or unique in certain localities or regions.[152] A disconnect exists among biomedical, disease models and how socio-cultural, spiritual beliefs affect patients' perception of mental illness symptoms and health seeking behaviours. Other factors in Africa are poverty, low income, and occupational status which are linked to a greater incidence of depression in Nigeria and South Africa.[153] Trauma in Africa is usually intergenerational and results from communities having to cope with migration, terror attacks, genocides, political issues, socioeconomic disparities, and ethnic discrimination.[154]

As a result of the COVID-19 pandemic, there has been an attention to emotional struggles in Africa, especially among vulnerable communities. There is a desire to ensure more equitable and better uptake of mental health services.[11] In Africa, faith-based MHC such as psychosocial support is used in humanitarian and crises settings.[12] However, the mental health treatment literature has not recognised the contribution of FBHPs in these settings.[11]

This study aimed to explore six types of biomedical and alternative MHC provided by FBHPs in Africa. Biomedical, mental healthcare for the purpose of this study will be defined as psychiatric standardised care provided by FBHPs or mission hospitals. Alternative MHC will be classified as herbal and traditional practices such as prayer, herbs, oils, and other rituals. Furthermore, this study aimed to assess the contributions of faith-based MHC such as magnitude (number of beds available, number of facilities, frequency of utilisation, availability which are classified as accessibility, affordability, and acceptability). Cultural and social acceptability is considered an important factor among faith-based MHC.[13-19] This study will also explore the quality of the faith-based, biomedical care and any evidence which indicates the negative impacts of faith-based, alternative care.

Finally, this study sought to create some synthesis of the types of FBHPs present in Africa to include individuals and organisations and those providing alternative or biomedical care. There was a focus on six categories of FBHPs: traditional-healers, faith-healers, religious leaders (Christian and Muslim clergy), traditional healing facilities, faith-based organisations (FBOs), and faith-based, biomedical, health facilities such as mission hospitals and psychiatric facilities.

The systematic review aimed to explore the contribution (types, magnitude, and quality) of faith-based MHC in Africa based on articles published between 2007-2024.

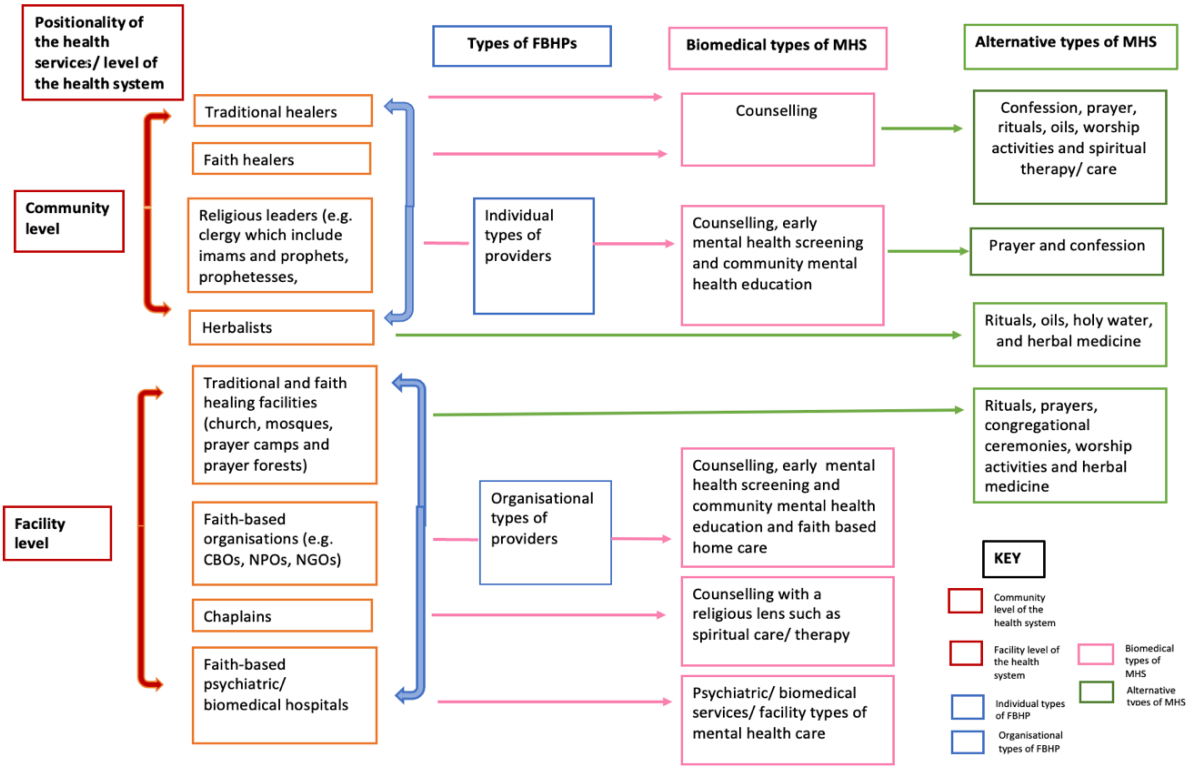
Methods

Eligibility criteria

The inclusion criteria were as follows: empirical, peer-reviewed studies which included information on FBHPs of MHC in Africa. This included evidence from the wide range of faith-based, mental healthcare (biomedical and alternative), and a variety of FBHPs which are including faith healers, traditional healers, religious leaders, herbalists, traditional and faith healing facilities (churches, mosques, prayer camps and prayer forests). Other faith-based entities include faith-based organizations (FBO) (community-based organisations, non-profit organisations, non-government organisations); faith-based hospitals/ facilities and biomedical/ psychiatric facilities, delivering services at community or facility level (see Figure 2). The included articles contained evidence relating to magnitude of FBHPs where frequency of use and availability were included as variables due to the limited evidence on the number of beds and facilities regarding faith-based MHC services. Availability included affordability, accessibility, and acceptability (cultural, social, and religious linkages) of both the alternative and biomedical types of faith-based MHC in Africa. The other articles included in this

systematic review were in relation to the types of FBHPs and MHC services, including referral, the quality of services provided, including the impact of MHC on mental-health, and harmful treatments (including training interventions and qualifications of FBHPs). The effectiveness of mental healthcare was assessed based on the mental health outcomes, whether positive or negative, on the mentally ill individuals and those seeking MHC.

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



Databases searched/search strategy

The databases that were searched included: PubMed, Scopus, EBSCOhost (Cinahl, AfricaWide, PsycArticles, AtlaReligion and PsycInfo), Google and Google Scholar. The search term clusters and variations are shown in Appendix 1. We used Google and Google Scholar to conduct further purposeful searches for material on faith-based, health facilities, such as hospitals and psychiatric care facilities, as this was not retrievable through standard academic search platforms. Additional articles on faith-based, psychiatric hospitals were searched according to their names and country location on databases (mainly Google scholar) to add towards the magnitude (availability and accessibility) to biomedical care. We also scanned the reference lists of included material for further items for inclusion (after the initial phase of exclusion). The search process was checked by Dr Jill Olivier.

Selection process

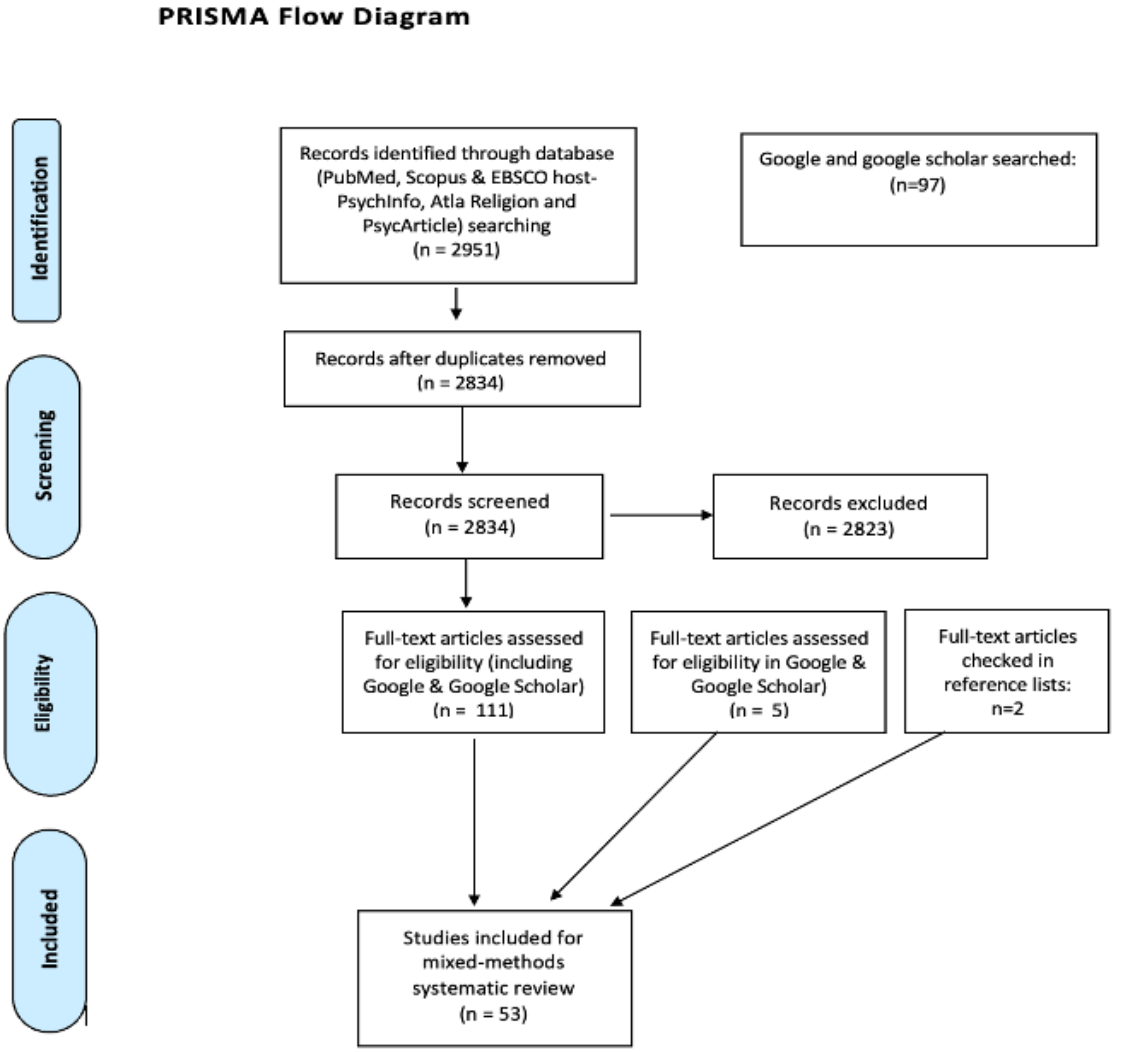
This review included quantitative, qualitative, and mixed methods studies; journal articles, book chapters, theses, organisational reports, and commentaries. Included studies were limited to English and published. The date range for inclusion was from 2007-2024. The rigour of the systematic review was enhanced by minimising bias in the selection and analysis of documents through the use of a quality

appraisal tool for mixed methods studies and transparency shown for the methodological process.[54] In the full text review, a small cluster of studies which solely focused on collaboration between traditional- or faith-healers and biomedical practitioners (BMPs) were mostly excluded, unless they had other information relating to the above inclusion criteria as well.

Data collection process

The second phase was a systematic review that extracted data, and we conducted a separate analysis dependent on data type (thematic analysis on qualitative data and meta-analysis on quantitative data) followed by data synthesis. Thus, the study was conducted iteratively with search terms and categories established in Phase 1 and refined through a further checking process. This was deemed necessary given the exploratory purpose of this research, the diverse data types and sources included, and the fact that this is a new research terrain. More extensive results using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) process are indicated in Figure 3.

Figure 3. PRISMA flow diagram for systematic review results



The main study characteristics and findings were extracted following the Thomas and Harden's approach to data extraction, drawing relevant findings from the studies into the extraction sheet.[57] A thematic, narrative synthesis (a qualitative analysis approach to identify common themes or ideas across texts) was applied to the extracted, qualitative data (using the categorisation in Figure 2 above and then inserted into the data extraction sheet).

For the quantitative data, similar statistics were collated and pooled (in a form of a meta-analysis used to synthesize and express the statistics on the various types and magnitude of faith-based, mental health provision and faith-based, mental health services). A random-effects model using Metaprop in STATA was used so that there could be an observed difference amongst the proportions and the distribution and mean (pooling estimates from the meta-analyses), where the mean could not be entirely dependent on sampling error and various other factors.[56,58,59,60] Finally, qualitative and quantitative data was synthesised from the relevant findings.

Results

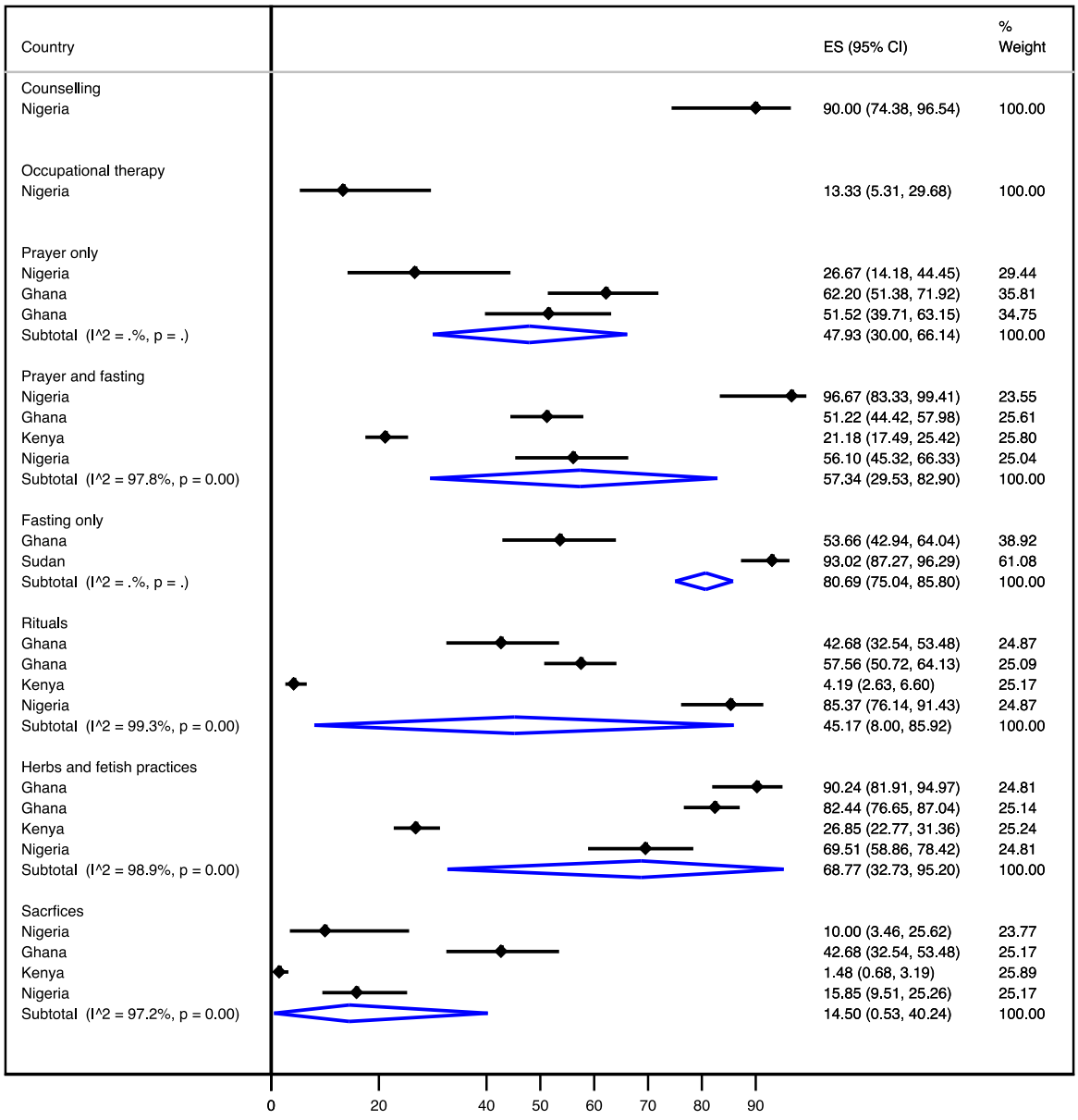
This systematic review applied PRISMA guidelines for conducting systematic reviews in order to explore the types, quality, and magnitude of faith-based, mental health provision in Africa (Figure 3). The African countries represented were Ghana (18/55), Nigeria (6/55), Kenya (5/55), Sudan (3/55), South Africa (3/55), Uganda (2/55), Tanzania (2/55), Tunisia (1/55), Somalia (1/55), Egypt (1/55), Ethiopia (1/55), Rwanda (3/55), and Zimbabwe (3/55).

Types and utilisation of faith-based mental healthcare delivered by FBHPs

There are varied and diverse types of FBHPs mentioned in the included studies, the most prevalent being individual providers (30/53) and the organisational types (12/53). Types included: traditional healers, faith healers, clergy, imams, FBOs, and faith-based, biomedical facilities (using standardised, psychiatric care).

We roughly pooled quantitative data on alternative types of MHC (described above). There was no quantitative data available on the main types of MHC — the only types being prayer only (3/55 studies), prayer and fasting (4/55), fasting only (2/55), rituals (4/55), herbs and fetish practices (4/55), and sacrifices (4/55) (Figure 4) selected from 21/55 studies. The program used to construct the meta-analysis was STATA. This specifically entailed an analysis on the frequency of use of these few types of MHC with studies from in Ghana, Kenya, Nigeria, and Sudan.[62-64]

Figure 4. Meta-analyses on frequency (%) of use based on :"biomedical" and "alternative" types of faith-based mental healthcare in Africa



There were qualitative and quantitative studies included showing that prayers and rituals are used as alternatives to or supplements of mental healthcare (as shown in 16/55 studies), for example, prophets and prophetesses within prayer camps, traditional and faith healers, FBOs, and churches across Africa.[17,18,65-77]

Prayer is expressed in a myriad of forms across African contexts. Prayer can take the form of consultations with God. This has been reported in a Kenyan study,[65] or a journey of healing as described in a Ghanaian study,[74] or as bereavement, preaching, and worship or Quran recitations to ban evil spirits.[13,72,73,75,77,78] Prayer only was used in three studies where quantitative data was shown among 8/30 (26.7%),[60] 51/82 (62%),[79] and 34/66 (52%)[63] respondents with mental illness (Figure 4).

Studies included a focus on Individuals with post-traumatic stress disorder (PTSD) who received faith-based, trauma healing.[155,156] This included prophet stories of the Quran and

prayer as well as other types of faith-based MHC which helped displaced communities as tailored services.[155] Another study focused on faith-based strategies for traumatised adolescents in schools by using Christian faith.[156]

Other types of alternative MHC were fasting and prayer where they were used together as shown in studies from Zimbabwe, South Sudan, Kenya, and Ghana as well as other emergency settings.[64,73,75,82] In three, sub-Saharan, African countries (Ghana, Kenya, and Nigeria) Esan, Appiah-Poku conducted as a series of randomised control trials where direct observations were used as a way of sharing practices, profiles, and mental health treatments of traditional and faith healers.[68]

Types of rituals included in the studies were birthing or death, cleansing rituals, divination, sacrifice, or dancing.[63,68,81,82,84] Overall, the alternative MHC of ritual was used very generally, and it was not clear enough what that entailed due to limited descriptions. Similarly, herbalists and traditional healers used herbal medicine as a treatment for emotional issues as described in 9/55 included studies.[68,80-83,85-88] These herbal and fetish practices included eating herbs, drinking herbal infusions, washing and herbal baths, herbal ointments, decoctions, incense, oils, and perfumes (Table 1).[16,68,73,80,82,85,86,89]

Some FBHPs, such as FBOs, clergy, and faith healers and traditional healers, provided more biomedical MHC.[16,65,67,73,76,84,90] Traditional and faith healers offered early mental health screening (2/55)[65,91] and in some cases, could recognise suicidal behaviour,[65] counselling (10/55),[13,14,17,60,61,65,67,71,72,73,74,76,82,90,92,94] social support,[76,94,95] and faith-based, home-based care (4/55)[18,19,66,93] were also provided. Ninety percent provided counselling in a Nigerian study reported in Table 1.

Table 1. Frequency of use of varied forms of FB MHC (based on meta-analyses of included studies with quantitative data)

Country	Title of study (year)	Ratio/ Frequency of use (%)
Counselling		
Nigeria	Agara 2008	27/30 (90%)
Prayer		
Nigeria	Agara 2008	8/30 (26.7%)
Ghana	Lambert 2020	51/82 (62%)
Nigeria	Kaiser 2020	34/66 (52%)
Fasting & prayer		
Nigeria	Agara et al., 2008	29/30 (96.7%)
Ghana	Esan 2019	105/205 (51.2%)
Kenya	Esan 2019	86/406 (21.2%)
Nigeria	Esan 2019	46/82 (56.1%)
Fasting only		
Ghana	Lambert 2020	33/82 (40.2%)
Sudan	Sorketti 2013	120/129 (93%)
Rituals		
Ghana	Lambert 2020	35/82 (42.6%)
Ghana	Esan 2019	118/205 (57.6%)
Kenya	Esan 2019	17/406 (17.5%)
Nigeria	Esan 2019	70/82 (85.4%
Herbs and fetish practices		
Ghana	Lambert 2020	74/82 (90%)
Ghana	Esan 2019	169/205 (82.4%)
Kenya	Esan 2019	109/406 (26.9%)
Nigeria	Esan 2019	57/82 (69.5%)
Sacrifices		
Nigeria	Agara 2008	3/30 (10%)
Ghana	Esan 2019	35/82 (42.6%)
Kenya	Esan 2019	6/406 (1.5%)
Nigeria	Esan 2019	13/82 (15.9%)

Notes. Sources: 18, 62, 63, 81

Community, mental health education as a type of mental healthcare provided by prophets (neo-prophetic ministers), traditional and faith healers, FBOs, and churches was found in 4/53 articles.[18,65,72,76] This included assistance with jobs, relationships, substance abuse, and addressing stigma and types of neglect.[19,63,72,92] A study mentioned that clergy who provided mental health education programmes imbue

patients with life-skills and coping mechanisms improving their mental health.[76]

Faith-based homecare was utilised in 4/55 studies as a type of MHC provided by FBOs. Traditional faith healers and Christian clergy are more accessible because they provide monetary support and gifts, enable communal ties, and possess less stigmatisation within their communities.[18,19,63,66,72, 77,83,93,96,97] A study from South Africa reported that 86% of traditional healers used their skills and knowledge to treat psychological issues, 90% frequently treated patients in their homes, and a further 98% visited their MH patients often.[92] Statistics have indicated that 86% of community members with emotional struggles are subjected to this MH stigma; and 26% of individuals with emotional issues became depressed due to being isolated within their communities.[96,97]

The literature also revealed that chaplains, mallams (Muslim religious leaders), and pastors located within biomedical, health facilities provided MHC with an alternative or religious lens as shown in 4/55 studies.[98-101] There was evidence to indicate that chaplains also visited their patients daily, prayed for them, and promoted the use of Holy Books to assist them with their psychological well-being.[98,99,101]

In Nigerian and Zimbabwean studies, it was indicated that although chaplains had a sensitive nature in their role, they were not always equipped to deal with severe cases of mental illness.[99,101] There were 6/55 studies that mentioned the use of psychiatric care at faith-based, biomedical facilities.[78,99,102-105] Examples are the Ruharo Mission Hospital and the Kisiijzi Hospital in Uganda and Le Centre Psychothérapeutique Icyizere in Rwanda (providing MHC for PTSD and substance abuse). Additional examples include the Presbyterian Church (a biomedical facility providing palliative care) in Kenya and the Christoffoel Blind Mission Hospital which is an NGO facility in Nigeria.[78,99,102-105] The Rwandan study mentioned a facility that found that 77% of patients received outpatient services, 95.3% had psychiatric medications prescribed, and 44.7% had either individual or group psychotherapy.[104] During the COVID-19 pandemic, the role of faith-based, mental healthcare evolved, and some individuals and organisations migrated into online recovery groups known as Project Exodus, rooted in Christian beliefs providing both biomedical and alternative, mental healthcare.[105]

Magnitude of faith-based mental health provision

Magnitude was operationalised in this study as "footprint," classified as the number of faith-based facilities, psychiatric beds, and any faith-based organisations providing biomedical, mental health care, and availability of faith-based, organisational providers of MHC (faith-based psychiatric care and faith-based organisations). It was also classified as the utilisation of individual types of FBHPs and the frequency of use based on faith-based MHC (mainly "alternative") due to a lack of data on faith-based "biomedical" MHC.

Frequency of utilisation

This review found 11/55 studies that discussed the frequency of utilisation of FBHPs (not all of them, only traditional, faith healers, and herbalists, as well as faith-based, biomedical facilities providing psychiatric care) and the various MHC services in Africa.[10,13,17,20,68,99,108-110] Kisiiki Hospital in Uganda had limited mental health professionals and medicines, but had 28 beds for outpatient, mental healthcare.[106,111] In Rwanda, CARAES-Ndera has over 288 beds and provides psychotherapies and medication to the patients who struggle with their mental health.[112] In Ghana, there were 877 spaces for admission of the mentally ill, while in Nigeria there were 677 beds for mentally ill patients within faith-based facilities and in Kenya, there were no beds for the patients.[68] These studies estimated the ratio of hospital beds to be between 0.14 and 0.27 per 1000 people, which is above the norm for biomedical practices that are usually between 0.01 and 0.1.[68]

Faith-based facilities at the Christoffel Blind Mission Hospital provided community, mental health levels but no primary-care facilities.[103] In Ghana and Nigeria, between 60%

and 90% of traditional and faith healers had inpatient facilities for patients with emotional struggles; however, there were no facilities for involuntary admissions.[68] In Kenya, sufficient capacity of MHC services is available based on the number of traditional healers providing MHC. In Ethiopia, there were 150 traditional healers and 164 mosques and churches with one imam/ priest each.[17,107,113]

A dynamic relationship is apparent between affordability, accessibility, and availability of faith-based, mental health services.[10,13,16,20,68,99,108-110] Various types of socially acceptable support are provided by individual (clergy and traditional/faith healers) and organisational providers (prayer camps and prayer forests) within African, mental health systems.[18,76] In Egypt, 30.4% of patients and in Ghana, 93% of women, found they preferred faith-based MHC over biomedical MHC.[20,94] Forms of support systems entailed prayer, financial support, positive words, and emotional care provided by family, community-based support, support for suicidal behaviour, and increased engagement of individuals who struggle emotionally in religious groups as shown in Nigerian, Ghanaian, Ethiopian, and Zimbabwean studies.[14,17-19,65,76,83]

Box 1. Operationalising key terms for results section (Availability, Accessibility. and Acceptability).

The following operationalisation will be utilised throughout this results section:

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

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

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

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

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

There are cultural rituals provided by traditional and faith healing facilities through providers across Africa.[13,14,65,67,74,114,115] These include bewitchment, rituals, and ancestorial connections shown across models.[13,14,65,67,114,115] In South Africa, it was shown that 41% of patients preferred traditional healers because of their cultural, spiritual, and religious beliefs and faith-based, mental healthcare in emergency and conflict settings have been implemented at a community level for the same reason.[75,116] In other settings, there are programs and models delivered that do not have cultural components but are effective in the primary healthcare settings.[74]

Studies in this review discovered that a vast disparity of 11-62% of mentally ill sought MHC from traditional healers as a first point of contact (Table 2).[10,12,13,20,110] In an Ethiopian study, it was emphasized that the use of traditional healers can be increased through education on types of treatments or referral pathways to FBHPs and from biomedical facilities.[17] Patients at faith-based, mental health facilities indicated that 53% of patients spent 1-2 months and 10 patients stayed over a year at the facilities.[64]

Table 2. The frequency of use from the limited types of FBHPs found in included studies which were sought for faith-based mental healthcare in Africa.

Author (date)	Country	Type of FBHPs sought for MHC	Frequency (%) of use/ ratio
Assad 2015	Egypt	Traditional healers	89/143 (62.2%)
Esan 2019	Ghana	Herbalist	13/205 (6.4%)
		Diviners	104/205 (51%)
		Christian faith healers	43/205 (21.1%)
		Islamic faith healers	3/205 (1.5%)
		Herbalist and Christian	28/205 (13.7%)
		Herbalist and Islam	13/205 (6.4%)
Esan 2019	Kenya	Herbalist	355/406 (88.8%)
		Diviners	5/406 (1.2%)
		Christian faith healers	14/406 (3.5%)
		Islamic faith healers	4/406 (1%)
		Herbalist and Christian	15/406 (3.8%)
		Herbalist and Islam	1/406 (0.2%)
Esan 2019	Nigeria	Herbalist	23/82 (28%)
		Diviners	20/82 (24.4%)
		Christian faith healers	11/82 (13.4%)
		Islamic faith healers	25/82 (39.5%)
		Herbalist and Christian	2/82 (2.4%)
		Herbalist and Islam	1/82 (1.2%)
Ibrahim 2016		Traditional or religious healers	25/107 (23.3%)
Ibrahim Awaad 2020		Traditional healers	97/232 (41.8%)
Khiari 2019	Tunisia	Traditional or religious healers	79 (34.1%)
Nartey 2019	Ghana	Faith-based practitioners	171/542 (31.5%)
Shin 2017	Ghana	Individual religion coping	562/703 (80%)
Sorketti 2013	Kenya	Traditional healer centres	68/129 53%
Sorketti 2011	Sudan	Traditional healers	169/405 (41.7%)
Sorsdahl 2010	South Africa	Traditional, spiritual advisor, and herbalist	73/3651 (20%)
Van Duijl 2014	Uganda	Traditional healers and churches	40/119 (33.7%)
Zingela 2019	South Africa	Traditional and alternative healers	78/254 (31%)

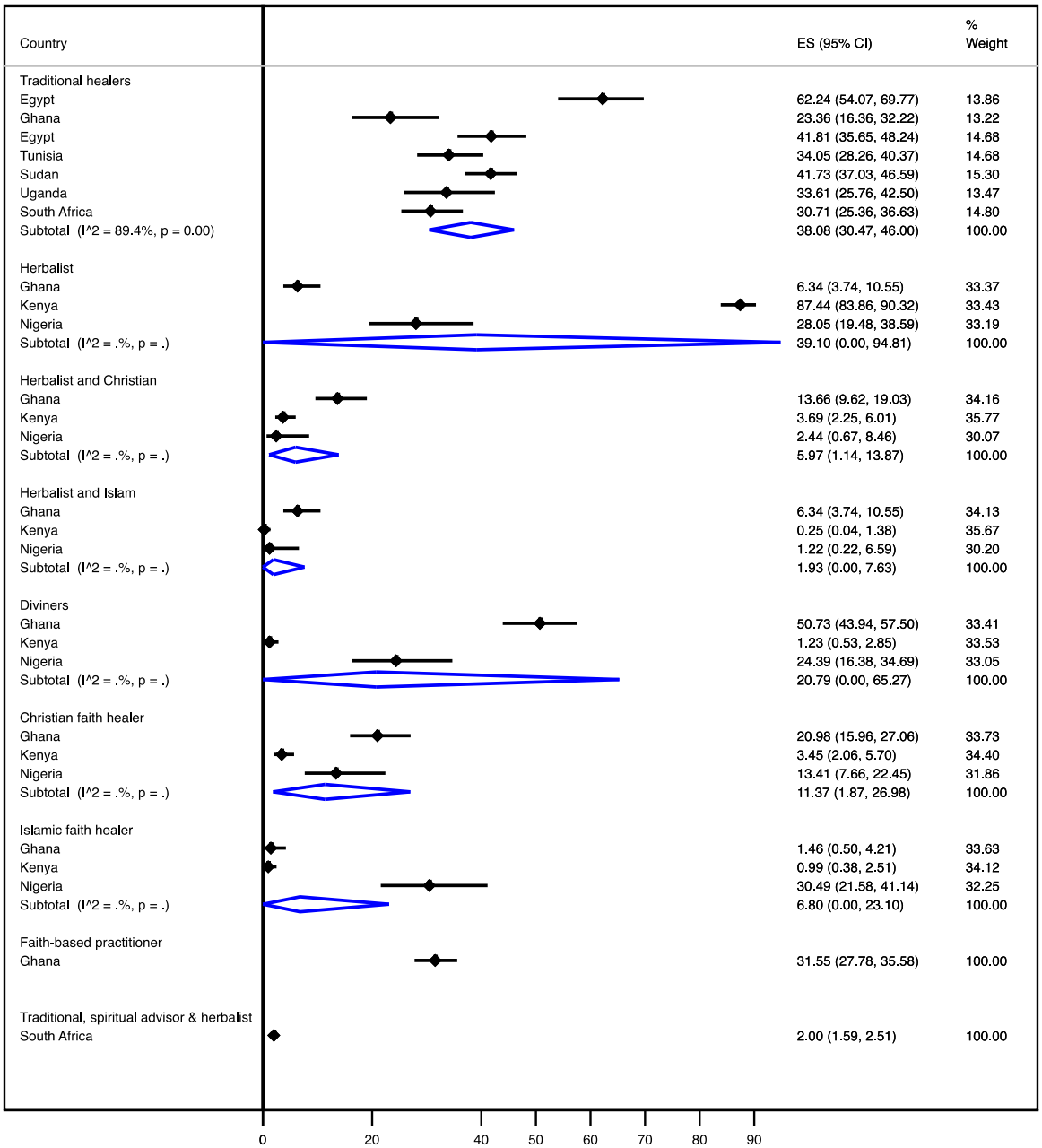
Notes. Sources: 10, 14, 20, 64, 68, 87, 93, 109, 110, 116

For the footprint of faith-based MHC, it was found that in the included literature of this study, there were 4 faith-based, biomedical facilities available, 3 studies mentioned the use of chaplains, 18 studies used traditional healers, 11 studies used faith-healers, 8 studies mentioned traditional and faith healing care, and 1 study used an FBO for treating the mentally ill in Africa (Table 2). Among these providers, they have used in-depth investigations and referral pathways. For example, of 128 patients seen in faith based, biomedical, MHC facilities in Malawi, 11.7% of patients sought these facilities as their first point of contact, whereas 22.7% had traditional healers as their first point of contact.[13] A study mentioned that 23.3% of patients lacked

accessibility to biomedical MHC and 21.7% of patients preferred seeking faith-based MHC as their first point of contract.[12] (Table 2 expands on the % of providers used in Ghana, Kenya, and Nigeria). The pooled estimate from the meta-analyses of using the various types of FBHPs as their primary point of mental healthcare was 1.93-38.1% (Figure 5).

Studies in Kenya and Malawi indicated that traditional and faith healers were more affordable than biomedical MHC where patients could pay them through gifts and donations, and there were less travel costs due to closer accessibility.[12,64,66,67,73,80] One study in Egypt estimated that 24.7% and another study estimated that 75% of FBHPs were more affordable than biomedical MHC.[12,19] However, in a Kenyan study, healers were found to be expensive, but overall it is suggested that FBHPs are more accessible as a form of mental healthcare.[67]

Figure 5. Meta-analyses of the magnitude of FBHPs (traditional, faith healers and herbalists) use for mental health services in included studies



In Africa, faith-based, mental healthcare is used more in rural areas, and biomedical care is used more in urban areas.[12,82] However, one example shows that limited access to biomedical services resulted in a higher utilisation of harmful, faith-based practices.[66] In some studies, the utilisation of prayers delayed seeking biomedical MHC as explained in a Rwandan study.[117]

Quality of faith-based, mental health care

Quality of care in terms of effectiveness of the mental healthcare was classified as entailing "health service provided by qualified FBHPs who ensure safe and correct treatment for mental illness."[106]

In this review, quality of faith-based MHC was measured according to whether there were improvements in mental health outcomes of individuals (an example would be also when FBHPs were trained and that relationship with mental health outcomes), also if FBHPs enhanced help seeking behaviour.

Improvement in mental health outcomes

Only five of the 55 included studies reported on whether faith-based, mental health services had an impact on mental health outcomes. However, these studies did not use standardised tools to measure mental health. There was a study which assessed 350 patients in comparison to bipolar disorder patients who used traditional healers and found improvements in their symptoms of hallucinations; however, with serious mental illness, patients did not experience any change in mental health outcomes.[20] A cross-sectional study in South Africa found that 145/258 (58%) patients reported better mental health as compared to seven who felt worse and 18 (23%) who showed no effect from consulting traditional healers.[116] A Rwandan study by Ng (2016) showed improvements in adults who were diagnosed with PTSD, psychosis, depression, and substance use disorders, and 20 of the patients improved at discharge.[102] However, two studies in Kenya found that suicidal ideation and depression increased from being treated by traditional healers.[88,90]

A Ugandan, Sudanese, and two Ghanaian studies found that faith-based MHC improved their mental health by 43-58%, and 57% felt completely healed, 9% felt worse, and 23% showed no effect, with overall positive coping mechanisms created.[62,80,87,116] In a Kenyan study, 58-78% patients suffering from mild to severe depression treated by FBHPs showed an improvement over a 12-week period.[118]

Harmful practices for mental health outcomes

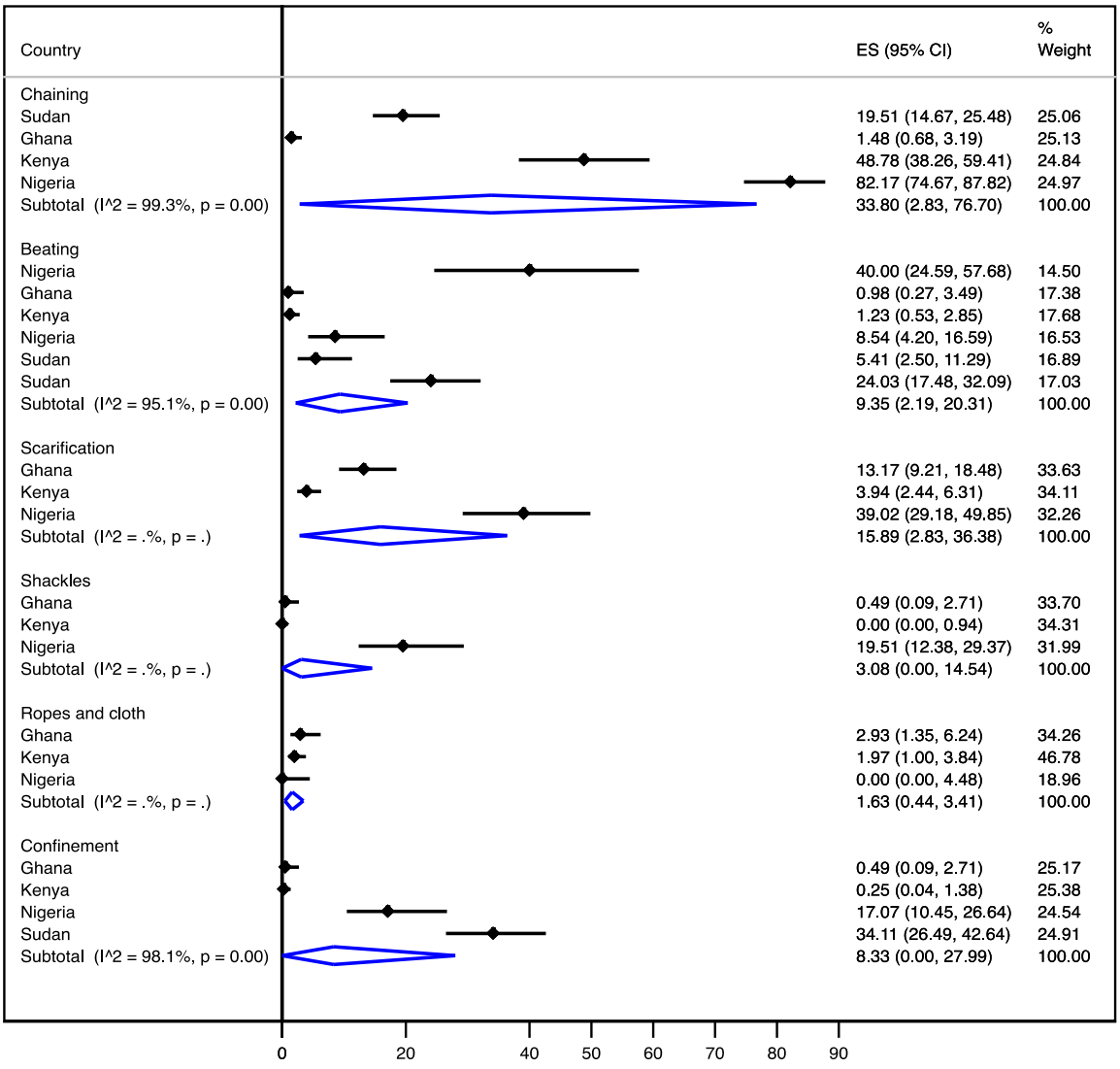
In Africa, harmful treatments in 13/55 studies were implemented by FBHPs (traditional and faith healers, and clergy) which impacted individuals with mental health issues negatively.[62,64,66-68,74,76,77,82,89,115,119] Examples of these were scarification, restraint, isolation, fasting, chaining, caning, beating, and incarceration.[66,68,71,76,82,89] Beatings were found to be used among traditional healers, purportedly to get rid of evil spirits, as well as to get a confession for wrongdoing.[66,68] (Table 3 and Figure 6) Other studies suggest some patients experience negative behavioural changes due to evil influences, which might question the quality of the MHC.[67,76,85] A Ghanaian study explained that patients who had PTSD and were exposed to some form of harmful treatments resulted in negatively impacting their mental health.[15]

Table 3. Results on the types of faith-based harmful practices in Africa

Type of harmful practice	Author (date)	Ratio of use of practices (%)
Chaining		
	Esan 2019	40/205 (19.5%)
Kenya	Esan 2019	6/406 (1.5%)
Nigeria	Esan 2019	40/82 (48.8%)
Sudan	Sorketti 2013	106/129 (82.2%)
Cumulative frequency	All studies	192/ 822 (23.4%)
Beating		
Country	*Title of study (year)*	*Frequency of use (%)*
Nigeria	Agara 2008	12/30 (40)
Sudan	Omer 2018	6/111 (5.4%)
Ghana	Esan 2019	2/205 (1%)
Kenya	Esan 2019	5/406 (1.2%)
Nigeria	Esan 2019	7/82 (8.5%)
Sudan	Sorketti 2013	31/129 (24%)
Cumulative frequency	All studies	63/834 (7.6%)
Confinement		
Ghana	Esan 2019	1/205 (0.5%)
Kenya	Esan 2019	1/406 (0.3%)
Nigeria	Esan 2019	14/82 (17.1%)
Sudan	Sorketti 2013	44/129 (34%)
Cumulative frequency	All studies	60/822 (0.07%)
Scarification		
Ghana	Esan 2019	27/205 (13.2%)
Kenya	Esan 2019	16/406 (3.9%)
Nigeria	Esan 2019	32/82 (39%)
Cumulative frequency	All studies	79/693 (10.8%)
Shackles		
Ghana	Esan 2019	1/205 (0.0048%)
Kenya	Esan 2019	0/406 (0%)
Nigeria	Esan 2019	16/82 (0.2%)
Cumulative frequency	All studies	17/ 822 (0.025%)
Ropes and cloth		
Ghana	Esan 2019	6/205 (0.02926%)
Kenya	Esan 2019	8/406 (0.0197%)
Nigeria	Esan 2019	0/82 (0%)
Cumulative frequency	All studies	14/822 (0.75%)

Notes. Source: 18, 62, 64, 115

Figure 6. Meta-analyses of religious perils (types of human rights abuses/ harmful practices) in Africa



Discussion

This review synthesised evidence on the types, quality, and magnitude of FBHPs of MHC in Africa.[120] The next sections focus on other emerging themes related to FHBPs in mental-health systems and issues. However, it should be noted that many of the more generic, discussion points have limitations as a result of generalising across very different types of FBHPs (within different religious traditions) and MHSs, especially given the limited literature available on the topic. Nevertheless, this review lays the foundation for future researchers and policymakers to strengthen mental health systems in Africa and globally.

Faith-based, health providers have been proven to provide mental healthcare beneficial to a person's psychological well-being. Faith-based MHC's positive aspects include affordability, accessibility, and availability which are needed within health systems.[10,13,16,20,68] These aspects tie into the idea of working towards Universal Health Coverage (UHC) in Africa and leveraging collaboration and integration of faith-based MHC into primary healthcare systems.[157] There is an article which advocates for the role of faith-based, primary healthcare through churches and proposed five models that can be used for the faith-based sector in delivering primary

healthcare.[158] Furthermore, there was a model by the Salvation Army in East Africa that was implemented and showed improvements in communities; however, FBHPs are complex in their variety and how they adapt to communities around them, so the quality of their practices would need to be improved.[159]

For better quality of faith-based MHC, one approach would be to provide human rights training to assist with less use of harmful treatments through mental health education.[80,86,149] This would also assist with better patient satisfaction.[6] Clergy in the Black American culture are being taught better interventions for mental health issues and to move away from more traditional models which are causing more harm than good.[160] There also needs to be more in-depth awareness with positive and negative aspects of faith-based healing and to break the stigma that not all practices cause harm.[160]

Given the lack of MHC professionals in Africa, a task-shifting approach where traditional and alternative faith-based healers can be trained to deliver more effective and less harmful mental health interventions based on biomedical models, reducing the burden on primary healthcare providers who are already overworked is an approach which is culturally acceptable.[10,126,127] Positives of FBHPs providing MHC include that they are culturally sensitive and acceptable and able to increase their knowledge and skills to provide better quality MHC as highlighted in this review.[17,83,109] However, it is noted that such interventions require many financial resources and time which are not always available as highlighted in the international arena.[150] It has been suggested that, "it would be helpful to have a benchmark of the ideal distribution of budget for general health and mental health for countries to have a guideline to work towards in each country."[161]

It has also been suggested by a Ghanaian study that the inclusion of traditional healers in future policies is important.[83] For example, herbal medicine could be standardised and regulated to improve its quality. This is found in various countries, including China and India, where traditional medication is regulated. Furthermore, formal qualifications in Ayurvedic medicine are necessary to become an Ayurvedic practitioner in India.[148] However, this has not been implemented in Africa due to time, effort, and quality control limitations.[145,146]

This review highlighted the types, quality, and magnitude of faith-based MHC as well as the importance of leveraging what is working and reallocating resources from what is not working through the recommendations below.

Box 2. Three top Recommendations for mental health systems in Africa. There is a potential need for integration of faith-based mental healthcare into primary healthcare for UHC

1. Improved budget planning to include faith-based mental health care and inclusion in PHC for attainment of UHC
2. Training of FBHPs would help in limiting harmful treatments and for better quality MHC
3. Integration of traditional medicine and faith-based MHC into policies and national level of health systems

Limitations

This study had research gaps where the faith-based biomedical field was under explored and due to the complexities of this study, search term compilation was tedious despite trial and error. This study only covered examples where data was available especially in the faith-based, biomedical category (commentaries were included due to a lack of data). Future research may benefit from focusing on one type of provider or specific services. This study also only included certain databases when searching for articles which could be expanded in future studies. More studies on magnitude such as availability (accessibility, affordability, and acceptability) are needed as well as more grey literature assessment.

Conclusion

This review covers a broad array of faith-based, health providers and the types of MHC they provide (biomedical, alternative, and harmful treatments). It also includes faith-based, psychiatric care using a more biomedical approaches focusing on availability, accessibility, and acceptability (magnitude). Studies included had both positive and negative impacts on mental health outcomes in terms of the effectiveness of faith-based MHC. This review emphasises the importance of incorporating FBHPs and the array of faith-based, mental healthcare and traditional and herbal medicine into policy and governance decisions moving forward. The integration of faith-based MHC into primary healthcare and for the attainment of UHC is an important recommendation to focus on in the future. Also, the implementation of cultural models from other regions into faith-based MHC is important. Task-sharing of faith-based, mental health providers to include more biomedical based models is also a recommendation. Finally, this review highlights how important the continued use and evidence provision of faith-based mental healthcare is. Overall, more research is needed in this field especially regarding training interventions for FBHPs and regulation of faith-based MHC.

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Appendices

Appendix 1 Search terms for systematic review

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(((((Africa OR African OR Algeria OR Angola OR Benin OR Botswana OR "Burkina Faso"[Text Word] OR Burundi OR "Cabo Verde"[Text Word] OR Cameroon OR Cameroun OR "Canary Islands"[Text Word] OR "Cape Verde"[Text Word] OR "Central African Republic"[Text Word] OR Chad OR Comoros OR Congo OR "Cote d'Ivoire"[Text Word] OR "Democratic Republic of Congo"[Text Word] OR Djibouti OR Egypt OR Eritrea OR eSwatini OR Ethiopia OR Gabon OR Gambia OR Ghana OR Guinea OR Guinea- Bissau OR "Ivory Coast"[Text Word] OR Jamahiriya OR Kenya OR Lesotho OR Liberia OR Libya OR Madagascar OR Malawi OR Mali OR Mauritania OR Mauritius OR Mayotte OR Morocco OR Mozambique OR Namibia OR Niger OR Nigeria OR Principe OR Reunion OR Rwanda OR "Saint Helena"[Text Word] OR "Sao Tome"[Text Word] OR Senegal OR Seychelles OR "Sierra Leone"[Text Word] OR Somalia OR "St Helena"[Text Word] OR Sudan OR Swaziland OR Tanzania OR Togo OR Tunisia OR Uganda OR "Western Sahara"[Text Word] OR Zaire OR Zambia OR Zimbabwe)) OR ("Africa"[Mesh])) NOT ((African American OR Rural South OR UK OR Asia OR Thailand))) AND (("Mental-health"[Mesh]) OR ((mental-health OR mental illness OR mental disorder OR mental disorders OR distress OR psychosis OR mental-health systems OR mental-health services OR psychosocial OR posttraumatic stress disorder OR counselling OR counselling OR counselling methods OR counselling methods OR counselling services OR counselling services)))) AND ((((((((((((faith-based OR faith-based organization OR faith-based organizations OR faith-based organisation OR faith-based organisations OR faith based organization OR faith based organizations OR faith based organisation OR faith based organisations OR faith-based providers OR faith-based health providers)) OR ((mission hospital OR church facility OR mission facility OR mission facilities OR church facilities))) OR ((non-state actors OR non-state providers OR private not-for-profit OR public-private partnerships))) OR ((faith healing OR faith healer OR faith leader OR imam OR imams OR clergy OR clerics OR religious leader OR religious healer OR Christian healer OR Muslim healer OR minister OR minister OR pastor OR pastors OR rabbis OR rabbi OR priest OR priests OR church-based or prayer))) OR ((traditional healer OR traditional healing OR traditional medicine OR African traditional medicine OR traditional health practitioners OR traditional medical practitioners OR indigenous healing OR traditional herbalist OR herbal OR herbal medicine OR witchcraft OR witch doctor OR demon OR demonic OR evil OR evil-eye OR spirit OR spirits OR spiritual therapies OR phytotherapy OR holy spirit OR holy spirits OR diviner OR ministrations of diviners OR medicine men OR sorcerers OR herbalist OR herb OR oils OR Sangoma OR Zulu healer OR Sanusi OR worship OR ritual OR incarceration))) OR ((religious OR religion OR Adventist OR Allah OR Anglican OR Baha'i OR Baptist OR Bible OR Buddhism OR Buddhist OR Caliph OR Catholic OR Christ OR Christian OR Christianity OR Church OR Church of Christ OR Confucianism OR Congregation OR Coptic OR Daoism OR Dutch Reformed OR Ecumenical OR Episcopal or Evangelical OR Evangelism OR Evangelist OR God OR Hindu OR Hinduism OR Holy Or Interfaith Or Islam OR Jain OR Jainism OR Jehovah's Witness OR Jesuit OR Jesus OR Jewish OR Jews OR Judaism OR Koran OR Latter-Day Saint OR Load Or Lutheran OR Mennonite OR Methodist OR Ministries OR Ministry OR Mission OR Missionaries OR Missionary OR Mohammed OR Mormon OR Mosque OR Muhammad OR Mullah OR Muslim OR Orthodox OR Pentecostal OR Presbyterian OR Protestant OR Quaker OR Qur'an OR Religion OR Religious OR Salvation OR Samaritan OR Seventh-Day Adventist OR Shia OR Shi'ite OR Shinto OR Sikh OR Sunni OR Synagogue OR Torah OR Wahhabi OR Zion OR Zionism OR Zionist))) OR ("Clergy"[Mesh])) OR ("Faith Healing"[Mesh] OR "Faith-Based Organizations"[Mesh])) OR ("Medicine, Traditional"[Mesh:NoExp])) OR ("Medicine, African Traditional"[Mesh]))

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

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(algeria OR angola OR benin OR botswana OR "Burkina Faso" OR burundi OR “cabo AND verde” OR cameroon OR cameroun OR "Canary Islands" OR "Cape Verde" OR "Central African Republic" OR chad OR comoros OR congo OR "Cote d'Ivoire" OR "Democratic Republic of Congo" OR djibouti OR egypt OR eritrea OR eswatini OR ethiopia OR gabon))) OR ((gambia OR ghana OR guinea OR "Guinea Bissau" OR "Ivory Coast" OR jamahiriya OR kenya OR lesotho OR liberia OR libya OR madagascar OR malawi OR mali OR mauritania OR mauritius OR mayotte OR morocco OR mozambique OR namibia OR niger OR nigeria OR principe OR reunion OR rwanda))) OR ((“saint AND helena” OR “sao AND tome” OR senegal OR seychelles OR “sierra AND leone” OR somalia OR “st AND helena” OR sudan OR swaziland OR tanzania OR togo OR tunisia OR uganda OR “western AND sahara” OR zaire OR

zambia OR zimbabwe))) OR (africa*))) AND (("mental-health" OR "mental illness*" OR "mental disorder*" OR distress OR psychosis OR "mental-health system*" OR "mental-health service*" OR psychosocial OR "posttraumatic stress disorder" OR counselling OR counseling))) AND ((religious OR religion OR adventist OR allah OR anglican OR baha'i OR baptist OR bible OR buddhism OR buddhist OR caliph OR catholic OR christ OR christian OR christianity OR church OR "Church of Christ" OR confucianism OR congregation OR coptic OR daoism OR "Dutch Reformed" OR ecumenical OR episcopal OR evangelical OR evangelism OR evangelist OR god OR hindu OR hinduism OR holy OR interfaith OR islam OR jain OR jainism OR "Jehovah's Witness" OR jesuit OR jesus OR jewish OR jews OR judaism OR koran OR "Latter-Day Saint" OR load OR lutheran OR mennonite OR methodist OR ministries OR ministry OR mission OR missionaries OR missionary OR mohammed OR mormon OR mosque OR muhammad OR mullah OR muslim OR orthodox OR pentecostal OR presbyterian OR protestant OR quaker OR qur'an OR religion OR religious OR salvation OR samaritan OR 'seventh-day AND adventist' OR shia OR shi'ite OR shinto OR sikh OR sunni OR synagogue OR torah OR wahhabi OR zion OR zionism OR zionist))) OR (("traditional healer*" OR "traditional healing" OR "traditional medicine" OR "African traditional medicine" OR "traditional health practitioner*" OR "indigenous healing" OR "traditional herbalist" OR herbal OR "herbal medicine" OR witchcraft OR witch AND doctor OR demon OR demonic OR evil OR "evil-eye" OR spirit* OR "spiritual therap*" OR phytotherap* OR "holy spirit*" OR diviner OR "ministrations of diviners" OR "medicine men" OR sorcerers OR herbalist OR herb OR oils OR sangoma OR "Zulu healer*" OR sanusi OR worship OR ritual OR incarceration))) OR (("faith healing" OR "faith healer" OR "faith leader" OR imam* OR clergy OR clerics OR "religious leader*" OR "religious healer*" OR "Christian healer*" OR "Muslim healer*" OR minister* OR pastor* OR rabbi* OR priest* OR "church-based" OR prayer))) OR (("non-state actor*" OR "non-state provider*" OR "private not-for-profit" OR "public-private partnership*"))) OR (("mission hospital*" OR "church facilit*" OR "mission facilit*"))) OR (("faith-based" OR "faith-based organization*" OR "faith-based organisation*" OR "faith based organization*" OR "faith based organisation*" OR "faith-based provider*")))) Published Date: 20060101-20211231 AND Apply equivalent subjects on 2021-06-08 02:38 PM"

Added search terms

Psychiatric, faith-based biomedical facilities, faith-based psychiatric service, faith-based psychiatric care.

Faith-based community mental health education, mental health screening, faith-based home care mental health

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