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FIELD STUDY

#29

MENTAL HEALTH TREATMENT IN TRADITIONAL AND FAITH-BASED HEALING CENTRES IN GHANA

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FIELD STUDY

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ABBREVIATIONS

BNGh - BasicNeeds-Ghana

MEHSOG - Mental Health Society of Ghana

CIDTP - Cruel, inhuman and degrading treatment or punishment

MHPSS - Mental health and psychosocial services

PTE – Potentially traumatic event

EXECUTIVE SUMMARY

INTRODUCTION

The World Health Organization estimated that 13% of the population in Ghana suffers from some form of mental health problem, with 2% likely having severe mental illness.[1] With a population nearing 30 million,[2] this translates into a high number of people potentially in need of care. Ghana passed a progressive mental health act in 2012 that aimed to create a community-based mental health care system and protect the rights of individuals with mental illness. Limited financial and human resources, however, have slowed implementation. [3] Consequently, the mental health treatment gap has persisted, with only about 2% of people with mental illness receiving treatment in the official health system.[1] Although access to mental health is limited, cultural traditions also play a role in service usage. It is estimated that 70% of the population turns to traditional or faith-based healing centres[2] for help with their symptoms.

Whereas some find benefit in treatments provided at traditional/faith-based healing centres, widespread abuses have also been documented.[3] The UN Special Rapporteur on Torture and other Cruel, Inhumane or Degrading Treatment or Punishment (CIDTP) visited healing centres during missions to Ghana in 2013 and 2015 and observed a range of human rights violations that amount to torture or CIDTP including non-consensual treatment, shackling, prolonged chaining, and forced fasting.[4] This type of treatment is potentially traumatising and may worsen existing psychiatric symptoms. Despite the widespread use of healing centres in Ghana, little is known about the characteristics and experiences of individuals who seek help for mental illness in these centres or the traditional/faith-based healers´ views on the treatment.

The present study is the result of a collaboration between the DIGNITY - The Danish Institute Against Torture, BasicNeeds-Ghana (BNGh), and the Mental Health Society of Ghana (MEHSOG). The purpose of the study was to generate knowledge on the treatment of mental illness in traditional and faith-based healing centres and determine the need for trauma-informed mental health and psychosocial support (MHPSS) among individuals treated in these centres.

METHOD

The study was approved by the Institutional Review Board of the University for Developmental Studies in Ghana and Ethical Committee at DIGNITY. The study was conducted in the Ga West Municipality in the Greater Accra Region and Zabzugu District in the Northern Region. These districts were chosen because of the prevalence of traditional and faith-based healing centres and because BasicNeeds-Ghana and MEHSOG have implemented projects in these regions.

Data collection was completed in two phases, using purposive and convenience sampling. In the first phase, data were collected from individuals who had received treatment in healing centres, traditional/faith-based healers, and peer-support volunteers who work with individuals with mental illness. The initial data were analysed and used to create a draft report which was presented to key stakeholders at a dissemination workshop in March 2019. Based on the valuable feedback received from workshop participants, the second round of data collection was initiated, wherein additional service users were interviewed as well as family members of service users. These data were then analysed with data collected in the first phase and used to create this report. The final sample consisted of 163 respondents: 82 individuals who had received treatment in a healing centre and 28 of their family members, 40 traditional/faith-based healers, and 12 peer supporters across the two districts.

KEY FINDINGS

The study provided useful insights into the treatment of mental illness at healing centres from the perspective of service users, their family members, healers, and peer support workers. Some of the key findings are listed below:

- Most service users from both study locations had more than one visit to a traditional/faith-based healer (84.8%). For those placed on admission at a healing centre (72%), stays lasted from a few days to more than one year.

- Users, their family members, and healers confirmed that most people are brought to the healing centres by other people, typically family members.

- The primary reasons for seeking help among those interviewed were mental illness (*n* = 52), spiritual concerns (*n* = 10), physical problems (*n* = 10) and epilepsy (*n* = 6). Most service users (80.5%) believed their presenting problem had a spiritual or supernatural origin, as did the family members who were interviewed.

- 30.5 % of the users of healing centres reported being exposed to potentially harmful treatment such as denial of food and water, restraint by chains or ropes, deprivation of sleep, and/or flogging. Despite this treatment, half of these individuals would go back to the healing centre. Nearly all family members (89.2%) interviewed reported their relative had been exposed to at least one potentially harmful treatment. 64.7% in Zabzugu District would send their family members back because they believed it to be helpful. Only one (.09%) family member from Ga West Municipality would send their family member to a healing centre in the future.

- 32 (39%) of the 82 services users reported lifetime exposure to some type of potentially traumatic event (PTE), with a higher number residing in the Zabzugu District (*n* = 20). Participants who were exposed to potentially harmful treatments in the centres were two times more likely to have experienced a PTE at some point in their lives than participants not exposed to this type of treatment in the centre.

- Respondents who reported exposure to a PTE or potentially harmful treatment in the healing centre were assessed for symptoms of posttraumatic stress. Twenty-two participants had scores that would be considered clinically significant. Of the 25 participants who reported exposure to some form of potentially harmful treatment in the centres, those who also had a history of exposure to at least one PTE had significantly higher symptoms of posttraumatic stress. However, it is not clear if the distress is related to experiences inside or outside the centres, or both.

- Users of healing centres in both regions reported high levels of impaired functioning in daily life. Approximately 72% of the sample had disability scores at or above 50% on the 12-item WHODAS 2.0.

- 90% of the traditional/faith-based healers stated mental illness was one of the typical presenting problems of users. 55% of the healers reported using physical restraint, primarily with chains or ropes as a part of treatment, more so in the Ga West Municipality (*n* = 14) than in the Zabzugu District (*n* = 8). 40% of healers reported using fasting, 30% all-night vigils, 22% exorcisms, and 12.5% used exposure to the elements. Most reported these practices were helpful for the recovery of the individual. Healers reported restraints helped calm aggressive individuals, prevented injury, and facilitated treatment; fasting was used clear toxins and evil spirits; exposure to the elements during treatment was said to have a calming effect.

- Most healers interviewed appeared to hold positive views towards the official health system. 72.5% reported they had referred users with mental illness or epilepsy to the hospitals and most (90%) reported a benefit in collaborating with health personnel.

- Half of the peer supporters reported that users appeared to have reduced symptoms after stays in healing centres. However, they also noted that most of the individuals with whom they worked continued to experience psychosocial problems, including stigma, difficulties in relationships, and difficulty with employment.

INTRODUCTION

In 2018, DIGNITY, The Danish Institute Against Torture, entered into a partnership with BasicNeeds-Ghana (BNGh) and the Mental Health Society of Ghana (MEHSOG) with the long-term ambition to reinforce organisational and institutional capacities among relevant civil society actors and health structures to provide access to timely and quality rehabilitation for survivors of torture and violence in Ghana.

The focus of this initial partnership was to generate knowledge to be better equipped to address the concerns raised by the Special Rapporteur on Torture and other Cruel, Inhumane or Degrading Treatment or Punishment (CIDTP), Juan E. Mendez, following his missions to Ghana in 2013 and 2015. In his report, he noted that approximately 70% of the Ghanaian population turns to spiritual healing in traditional or faith-based healing centres in cases of illness. Individuals with mental illness are particularly likely to be treated in such centres because these conditions are widely believed to have a spiritual or supernatural cause. Furthermore, he documented a range of human rights abuses in that "continue with impunity…including the non-consensual admission and ´treatment` of children and adults, inhumane practices amounting to torture, such as shackling, prolonged chaining and restraint, and mandatory fasting" (pp. 19). [5]

The maltreatment of people with mental illness in Ghana´s healing centres has also recently received attention in the international media, perhaps most notably as part of an investigative report by the BBC in 2018 in which individuals were pictured chained and caged in prisonlike cells.[6] Such treatment is potentially traumatising and may exacerbate existing mental health difficulties. Yet, traditional/faith-based healers continue to be the first point of contact for many who suffer from mental health problems. Despite widespread use, scant data are available on the experiences and characteristics of people who seek traditional/faith-based healing for mental illness or the healers´ perspectives on the treatment of mental illness.

In Ghana, traditional/faith-based healers are a heterogeneous group that includes Christian and Islamic faith-healers, herbalists, and shrine priests or medicine men.[7] Practices of the healers vary widely. Some provide as-needed consultations, whereas others run residential facilities, commonly referred to as prayer camps or healing centres, where people may stay for weeks or even years. Herbalists primarily prescribe tonics and ointments, whereas the faith-based healers use scriptures or religious beliefs to guide their treatment plans which may include a range of prescribed behaviours including fasting and prayer. Although Ghana's mental health law (Act 846, 2012) and other legal frameworks banned flogging, shackling and chaining, the practice has continued at healing centres throughout the country.[8]

The exact number of traditional/faith-based healers is not known because not all traditional and faith-based healers are regulated by the Traditional Medicine Practice Council or belong to the Ghana Federation of Faith-based and Traditional Healers; by one estimate, there is one healer for every 200 people in the country.[9] In contrast, the most recent data available indicated there are a total of 39 psychiatrists[10], 86 clinical psychologists, and 47 counselling psychologists[11] for the entire country. With a population nearing 30 million, it is not surprising that only an estimated 2% of individuals with mental illness receive treatment in the official healthcare system. However, in addition to access, help-seeking behaviour is strongly influenced by cultural belief systems. The population of Ghana is one of the most religious in the world[12] , and symptoms of mental illness are commonly believed to be spiritual or supernatural in nature, caused, for example, by evil spirits, punishment from God, or curses.[13] [14] Many individuals will first seek help from a spiritual healer who holds a similar worldview.

The purpose of this study was to generate knowledge on the treatment of mental health problems in traditional/faith-based healing centres in Ghana and to determine the need for trauma-informed MHPSS among individuals treated in these centres. The first objective was to understand the experiences and characteristics of individuals treated for mental health problems in healing centres (i.e., service users) including possible exposure to maltreatment by a healer, prior trauma exposure, psychological distress and impaired functioning. The second was to gain insight into the reasons for seeking help from traditional/faith-based healers from family members of service users. Third, we sought to clarify the beliefs about mental illness held by traditional healers and their willingness to collaborate with the official health system. Last, we interviewed peer support workers who provide psychosocial support to individuals in the community to learn about their experiences working with individuals with mental illness who have received treatment in healing centres.

METHOD

STUDY LOCATION AND DESIGN

The study was conducted in the Ga West Municipality in the Greater Accra Region and Zabzugu District in the Zabzugu District. These districts were chosen because of the prevalence of healing centres and because BasicNeeds-Ghana and MEHSOG have projects in these regions. Collection of data in the two locations also allowed for comparison of urban and rural areas.

Ga West Municipality in Greater Accra has a population of just under 270,000[15] in an area of approximately 305 square km. According to the most recent census data, gathered in 2010,[16] the predominant religions are Christianity (87.9%) and Islam (8.3%), with few Traditionalists (.3%). Approximately 92% of the population in this district was literate in 2010, and the most common employment was in service/sales (38%), craft/trade (22.6%) and professional or managerial (14.2%) sectors.

Zabzugu District is one of 26 districts in the Northern Region of Ghana. The district has a population of just under 79,000 in an area of approximately 1,100 square km.[17] According to the most recent census data, also gathered in 2010, [18] the most common religions are Islam (49.4%) and Traditionalist (36%) followed by different denominations of Christianity (10.6%). In 2010, 30.8% of the population was literate, which is far lower than the national average which was approximately 71%[19] in the same year. Employment (86.3%) is primarily in the agricultural sector.

Data collection was conducted in two phases. In the first phase, data were collected from service users (*n* = 51), traditional healers (*n* = 40), and peer-supporters who work with individuals with mental illness in the two districts (*n* = 12). These data were analysed and used to create a draft report which was presented to key stakeholders during a dissemination workshop in March 2019. Based on the valuable feedback received from workshop participants, the second round of data collection was initiated, wherein additional service users (*n* = 31) and family members of service users (*n* = 29) were interviewed to learn more about why individuals chose traditional healing. Data from both phases were analysed and are presented in this report.

We utilized purposive sampling, using key informants and snowballing to identify participants in each group who met study criteria. In addition to being someone who was treated by a traditional healer, a family member of someone treated, or a traditional healer, all participants were required to be at least 18 years of age and capable of providing informed consent. All data were collected using semi-structured interviews conducted by trained enumerators. The final sample consisted of 163 respondents: 82 individuals who received treatment from a traditional healer and 29 of their family members, 40 faith-based/

traditional healers, and 12 peer supporters across the two districts. It should be noted that whereas purposive sampling allowed us to identify participants who met our specific criteria, the samples are not representative of the general population.

ETHICAL CONSIDERATION

The study was approved by the Institutional Review Board of the University for Developmental Studies in Ghana and DIGNITY´s Ethical Committee. All respondents gave their informed consent before the data collection processes began. Due to the sensitive nature of some questions, respondents were informed they could refuse to answer any questions or withdraw from the study at any time. Names and identifying information were not stored with participants' responses to ensure confidentiality.

PROCEDURE

Training of interviewers

DIGNITY carried out a one-day training of all staff involved in the project prior to beginning data collection. The workshop focused on research ethics and methodology and provided the opportunity to practice the administration of interviews. Additionally, interviewers had previously completed the Research Ethics and Compliance Training through the Collaborative Institutional Training Initiative Program.

Data collection

Semi-structured questionnaires were administered in individual, face-to-face interviews by seven trained data collectors. Five data collectors were deployed in the sparsely populated Zabzugu District in the Northern Region, and two data collectors were deployed in the densely populated Ga West Municipality. Each respondent was interviewed individually, either in their homes or in a place where privacy could be assured. A BNGh supervisor was present at interviews in order to ensure the safeguarding of respondents as well as to protect the integrity of the data collection process.

Responses were recorded on paper forms and later entered into an electronic database. Interviews with service users lasted 60-85 minutes, interviews with family members were 25 to 30 minutes, interviews with peer supporters lasted 45-50 minutes, and interviews with healers lasted 50-60 minutes.

MEASURES

Service users

A total of 82 participants were interviewed, 51 in the first phase of data collection, and 31 in the second. A semi-structured questionnaire was developed to gather information on a) the reasons for, frequency, and duration of treatment in healing centres; b) exposure to potentially harmful treatment in a healing centre; c) perceptions on the cause of their illness or problem; and d) basic demographics. All participants were asked whether they would seek treatment from a traditional healer in the future. Participants who took part in the second phase of data collection were asked why or why not. This was the only modification to the questionnaire in the second phase of data collection; the change was based on recommendations from key stakeholders provided during the dissemination workshop.

A modified version of the Life Events Checklist[20] was used to assess respondents' history of exposure to potentially traumatic events. The Posttraumatic Stress Disorder Checklist for the DSM-5[21] was administered only to individuals who reported exposure to potentially traumatic events or harmful treatment at a healing centre. The 12-item World Health Organization Disability Assessment Schedule 2.0[22] was used to assess the adaptive functioning of respondents.

Family members of service users

A semi-structured interview for family members of users was developed for the purpose of this study. The family members were asked why the user was referred to the centre and by whom, their experience in the centre and perceptions on the effectiveness of treatments.

Traditional/faith-based healers

A semi-structured questionnaire was developed for this study to obtain information on centres from the perspective of healers. Respondents were asked to provide general information about the centre (religious affiliation, years in existence), their perspectives on why people come to the centres, and types of treatment methods that are typically used. Respondents were also asked about referrals to medical centres and perspectives on collaboration with mental health professionals. Data were collected from 40 traditional healers.

Peer supporters

A semi-structured questionnaire was developed for the purpose of this study. Twelve volunteer peer supporters were asked about their perspectives on traditional healing and their experiences providing support for individuals with mental illness who received traditional healing.

RESULTS

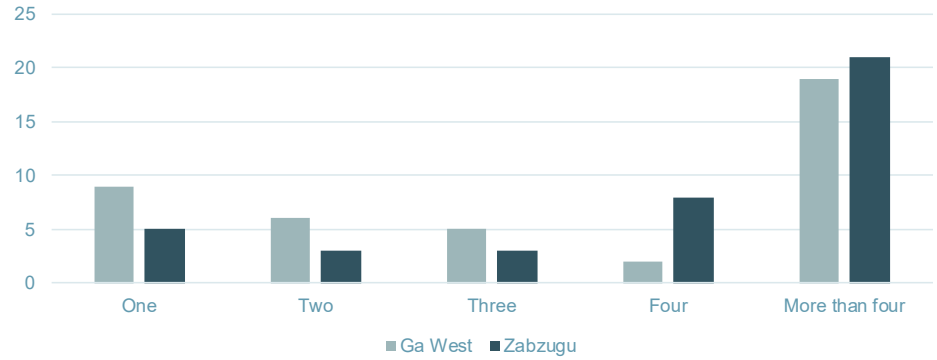
USERS OF HEALING CENTRES

Approximately half of the respondents were female; the average age was roughly 33 in each location. As shown in Table 1, in the Ga West Municipality, respondents primarily identified their religion as Christian, with fewer identifying their religion as Islam or Traditional. Respondents in the Zabzugu District primarily identified their religion as Islam (50%), followed by Christian and Traditional. Additional demographic information for participants by location is also shown in Table 1.

Table 1. Demographic Information for Service Users		
	Northern District (*N* = 44) *n* (%)	Ga West Municipality (*N* = 38) *n* (%)
Gender		
Male	19 (47.4%)	18 (47.4%)
Female	25 (56.8%)	20 (52.6%)
Average age (SD)	33.68 (15.09)	34.89 (14.73)
Marital status		
Single	16 (36.4%)	17 (44.7%)
Married	14 (31.8%)	10 (26.3%)
Divorced	9 (20.5%)	6 (15.8%)
Widowed	5 (11.4%)	4 (10.5%)
Missing	--	1 (2.6%)
Average number of children (SD)	1.89 (1.52)	3.93 (3.53)
Religion		
Christian	12 (27.3%)	33 (86.8%)
Islam	24 (54.5%)	3 (7.9%)
Traditional	6 (13.6%)	2 (5.3%)
Missing	2 (4.5%)	--
Employed	13 (29.5%)	20 (52.6%)

Most respondents from both study locations had more than one visit to a traditional healer (84.8%). For those placed on admission at a healing centre (72%), stays lasted from a few days to more than one year. The frequency of visits to healing centres by study location is shown in Figure 1.

Figure 1. Number of Visits to Healing Centres



The primary reasons for seeking help were mental illness (*n* = 52), spiritual concerns (*n* = 10), physical problems (*n* = 10) and epilepsy (*n* = 6). Most (84.31%) indicated the problem had a spiritual or supernatural origin (i.e., curse, spiritual attack, or caused by God). Other explanations for the problem included an infection, substance abuse, or an accident. Most respondents reported other people (64.3%), primarily family members (60.7%) made the decision for them to go to the healing centre.

Twenty-five of the 82 (30.5%) respondents indicated they experienced at least one potentially harmful treatment during one or more of their visits to a healing centre (see Table 2); 15 from Zabzugu District and 10 from Ga West Municipality. Twelve were male, and thirteen were female. Fourteen reported their religion as Christianity, 10 reported their religion as Islam and one as traditional. Most (72%) reported four or more visits to healing centres, perhaps indicating their symptoms were more severe and/or chronic.

Table 2. Number of participants who reported potentially harmful treatment in centres

	Northern District (*N* = 44) *n* (%)	Greater Accra (*N* = 38) *n* (%)
Restraints	8 (15.8%)	6 (18.2%)
Denied food	9 (20.5%)	5 (13.2%)
Denied water	10 (22.7%)	2 (5.3%)
Sleep deprived	8 (18.2%)	1 (2.6%)
No sleeping place	3 (6.8%)	3 (7.9%)
Flogging	4 (9.1%)	2 (5.3%)

Note. Total n reporting harmful treatments = 15 in Zabzugu and 10 in Ga West

Of the 82 participants, 32 (39%) reported exposure to some type of PTE during their lifetime. It is not clear why, but the majority of these participants lived in the Zabzugu District; the most commonly reported events in this region were physical assault by a non-family member (n = 9) or family member (n = 8) and traumatic death of a family member (n = 8). In the Ga West Municipality, the most common events were traumatic death of a family member (n = 4) and motor vehicle accident (n = 3). Notably, participants who were exposed to potentially harmful treatments in the centres were two times more likely to have experienced a PTE at some point in their lives than participants not exposed to this type of treatment [Chi-Square (1, N = 82) = 18.33, p < .001].

Respondents who reported exposure to a PTE or potentially harmful treatment in the healing centre were assessed for symptoms of PTSD. The average score for this subsample (n = 40) was 31.63 (SD = 21.27); 22 participants had elevated scores (i.e., above 33), indicating clinically significant symptoms. Scores were not significantly different among respondents from Ga West (M = 25.82, SD = 18.91, n = 17) and respondents from Zabzugu District (M = 35.91, SD = 22.29, n = 23) [t(39) = 1.51, p = .14]. Of the 25 participants who reported exposure to some form of potentially harmful treatment in the centres, those who also had a history of exposure to at least one PTE had significantly higher scores on the PCL-5 (M = 29.80, SD = 27.52, n = 17) than those with no history of exposure (M = 44.71, SD = 16.3, n = 8) [t(25) = -2.23, p = .035].

Respondents in both regions reported impaired functioning in daily life across six domains: cognition, mobility, taking care of one's self, interpersonal relationships, daily life activities (in the home and/or at work) and participation in community life. Approximately 72% of the sample had disability scores at or above 50% on the 12-item WHODAS 2.0; on this measure, a score of 0% indicates no disability whereas a score of 100% represents full disability. Average disability percentage scores were similar in samples from both study locations (Zabzugu District = 65.96%, Ga West = 56.63%). Overall, these scores indicate that most respondents in the sample were struggling to meet the demands of day to day life.

All participants were asked if they were likely to seek help in the future from a traditional healer for the same or another problem. The 36 respondents who reported they would return to a healing centre primarily resided in the Zabzugu District (66.7%), 21 were female, and 15 were male. These individuals were mostly Christian (47.2%), single (41.7%), and unemployed (75%). Of the 45 respondents who reported they would not return, 64.4% were in the Ga West, 23 were female, 40% were single and 60% identified as Christian. Just over half was employed (53.3%).

Despite their experiences, 13 of the 25 respondents (52%) who reported some form of potentially harmful treatment in the healing centre reported they would return. Around the same percentage (57.9%) of individuals who did not experience potentially harmful treatment were also willing to return. A subsample (n = 31) of respondents who took part in the second phase of data collection was asked why they would or would not return to the healing centre if the experienced another problem in their lives. Of the 15 respondents who said they would return most indicated the treatment was beneficial (n = 11) with a few noting that it was the most affordable treatment available to them (n = 3). Seven of these individuals reported some form of potentially harmful treatment in the centre. Of the 17 who reported they would not return, most stated it was because the treatment was not effective (n = 11), or they were dissatisfied with the conditions of the centre and with the way they were treated (n = 5).

FAMILY MEMBERS OF SERVICE USERS

The 28 family members who took part in the study reported information on the use of healing centres by their fathers (n = 11), mothers (n = 5), grandparents (n = 3) spouses (n = 6) and uncle (n =1); two participants did not provide this information. Seventeen were from the Zabzugu District and 11 from Ga West. A slight majority (n = 15) was Muslim with the others being Christian (n = 12) or traditional religions (n = 1). Most reported little formal education, with only eight participants having completed secondary school.

Regarding the type of healing centre, 13 individuals reported their family member first went to a prayer camps, 7 went to shrine priests, 5 to Islamic faith-

healers and 3 to herbalists. In most cases (*n* = 26) a family member made the decision to send the person, most commonly the father (*n* = 11). More than half of the participants reported their family member had been to a healing centre four or more times. The problems for which they sought treatment were mental illness (*n* =14), spiritual issues (*n* = 4), or a combination of the two (*n* = 4). A majority stated the problem had a spiritual or supernatural cause, with only four participants stating it had biological or social causes.

As shown in Table 3, the reasons for choosing traditional healing varied by location. In the Zabzugu District, perceived efficacy of the treatment was the primary reason, whereas in Ga West proximity was the primary reason. The type of illness the person was suffering from also played a role in both locations.

Table 3. Reasons for seeking traditional healing reported by family members

	Zabzugu District (*N* = 17) *n* (%)	Greater Accra (*N* = 11) *n* (%)
Perceived efficacy	12 (70.6%)	2 (18.2%)
Affordability	2 (11.8%)	3 (27.3%)
Proximity	--	6 (54.5%)
Type of illness	5 (29.4%)	4 (36.4%)

Family members reported a range of different practices were implemented by the healer, including prayer, the sacrifice of animals, and the application of herbs. Twenty-five of the family members reported the user had been exposed to some form of potentially harmful treatment, 15 in the Zabzugu District and 10 in Ga West. These included flogging (*n* = 7), mandatory shaving of hair (*n* = 8), use of physical restraint (*n* = 11), being kept awake with all-night vigils (*n* = 13), and obligatory fasting (*n* = 14). The frequency of treatments by study location is shown in Table 3.

Table 4. Family members´ report of potentially harmful treatment in centres		
	Zabzugu District (*N* = 17)	Greater Accra (*N* = 11)
Restraint	7 (41.2%)	3 (27.3%)
Fasting	9 (52.9%)	5 (45.5%)
All-night vigil	7 (41.2%)	7 (54.5%)
Flogging	4 (23.5%)	3 (27.3%)
Exposure to elements	2 (11.8%)	--
Shaving of head	8 (47.1%)	--

Family members were asked if practices shown in Table 4 were beneficial. In the Zabzugu District 11 (64.7%) participants stated they were helpful in that they observed improvements in symptoms of the person treated, including reduction of seizures and agitation. Six participants (35.3%) reported the practices were not helpful because the person did not respond well to restrains (*n* = 2) or generally did not show improved symptoms (*n* = 3). One person did not report a reason. The 11 family members who believed the treatment was effective would send their relative back to the centre, whereas the other six would not.

In contrast, only one person in Ga West believed the treatments had been helpful. One participant stated that flogging made everything worse, whereas others stated they saw no improvement after treatment (*n* = 10). One participant in Accra would send their relative to a healing centre again because they believed it would be helpful; others (*n* = 10) stated they would not because it was not helpful or because the person was now getting help in the official medical system (*n* = 2).

TRADITIONAL/FAITH-BASED HEALERS

Demographic information for healers by location is shown in Table 4. The healers who took part included 28 males and 12 females with an average age of approximately 52 years. Most (60%) reported no formal education; 35 % of respondents had basic school or middle/secondary level education; 2,5 % of respondents possessed technical and tertiary level education, respectively. Just over half (52.5%) of the healers inherited their function, 40% came to their role from a calling, and 25% through apprenticeship. As shown in Table 3, most had been in the role of healer for more than 5 years.

Table 5. Healer Demographic Information		
	Zabzugu District (*N* = 20)	Ga West (*N* = 20)
Gender		
Male	19 (95%)	9 (45%)
Female	1 (5%)	11 (55%)
Age Mean (SD)	51.50 (17.47)	52 (12.41)
Education		
None	19 (95%)	5 (25%)
Primary	1 (5%)	6 (30%)
Middle School	0	7 (35%)
High School	0	0
Vocational	0	1 (5%)
Tertiary	0	1 (5%)
Length of time as a healer		
1 to 5 years	3 (15%)	2 (15%)
6 to 10 years	8 (40%)	4 (20%)
11 to 15 years	2 (10%)	3 (10%)
More than 16 years	7 (35%)	11 (55%)

Descriptive information for the centres where healers worked is provided in Table 4. Respondents primarily described their centres as “traditional healing centres” and “prayer camps.” Most identified the religious affiliation of their healing centres as Christian (30%) or traditionalist (25%) with fewer reporting Islam (12.5%). Thirteen stated the centre was not affiliated with a specific religion. Most centres in both locations had been open for more than 5 years. In the Zabzugu District, more than half had been in existence for more than 16 years. In Ga West, 90% of the centres placed people on admission, meaning clientele are admitted for periods of less than one week to more than one year; 85% of the centres in the Zabzugu District admitted clientele.

Table 6. Characteristics of Healing Centres		
	Zabzugu District *n* (%)	Ga West *n* (%)
Type of centre		
Prayer camp	6 (30%)	11 (55%)
Traditional	13 (65%)	8 (40%)
Other	1 (5%)	1 (5%)
Religious affiliation of centre		
Christian	2 (10%)	10 (50%)
Islam	5 (25%)	--
Traditional	8 (40%)	2 (10%)
Length of time centre open		
1 to 5 years	2 (10%)	5 (25%)
6 to 10 years	4 (20%)	8 (40%)
11 to 15 years	3 (15%)	2 (10%)
More than 16 years	11 (55%)	5 (25%)

Respondents in both the Ga West Municipality (85%) and the Zabzugu District (95%) reported that mental illness is one of the common reasons for seeking treatment at their centres. Most, 90% in Greater Accra and 80% in the Zabzugu District reported that problems were caused by spiritual or supernatural causes. In the Ga West Municipality and the Zabzugu District, 75% and 85% of respondents indicated, respectively, that most of the time, someone other than a service user, typically a family member, makes the decision to seek treatment at the centre.

Respondents across both locations reported commonly using herbs (90%) and prayer (62.5%), followed by ritual sacrifice (42.5%) and use of charms (37.5%) during treatment.

The most frequently used potentially harmful treatment, reported by 55% of the total sample of healers, was the use of physical restraint, which was typically done with chains or ropes. As shown in Table 5, this was more common in the Ga West Municipality (n = 14) than in Zabzugu District (n = 8). In the Ga

West Municipality, healers who reported using restraints were primarily from Christian (*n* = 8) or non-affiliated centres (*n* = 5); in the Zabzugu District, they were primarily from traditionalist (*n* = 4) or non-affiliated centres (*n* = 2). Healers reported restraints helped calm aggressive individuals, prevented injury, and controlled movement so medicine could be applied without interruption. Two healers reported restraining helps users to be humble and prevents escape.

Table 7. Potentially Harmful Treatments

	Zabzugu District (*N* = 20)	Ga West (*N* = 20)
Restraint	8 (40%)	14 (70%)
Fasting	8 (40%)	8 (40%)
All-night vigil	10 (50%)	2 (10%)
Exorcism	5 (25%)	4 (20%)
Exposure to elements	5 (25%)	0

Additional potentially harmful treatment included mandatory fasting (40%), all-night vigils (30%), exorcism (22.5%) and exposure to the elements (12.5%). Fasting was primarily used in Christian centres in the Ga West Municipality (*n* = 7) and non-affiliated centres in the Zabzugu District (*n* = 3). All night vigils were used in Christian centres in the Accra (*n* = 2) and most commonly non-affiliated (*n* = 4) and Islamic (*n* = 3) centres in the Zabzugu District. Exorcism was only performed in Christian centres in the Ga West Municipality (*n* = 4) but in different types of centres in the Zabzugu District (*n* = 5). Exposure to the elements was practised in five centres in the North of various types. Most healers reported that these practices were helpful for the recovery of the individual. For example, fasting was used clear toxins and evil spirits, whereas exposure to the elements during treatment was said to have a calming effect.

Regarding referral, 65% of the healers in the Zabzugu District and 80% of the healers from the Ga West Municipality reported having referred users with mental illness or epilepsy to the hospital. Analysis of the reasons given by respondents on why they referred users delineated two main trends. Statements from seven respondents suggested that they refer users to the hospitals for laboratory tests to inform diagnosis. Ten respondents indicated that they referred users to hospitals because users had health problems they were at their facilities. Other reasons included the following: medicines from hospitals work effectively, hospitals yield better results, hospitals give further treatment of users' condition.

Most respondents (85% from Zabzugu and 95% from Ga West) agreed that collaboration with health professionals could benefit their users. Some common reasons healers gave for encouraging collaboration included: collaboration aids quick and better recovery, it helps users to get medicine, it helps users get properly tested before treatment, it helps users to heal faster to be reintegrated with their families. Of the three respondents who did not believe collaboration would be beneficial, only one provided a rationale; this individual reported concerns that the hospital and not the healer would be credited for the improvement.

PEER SUPPORTERS

Twelve peer supporters who provide psychosocial support to individuals with mental illness living in the communities of the Ga West Municipality (*n* = 7) and the Zabzugu District (*n* = 5) took part in the study. The sample was composed of 10 males and two females with an average age of 36.5 years. Most (93%) had volunteered for five years or more. All peer supporters engaged in a variety of psychosocial support activities, including leading self-help groups, providing psychoeducation, and facilitating treatment access.

Given the small sample and similarity of responses, data are reported for the total sample. Peer supporters reported that users go to healing centres primarily because of mental illness and spiritual concerns. A majority (75%) indicated that someone other than the user typically makes the decision regarding admission to the centre. Peer supporters reported referring their users to services within the healthcare system; three indicated they had referred users to healing centres. Half of the peer supporters reported that users had reduced symptoms after stays healing centres. Most (91,7%) indicated that users continue to experience psychosocial problems after receiving traditional healing, including stigma, interpersonal difficulties, and problems with employment.

Table 8. Peer supporters' perceptions of user problems after being in healing centres

	Yes	No	Missing
	N (%)	*N* (%)	*N* (%)
Stigma	8 (66.7%)	3 (25%)	1 (8.3%)
Employment	4 (33.3%)	7 (58.3%)	1 (8.3%)
Family relations	6 (50%)	5 (41.7%)	1 (8.3%)
Social relations	6 (50%)	5 (41.7%)	1 (8.3%)

KEY FINDINGS

The study provided useful insights into the treatment of mental illness at traditional/faith-based healing centres from the perspective of service users, their family members, traditional/faith-based healers, and peer support workers. Some of the key findings from the study are:

- Most service users from both study locations had more than one visit to a traditional healer (84.8%). For those placed on admission at a healing centre (72%), stays lasted from a few days to more than one year.

- Users, their family members, and healers confirmed that most people are brought to the healing centres by other people, typically family members.

- The primary reasons for seeking help were mental illness (*n* = 52), spiritual concerns (*n* = 10), physical problems (*n* = 10) and epilepsy (*n* = 6). Most service users (80.5%) believed their presenting problem had a spiritual or supernatural origin, as did the family members who were interviewed.

- 30.5 % of the users of healing centres reported being exposed to potentially harmful treatment such as denial of food and water, restraint by chains or ropes, deprivation of sleep, and/or flogging. Despite this treatment, half of these individuals would go back to the healing centre. Nearly all familymembers (89.2%) interviewed reported their relative had been exposed to at least one potentially harmful treatment. 64.7% in the Zabzugu District would send their family members back because they believed it to be helpful. Only one (.09%) family member from the Ga West Municipality would send their family member to a healing centre in the future. This could be related to greater accessibility of mental health services in Greater Accra.

- 32 (39%) of the 82 services users reported lifetime exposure to some type of potentially traumatic event (PTE), with a higher number residing in the Zabzugu District (*n* = 20). Participants who were exposed to potentially harmful treatments in the centres were two times more likely to have experienced a PTE at some point in their lives than participants not exposed to this type of treatment in the centre.

- Respondents who reported exposure to a PTE or potentially harmful treatment in the healing centre were assessed for symptoms of posttraumatic stress. Twenty-two participants had scores that would be considered clinically significant. Of the 25 participants who reported exposure to some form of potentially harmful treatment in the centres, those who also had a history of exposure to at least one PTE had

significantly higher symptoms of posttraumatic stress. However, it is not clear if the distress is related to experiences inside or outside the centres, or both.

- Users of healing centres in both regions reported high levels of impaired functioning in daily life. Approximately 72% of the sample had disability scores at or above 50% on the 12-item WHODAS 2.0.

- 90% of the traditional/faith-based healers stated that mental illness was one of the typical presenting problems of users. 55% of the healers reported using physical restraint, primarily with chains or ropes as a part of treatment, more so in the Ga West Municipality (n = 14) than in the Zabzugu District (n = 8). 40% of healers reported using fasting, 30% all-night vigils, 22% exorcisms, and 12.5% used exposure to the elements. Most reported these practices were helpful for the recovery of the individual. Healers reported that restraints helped calm aggressive individuals, prevented injury, and facilitated treatment, fasting was used clear toxins and evil spirits, and exposure to the elements during treatment was said to have a calming effect.

- Most healers interviewed appeared to hold positive views towards the official health system. 72.5% reported that they had referred users with mental illness or epilepsy to the hospitals and the majority (90%) reported a benefit in collaborating with health personnel.

- Half of the peer supporters reported that users appeared to have reduced symptoms after stays in healing centres. However, they also noted that most of the individuals with whom they worked continued to experience psychosocial problems, including stigma, difficulties in relationships, and difficulty with employment.

LIMITATIONS

Sample

The sample size in each category of participants was relatively small, which limits the degree to which we can draw conclusions about differences among subsamples. There appear to be some differences in the treatment of users based on the religious affiliation of the centres, but the small sample size prevents drawing conclusions about these differences. We used purposive sampling to ensure participants met specific criteria; however, this may have resulted in a biased sample. Nearly all healers who took part in this study, for example, were willing to collaborate with official health structures. It is possible that those who were willing to be interviewed also hold a more positive view of the official system than other healers. Furthermore, the majority of service users we interviewed received services from one of our partner organizations.

Thus, findings may not be representative of the larger populations of traditional/faith-based healers and service users in Ghana.

Language

Ghana is a multilingual country. The questionnaires were not translated into local languages because most of the population only read in English. Instead, the task of translation rested upon the interviewers who were asked to administer the questionnaire in the language used by the respondent. Prior to data collection, the team agreed appropriate translation of study questions.

Validation of PCL-5 in population

To our knowledge, the PCL-5 has not yet been validated with this population; future research is needed to understand better if Western conceptualisation of PTSD captures the symptomology of trauma-exposed individuals in Ghana.

CONCLUSION AND RECOMMENDATIONS

The present report is to be seen within the framework of the pilot project between DIGNITY, BNGh and MEHSOG. Despite the limitations, the study constitutes an important milestone towards enhancing contextualised knowledge on the treatment of mental health problems by traditional healers in Ghana and the need for trauma-informed MHPSS in the study areas. Results were used to develop an educational intervention on the impacts of violence and other types of traumatic events that will be used BNGh and MEHSOG to raise awareness among non-specialist mental health providers, traditional healers, and other community stakeholders. Findings will continue to influence our work in Ghana, and the West Africa region, which is focused on advocacy and ensuring access to treatment for trauma-affected individuals. Results point to the following future directions:

To increase awareness and knowledge on trauma and its consequences in local communities and among health workers and traditional healers.

A relatively high percentage of service users (39%) reported lifetime exposure to some type of potentially traumatic event as well as elevated symptoms of posttraumatic stress. Participants who experienced potentially harmful treatment from a traditional healer were more likely to have had prior trauma exposure and had significantly higher symptoms of posttraumatic stress. This topic requires further exploration to understand whether individuals are seeking help at healing centres for trauma-related distress or whether a pre-existing mental illness has made them more vulnerable to experiencing both trauma and maltreatment in the centres. Although we cannot identify the precise cause of posttraumatic symptoms in the sample, results indicate the relevance of a trauma-informed psycho-educational intervention to raise awareness and knowledge among service users, their families, traditional/faith-based healers, and health workers.

To promote collaboration between traditional/faith-based healers and official health structures as a means of improving the services for individuals with mental illness.

Consistent with other research,[23] our findings suggest there is a high degree of trust in traditional/faith-based healers and that many will go there before the official health system. This is likely due to both accessibility and cultural factors. There are far more traditional/faith-based healers than mental health practitioners. However, belief systems also appear to play a key role in help-seeking in this context; service users, their family members, and healers by in large reported the belief that mental illness has a spiritual cause.

There is a long history of attempted collaborations between traditional/faith-based healers and the official health system in Ghana, with varying degrees of

success. These have primarily focused on the treatment of physical illnesses (e.g., integration of herbal

medicines), but more recently, some have focused on the treatment of individuals with mental illness. Unfortunately, many have been unsuccessful. The failure has been attributed to general mistrust and lack of appreciation between mental health providers with a biomedical view and traditional healers.[24]

There are, however, some examples of successful collaboration, including those fostered by BNGh and MEHSOG. Although previous studies have documented a lack of trust in the biomedical health system, most healers interviewed in this study had referred people to hospitals. Moreover, the healers were generally open to collaborating with official health structures with the aim of helping their users to a quick and better recovery. This openness among the healers demonstrates the potential for creating new and strengthening existing linkages between healing centres and official health structures. Collaboration is essential to strengthen local referral systems and facilitate access to MHPSS for individuals in need. It will be important to document these collaborations to identify best practises and share learnings.

To further investigate the interrelationship between belief systems and mental health conditions as a means to appropriately adapting trauma-informed MHPSS interventions.

Our findings suggest there is a need for trauma-informed MHPSS in both study locations. At the same time, as noted above, findings demonstrate that mental health symptoms are often considered to have a spiritual or supernatural origin. The healing centres are recognised among the users, their families and peer supporters as a legitimate service provider. Despite being exposed to what we have labelled *"potentially harmful" practices*, half of the users would go back to the healing centres. This is a clear illustration of how belief systems inform people's perceptions and practices related to mental health and is an essential consideration for program implementation in this and other contexts. Indeed, cultural differences in beliefs about the causes of mental illness and a lack of understanding of local contexts were recently identified as key challenges to effectively scaling mental health interventions in low and middle-income countries.[25] We believe this needs to be further investigated in order to appropriately localise MHPSS programs to meet the needs of trauma-affected individuals and others suffering from mental health problems.

To promote the need for allocation of resources to ensure the inclusion of marginalised individuals with mental illness.

Results of the study indicated that users of healing centres had impaired functioning in daily life and that those exposed to trauma and maltreatment had elevated symptoms of posttraumatic stress. This population is potentially

vulnerable and may benefit from MHPSS to reduce symptoms and improve adaptive functioning, so they are able to

participate in family and community life actively. In line with the Sustainable Development Goal (SDG) *leave-no-one-behind* principle, we believe it is important to promote the need to allocate more resources to facilitate access to care. It is our assumption that we need to prioritise this area if we are to break the vicious cycle of vulnerability impacting this population.

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MENTAL HEALTH TREATMENT IN TRADITIONAL AND FAITH-BASED HEALING CENTRES IN GHANA

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