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The Perceptions and Motivations of Communities in Seeking Indigenous Healing in Cases of Mental Illness in Zimbabwe

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Abstract

This study aimed to assess perceptions and motivations of communities in seeking IH in cases of mental illness in a settlement north-east of Harare in Zimbabwe through an exploratory qualitative methodology in order to inform how IH may be used to create cultural sensitivity in the delivery of mental health care in Zimbabwe. Thirty in-depth interviews and three focus group discussions with key-informants were conducted. Gathered data were coded using Constant Comparison Method with multiple members of the research team, enhancing validity and reliability. The results of the study revealed that patients believe that mental illness has supernatural causes, and it follows that mental illness with a supernatural cause can only be treated in IH. The other reasons given are that IHPs are supporting patients with mental problems that are chronic, or have no cure from BT. In addition, patients perceive that only IHPs can fix spiritual problems. Patients find rituals useful because rituals meet their cultural expectations and patients' religious faith. Furthermore, IHPs provides holistic care and are affordable, offer friendly services and there is no alternative approach. Patients are referred from the other healing agents and some patients are avoiding the problems in BT such as their fear of chemotherapy similar to the ideas of Ivan Illich's clinical iatrogenesis (1976). The data, however, suggests that IH meet cultural expectations of Zimbabwean patients in the treatment of mental health disorders and should be harnessed with BT to make therapy culturally appropriate.

Keywords

Health-seeking Behaviour, Indigenous Healing, Indigenous Healing Practitioner, Mental Disorders

1. Introduction

Understanding health-seeking behaviour of the community is of paramount importance in promoting utilisation of health facilities and promotion of mental health. In sub-Saharan Africa, 80% of the population continues to use Indigenous Healing (IH) as a resource for primary health care that includes treatment of mental illnesses [1]. Despite the widespread use of IH, very little is known about health-seeking behaviour in IH, in parallel to or combined with biomedical psychotherapy (BT) [2]. The aim of the study is to assess perceptions and motivations of communities in seeking IH in cases of mental illness in a settlement north-east of Harare in Zimbabwe.

Health-seeking behaviours entail an understanding of health needs, a desire for specific health outcome and then taking specific action to implement this desire or goal [3]. In Zimbabwe, often the first assumption for most patients is that their illness is natural and normal and can be treated with standard remedies, such as over-the-counter medications or herbal remedies [5]. Taylor views that when conventional efforts fail to relieve symptoms, patients might then suspect that their illness is not normal or natural, and turn to IH to identify underlying causes for sickness and disease [3].

This is because IH is thought to provide a platform for

patients' sociocultural beliefs which informs therapeutic choices to use IH, BT, or both as is often the practice in most African countries, including in Zimbabwe [4].

Unlike BT, IH is believed by many people to be accessible, affordable and actively engages with patients, resulting in holistic care [2]. In spite of its popular use, IH has attracted criticism and skepticism from academic or BT communities [6]. Many biomedical professionals, even those in countries with a strong history of IH, express strong reservations and often frank disbelief about the purported benefits of IH because of the dearth of evidence-based research on IH [6].

Fortunately, most African countries recognize the role of IH in society; but very few have established procedures for regulations because IH operate outside formal health structures. In addition, in many parts of the world, policy makers, health professionals and the public are wrestling with questions about cultural appropriateness of the delivery of mental health services [7]. Some academics have argued that IH might be a more culturally appropriate vehicle for addressing mental health needs in Africa [8].

1.1. Indigenous Healing

The World Health Organization looks at IH as health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to maintain well-being [9], as well as to treat, diagnose or prevent mental disorders.

1.2. Mental Disorders

Mental health disorders include a wide range of mental health problems that present in primary care as an important source of disease burden worldwide, including in Zimbabwe [5]. The most burdensome problems are common mental disorders, including anxiety, depression, post-traumatic stress disorder and substance abuse, and to a lesser extent "the severe long-term health disorders" such as schizophrenia and dementia [10]. Although primary care has an important role to play in the management of more severe disorders, common mental disorders are generally viewed as the main remit of primary care [11]. While biomedical therapies are evidence-based mental health treatments, they fail to attract patients because they are not culturally sensitive to indigenous patients since they are developed in Western cultures [12]. Although IH therapies have been formally evaluated as health treatments (Nortje et al., 2016), their work in mental health care is not known [13]. Furthermore, it is not known how many patients consult IH, or why they seek therapy for mental health problems [1].

1.3. Context of the Study: Mental Disorders in Zimbabwe

In Zimbabwe mental disorders are commonly occurring in the general population, are on the increase, often have an early age-of-onset, and are associated with significant adverse societal costs [14]. Zimbabwe went through two decades of economic melt-down and this has had a devastating mental, emotional and physical toll on the generality of Zimbabweans who can no longer absorb rigours of the meltdown [15].

World Health Organisation (WHO), reports that some 1, 3 million of the country's 14 million people, representing 10 percent of the population, have one form of a mental disorder or another [16]. This is quite a huge increase and the figure has more than doubled in less than 20 years, considering that there were just above 600 000 mentally ill patients in 1999 [17]. Unfortunately, the increase in numbers of mentally ill people does not match the staff complement in the country. WHO estimates show that Zimbabwe has only 14 psychiatrists to cater for the 1, 3 million mental patients, translating to a doctor to patient ratio of 0, 08 percent per 100 000 people? In addition, there is a shortage of mental health facilities, including staff and drugs, across the country. The whole country has only 20 registered clinical psychologists and nine public mental health institutions [15].

Although there are high rates of psychopathology in Zimbabwe, the main challenges that mental patients face include among other things, shortage of mental health specialists, limited care and support and culturally insensitive mental healthcare programmes. This implies that many people consult in IH, but no one knows the benefits, because of there is no evidence of work in this field. This is the gap that this paper is trying to cover.

1.4. Rationale

The current state in the delivery of mental health service in Zimbabwe is creating [18]. While biomedical therapies are evidence-based mental health treatments, they are not culturally sensitive to indigenous patients because the therapies are developed in western cultures [12]. More people shun BT and use IH in large numbers in resource poor countries, unfortunately it is not known why, except for the fact that IH is affordable. Furthermore, it is not known what the attractions can do if blended with BT; and whether the outcome will provide quality health, or not that is more accessible, equitable, efficient and sustainable [1]. In Zimbabwe, many studies have looked at IH in general [2, 5, 19] but not much has been done to establish health seeking behaviour of people in IH [20]. Once information is known, it can form ingredients that modifies therapy and increases user uptake and widen the scope for therapy. The combined therapeutic forces of IHPs and BTPs will be expected to make therapy culturally sensitive to users, through the use of non-specialised IHPs and nurses in resource poor settings. The outcome will be tested in future studies.

1.5. Justification of the Study

Many people with mental disorders in Africa, including in Zimbabwe consult in IH and only a few patients access BTPs. To address the high burden of disease, WHO advocates for collaboration between IH and BT [21]. Therefore, evidence from this research is useful to explore the benefits of the

African indigenous healing system to discover what aspects can be used in a partnership with BT in the provision of mental health service in Zimbabwe in order to reduce the burden of disease. This paper therefore will contribute to body of knowledge practice and policy influence. The paper would add to the work of Shaik, Haran & Hatcher (2008) who found that an understanding of why patients use indigenous healing may provide insights into how to motivate people to utilize mental health care and to optimize the health care choices available in low-income countries [22]. In addition to acting as an evaluative research for IHPs, this research will be a measure of merit of worth of IH in mental health treatment in national response to the high prevalence of mental disorders. The results will act as direct evidence of the importance of IH in the treatment of mental disorders resource poor countries. Many studies across the world, show that many people in resource poor countries depend on IH for many reasons. However, the motives of people to use IH in the treatment of mental disorders are not known. Therefore, the outcome of the study will inform how IH may be used to create cultural sensitivity in the delivery of mental health care in Zimbabwe. This paper would help to set up building blocks for collaboration between IHPs and nurses. The results of the study will affect planning of mental health work at policy level. Policy makers will be sensitized in favour of collaboration between IHPs and bio-medically trained nurses in mental health treatment and the results will act as resource for substantive policy and guidelines for partnership in mental health treatment. In addition to the above, the study is particularly critical for a number of reasons. Once the results are known the effect of manpower shortages will go away. Next, the current redundancy of IHPs will also disappear as IH will be an acceptable scientific approach and scope for therapy will be wider than before for patients. The author therefore anticipates that evidence that will be gathered would contribute invariably to decisions regarding development of a culturally appropriate therapy that is tailor made to the needs of mental health patients in Zimbabwe. However, there is a dearth of scientific literature on customization of mental health care to patients in resource poor countries; and this paper will try to fill that gap in Zimbabwe.

2. Literature Review on Health-Seeking Behaviour of People in Indigenous Healing for Mental Health Care

In this section the paper discusses literature on health-seeking behaviour in IH of mental health care. This is important because information on health-seeking behaviour will help readers to understand the significant cultural ingredients of culturally appropriate therapy in mental health treatment [22].

In sub-Saharan Africa, 80% of the population continues to use IH as a resource for primary health care that includes treatment of mental illnesses [1]. Despite the widespread use of IH, very little is known about why patients continue to use IH (*Hun'anga)*, in parallel or in conjunction with BT and it should be a research priority [2].

Although IHPs are ubiquitous in Zimbabwe, very few academics or BTPs know and understand why IH attracts many people because of secrecy and lack of rigorous studies on sociocultural practices [2. 3. 23]. The dearth of understanding about IH and its practitioners has led BTPs in Zimbabwe to mistrust and be hostile towards IH approaches [20]. Currently most people suffering from a mental illness do not receive treatment and have less than positive attitudes towards mental health services in Zimbabwe. Ironically, the majority of people seek care in the informal IH care [5]. This may be explained by the fact that the causes of mental health problems in IH are believed to be mainly through supernatural factors (gods, spirits, and ancestral spirits) or natural causes [24]. When IH deal with these people's cultural explanations on the causes of mental illnesses are met. In addition, many people believe that IH holistically engages the patients' mind, body, spirit and culture [18].

IHPs depend on indigenous knowledge, theories, beliefs, practices and experiences of health and healing, especially in the diagnosis, treatment and prevention of physical and mental illnesses [9]. While BTPs are not culturally appropriate, they give access to only a few people because they are expensive, limited in numbers, and are often available mainly in urban areas [2]. The perceived advantages of IH are overwhelming; namely low-cost, affordability, ready availability, accessibility and acceptability and perhaps low toxicity [7]. IHPs have been generally acknowledged excellent at primary health care levels [25]. Unfortunately, BTPs continue to cast accusations against the role of IHPs in therapy, accusing IH among other things, of lack of adequate scientific proof, imprecise diagnosis and dosage, non-tested medicines and occultist practices, because little is understood about IH services [19]. In addition, there are no measurements for herbal treatments which potentially make the approach dangerous for clients [9]. In contrast, biomedical specialists are not culturally appropriate, give access to only a few people because they are expensive, limited in numbers, and are available mainly in urban areas [2]. BM does not address the spiritual needs of an indigenous patient, which IH fulfils [26]. In 2002, the WHO recommended that traditional medicine be included in national responses to mental health problems, in order to increase the user uptake of mental health care [27]. Before inclusion of IH approach into mental health care, people's health-seeking behaviour has to be understood. This paper analysed health-seeking behaviour of people in IH for mental health care in order to inform the customization of mental health care to patients in Zimbabwe and other resource poor countries to make therapy culturally appropriate.

2.1. Objectives of the Study

The broad objective was to assess perceptions and motivations of communities in seeking IH in cases of mental

illness in Zimbabwe.

The specific objectives guiding this paper are:

1. To examine perceptions of communities in seeking IH in cases of mental illness in Zimbabwe; and
2. To identify the motivations of communities in seeking IH in cases of mental illness

2.2. Research Questions

This proposal posed the following questions:

1. What are the perceptions of communities in seeking IH in cases of mental illness in Zimbabwe?
2. Why do communities seek IH in cases of mental illness in Zimbabwe?

Theoretical framing of indigenous healing practices in the treatment of mental disorders

This paper used explanatory model of illness (EMI) as its theoretical framework to guide the study involving health-seeking behaviour of people in indigenous healing approach [28]. This theory explains why majority of people in Zimbabwe opt for indigenous healing practices in mental health care. EMI postulates that health-seeking behaviour and utilization of health facilities is best understood using EMI which gives physician knowledge of beliefs a patient holds about his illness, personal and social meaning he attaches to his disorder, his expectations about what will happen to him, what the doctor will do and his own therapeutic goals [29]. The term 'explanatory model' was introduced by Kleinman who defined it as the complex, culturally determined process of making sense of one's illness, ascribing meanings to symptoms, evolving causal attributions, and expressing suitable expectations of treatment and related outcomes [28]. Kleinman further notes: "[The notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process]" Kleinman p. 105. More simply, explanatory models might be described as culturally determined beliefs that individuals hold about misfortune, suffering, illness and health [30]. These models are shaped by and shape societal expectations of the sick role, individual illness behaviour and help-seeking [31]. Research has shown that explanatory models are always changing and complex constructs that may change in response to a number of factors, including the type of questioning, the relationship with the clinician, mood and migration history [32]. In the clinical encounter, exploration of EMI provides valuable information about the meaning of illness for the patient and his/her family, and helps to build an understanding of their culture, therefore permitting the richness of the patient's perspective to emerge in a narrative form. EMI was used to provide a framework that informed methods, development of study tools, data analysis and a discussion on the implications of the research findings.

3. Methods

This study used a sample of 48 participants which included; 30 patients of IHPs for one on one interviews and 18 members from the community who were distributed in three focus groups, each cluster with six members of the community. People representing mixed views came from different regions of the country to settle in the seven wards of Epworth community. They were enrolled in the study and the sample was calculated using information in Glaser & Strauss, 2009. This was done to minimize the sources of error in subject selection and comparability [33]. A qualitative design was selected because it was appropriate in this case. Little was known about people's motivations for therapy in IH and a qualitative approach would allow for a deep, textured exploration of perspectives on health-seeking behaviour of people in IH in Zimbabwe [34].

In this study, understanding health-seeking behaviour of people for mental health treatment in IH emerged from the interviews with participants and direct observations by the researcher of IH practices. A case study was selected because IH was of special interest and dealt with unique issues in the management of mental health [35]. This would help to understand why people chose IH in the treatment of mental disorders within the local settings. Epworth community, a large peri-urban settlement which is of very diverse cultural composition, 16 kilometres north-east of Harare, was selected for the study. Convenience sampling method was used to recruit members of the community while snowballing was used to recruit visitors of IHPs [33]. The participants were selected for the study if they spoke any of the main indigenous languages in Zimbabwe (i.e. Shona or Ndebele) and if they were 18 years of age or above. The participants were excluded from the study if they were minors (under 18 years of age) including those with severe cognitive impairments.

The researcher examined the Zimbabwe National Traditional Healers Association (ZINATHA) records to determine names of all of indigenous healers in Epworth then located those available with assistance of the local community health workers.

After locating indigenous healers, the researcher requested indigenous healers for their permission to let the researcher recruit patient participants at their healing shrines. To recruit eligible patients, the researcher used snowballing sampling strategy by first approaching one patient who had seen an IHP and requested him/her to link him to the next patient they knew had consulted an IHP. The investigator explained the study objectives, procedures and obtained informed consent from all participants. Community members were recruited at social gathering sites; such as food distribution depots, using a convenience sampling strategy as they were leaving the site. The investigator explained the study objectives, procedures and obtained informed consent from all the participants.

From June to December of 2018, the researcher conducted interviews in Epworth. The researcher used a number of data collection methods which included 30 in-depth interviews (IDI), three focus groups and observation for triangulation purposes. Two research assistants helped with notes taking and audio recording. The researcher started by conducting in-depth interviews with patients of IHPs, and conducted focus

group discussions with members of the community to collect their reasons for consulting in IH for mental health treatment. During the study period, the researcher made observations on patients consulting in indigenous healing approach.

IDI were used because the researcher wanted detailed information about a person's thoughts and behaviours about consulting in IH or to explore new issues in depth [36]. This study explored experiences of patients when they visited IHPs and why they preferred IHPs to BT specialists using IDIs. IDIs were used with patients of IHPs in place of the focus groups because the patients consulting HPs might have not been comfortable talking openly in a group. In addition, the researcher preferred to distinguish an individual (as opposed to a group) opinions about the IH approach. The IDI was conducted using semi-structured interview guides and patients were chosen because they would give their perceptions on why they preferred to depend on IH in the treatment of the mental disorders in Zimbabwe

Next, the interviewer used a focus group guide to keep interactions focused while allowing the individual perspectives and experiences on IH to emerge [38]. Six people with similar backgrounds participated in each of the three focus group interviews to get a variety of perspectives and increase confidence in whatever patterns of motives emerged [39]. The researcher engaged two research assistants to help managing the groups so that one person focused on facilitating the group while the other research assistant took detailed notes and dealt with mechanics such as tape recorders, cameras, and any special needs that arose, for example, someone needing to leave early or becoming overwrought [33]. Even when the interview was recorded, good notes helped in sorting out who said what when the tape recording was transcribed. The focus group interviews had several advantages as noted by [38]

Additionally, the researcher was involved in non-participant observations during each of the approximately one-hour sessions He made detailed descriptions of the whole process of IH using an observation check list [39]. The researcher introspected himself, in terms of his reactions during all the encounters (Patton, 2008). This method was used to gain first-hand experiences of IHPs' practices and why patients came to see IHPs, in order to triangulate the information with the other data obtained from patients of IHPs and members of the community [33]. In-depth and focus group discussion interviews were conducted in Shona, audio recorded, professionally transcribed, translated into English, and then back-translated to Shona to check for consistency. The researcher pilot-tested the instruments using interview guides and observational checklist. Data was collected from two patients of IHPs and one focus group discussion session for the pilot study. After obtaining data from the participants, the researcher then modified interview guides and observational checklist [38]. The pilot study enabled the researcher to test and fine tune the interview guides, procedures, and observational skills to determine the final sample.

Data were analyzed using constant comparison method. The actual process of data analysis usually took the form of clustering similar data. In this study data was transcribed from audio recorders and themes were developed from transcripts. Analysis of the data was guided by the objectives.

The study was approved by Chinhoyi University of Technology and Medical Research Council of Zimbabwe (MRCZ). Approval was obtained from Kunaka District Hospital in Epworth and Zimbabwe National Traditional Association (ZINATHA) before beginning of the study. Informed consent was obtained from all participants, including permission to audio-tape the interviews.

4. Findings, Discussion and Conclusion

The aim of the paper was to analyse why IH systems still thrive despite the presence of more scientifically advanced biomedical therapies. The results from the thick descriptions made from direct observations by the investigator were synthesized with responses from the in-depth interviews of the indigenous healers' patients and members of the community. First, the paper presents demographics for study participants.

4.1. The participants' Demographics: The Sample Characteristics of All Key Informant Interview Participants

The study recruited a total of 48 key informant participants, 30 patients of the IHPs, 70% women and 30% men at the IHPs' shrines, and 18 participants for the three focus group discussions, each with six people (see table 1 below). The mean age for the participants was 43 years and the mean number of years of formal education was nine. All of them were Shona-speaking. Of the 51, participants approached, 48 accepted to take part as the key informants; 3 declined because they were too busy at the time and one was cognitively impaired. The sample approximates many other studies that involved mental health, with more women than men in both subsamples.

Table 1. *Sample characteristics of IHPs' patients and community members.*

	No	% Males	% Females	Range	Mean education	Language Spoken
Patients' sub-sample	30	30	70	18yrs-56yrs	10	Shona
Community members' sub-sample	18	33	67	70yrs-21yrs	11	Shona

From the focus group discussions and the one-on-one key informant interviews, the reasons emerged to explain why some (but not all) Zimbabwean patients use IH, for mental health disorders.

4.2. The Rationale for Using Indigenous Healing

4.2.1. Some (But Not All) IHPs' Diagnosis had No Matching Category in BT

The most popular reason (15out of 18) reported for depending on IH can be described as treatment specificity [4]. Data confirms the selected theoretical framework, EMI for this study [29]. The patients are presenting with mental disorders where there is not a category to classify the kind of diagnosis from a biomedical point of view [26]. Patients understand their illnesses in a culturally specific way that does not correspond with biomedical explanations of illness [39]. They discuss illnesses that are not considered pathological in biomedicine and only trust IHPs with their care. A female community member who had the depression-like symptoms and was seeing an herbalist observed,

"I have munyama (bad luck) and I find it difficult to get married for me to go to hospital complaining that I need to get married, is not possible. The people will actually laugh at me (Community member)".

Patients believe that mental illness has supernatural causes, and it follows that mental illness with a supernatural cause can only be treated in IH [23]. For this reason, a majority of Zimbabweans seek therapy in IH similar to what obtains to Australian Aborigines and IH attract more patients than those who go to see BT specialists [41]. It is clear that any therapy program that seeks to attract a majority of Zimbabweans should address patients' cultural belief systems. The result corroborates other findings in Africa and other resource poor countries [42].

4.2.2. Witchcraft Problems *(Huroyi)*

Among patients' participants, 28 out 30 mentioned they visit indigenous healers because they perceive only IH can resolve *huroyi* (witchcraft problems), or mysterious or unidentified illnesses where nobody understands the illness [5]. A 40-year-old female community member observed,

If the illness arises from culture (mushonga wechibhoyi), or after getting beaten by zvidhoma (goblins), which are mystic creatures used for evil purposes, a person may go to a doctor who will obviously fail to see what happened because the doctors don't believe in these things (Community member).

Witchcraft is perceived to be real in Africa and other low-income countries and is believed to result in mental disorders [23]. IHPs address witchcraft issues when treating mental disorders among the majority of Zimbabweans similar to what obtains among Australian Aborigines. This fulfilled the TRA/TPB: Behavioural intentions to reduce witchcraft risk under the theoretical frameworks

This attracts more patients than those who consult in BTPs [40]. The study shows that witchcraft is perceived to play a major role in motivating patients to seek therapy for mental disorders in IH [23]. Ironically, witchcraft is outlawed in Zimbabwe, but this category continues to be used as an important way of explaining misfortune by people and it requires attention [43]. A similar result has been found in other Sub-Saharan African countries, for example Malawi, Uganda and Zambia, where many authors note the significant similarities in beliefs relating to indigenous healing, religion and health [44, 45, 46]. Although literature demonstrates that while views about the role of witchcraft in mental disorders are changing and the spiritual causal models are becoming increasingly unimportant in urban settings, the majority of patients who live in rural settings still hold onto these beliefs in witchcraft and this issue is central in explaining health-seeking behaviour of patients in IH [46].

4.2.3. Chronic Mental Health Problems

Some patients (8 out of 30) reported they consult doctors without any progress to their mental health conditions, but after using herbs from an indigenous healer, they recovered. A few patients (4 out of 30) testify that they are later successfully treated by IHPs. There is a lot of oral evidence in the international communities for support of the local healer's success where biomedical medicine is failing (Struthers & Eschiti, 2004) This was noted by a 29-year-old male patient who could not talk in the previous month and the cause had not been established in BT:

It was after I had gone to the clinic being ill, when the nurses had tried everything at the clinic and failed. I was not given a diagnosis. Someone told me about an IHP (n'anga) who could help. I then came for treatment to the IHP and my condition has been treated successfully (Patient).

Data suggests that IHPs are using herbs to treat problems which BT specialists are perceived to fail to treat, and this can explain why majority of Zimbabweans still trust IHPs and use IHPs' approach concurrently with BT specialists, or one after the other. The result supported findings from other studies [41]. This means IHPs are complementing services of BT specialists. This relationship should be encouraged as it is the basis for partnership. More research is required to test the effectiveness of IHPs' herbs before they can be adopted into formal therapy.

4.2.4. The Perception that Only IHP Could Fix the Spiritual Problem

Many community members (16 out 18) reported that they were coming to see the IHPs instead of going to the clinic because they were under the impression that only the IHPs could fix their problems [41]. This was noted by a 37-year-old female community member, who was living with a 42-year old female patient with psychosis-like symptoms who said: "When we go to see the doctors, we are told the diagnosis is not clear, because the person is perceived to be molested by evil spirits". Since aetiology of mental illnesses is understood to be strongly linked to the spiritual factors by majority of the Zimbabweans. Spiritual problems are believed to respond more positively to methods of the IH rather than to biomedicine, because the doctors often failed to establish the causes where there were suspected spiritual issues of relating to evil (Sandlana & Mtetwa, 2008). It is clear that majority of Zimbabweans will continue to use IHPs in order to deal with causes of their illnesses [3].

4.2.5. IHPs' Use of Rituals in the Treatment Which Met Patients' Cultural Expectations

In addition, many community members (13 out of 18) mentioned that they are attracted by the IHPs' ritualistic techniques which meet their cultural expectations as regards mental health in terms of causes and management of the same. They perceive rituals as effective. For example, many community members reported the use of the charms as therapeutic. Many patients (14 out of 18) perceive *nyora (*incisions and rubbing in of herbs through openings), is a good method of healing mental illness. The results support the previous findings from the international community [47]. The IH was thus a useful resource for increasing the utilization of the mental health resources [49]. There is need to harness the indigenous health care services with biomedicine which is likely to facilitate the patient's "buy-in" to therapy because it establishes a cultural bridge that links the patient's cultural beliefs to treatment [50].

Furthermore, the findings suggest that people chose IH because of their perceptions of what works in the approach which includes indigenous healer's communication skills which are appropriate to their culture. People's perceptions were critical to the mental health service utilisation of the IHPs and many people came to utilise the IHPs' service because their expectations were met. However, research elsewhere highlights that people change their beliefs as they met the new experiences over time. A study on the attributions, for example, shows how patients' understandings of services change over time, for example, they might re-attribute their illness to biological causes [22]. There is need to do research to corroborate these findings.

4.2.6. Religious Faith as a Motivating Factor

All religious patients (6 out 6) mentioned religious faith (*Chitendero muna Mwari)* as therapeutic and they had a strong belief in prayer and hope in God, as observed by a 38-year-old Christian patient who stated: "*Minamato* (The prayers) are healing. If you are instructed to pray and you believe that God will help you, the prayer will work for you. It is your belief… My faith improved my health. I am feeling much better now.

The role of conviction is a strong therapeutic element which drove patients to IHPs' treatment. There is need to do research in order to establish how religious groups should be integrated into therapy programmes.

4.2.7. IHP's Communication Was Culturally Appropriate for the Patients' Mental Health Care Needs

Almost all patients (29 out 30) said IHPs communicated appropriately with the patients *(kutaura zvinonzwika)* and when consulting the IHPs addressed their spiritual needs; i.e. they treated the mind, body and spirit. A 26-year-old female community member who relied on IH for her anxiety-like symptoms noted:

Some IHPs may start by chanting (kudeketera) to the ancestral spirits for their support in the treatment before they start the healing process. This is different from the hospital set up where ancestors are not recognized and no nurse will refer you to any of your ancestors for their protection (kudeketera kumidzimu). It feels good to be connected with one's ancestors (midzimu) and I now feel better (Community member, FGD1).

The concept of *"midzimu"* (spiritual ancestors) is a sacred issue among the majority of Zimbabweans and because IHPs are part of the community. They communicate well with the people, consequently, attracting many more patients than those going for the BTPs. In addition, many patients (23 out of 30) believed that the IHPs offered more user-friendly services than the BTPs. A 32-year-old woman from the community who depended on IH despite the fact that her family preferred care from the BT noted: "I am given the special care and I receive their total attention since they are only attending to me as an individual" (Community, FGD 3)". IHPs' customer care is considered appropriate by majority of Zimbabweans and many patients depend on IHPs than BT and IHPs communicate better with patients than the BTPs [2].

4.2.8. Issues with Biomedical Therapy

However, a few patients (5 out of 30) highlighted their mistrust of BT as the reason that drove them to visit IH [2]. In visiting the indigenous healers, many patients reported that they were trying to avoid the perceived numerous problems in BT. One 26-year-old female patient stated:

If you go to hospital, they use chemotherapy. I don't want to be burnt with chemotherapy and have my breast removed because I have seen many people who had cancer but got treatment through the indigenous healing. They still have their breasts in spite of the cancer.

For example, (6 out of 30) patients mentioned that they feared the BT procedures similar to what Ivan Illich describes as "clinical iatrogenesis": that visiting the clinic can make their condition worse, that chemotherapy at the hospital can be toxic, or amputation of a body part [52]. The patients had fears about dependency on BTPs and these fears led them to reliance on IH instead. This is especially true for mental health in Zimbabwe because most participants fear that dependency on BTPs will lead to them being institutionalised which to them is akin to imprisonment. Institutionalisation in public mental health institutions is related to stigma and many are fearful of being locked with *'vanhu vanopenga'* (people who are mad).

4.2.9. The IH as a Treatment Approach of Choice by Default, Is Affordable and Through Direct Referrals

IH was noted to be the only healing approach available in some remote areas of the country which is similar to the international findings [52]. A few patients (2 out of 30) perceived the lack of an alternative therapy to IH, such as biomedicine, as their reason for using the IH. This was noted

by a 36-year-old male patient with anxiety-like symptoms who said: "I opted for an indigenous healer because in my area there wasn't any clinic nearby. There were no BT health providers except for the indigenous healers". In many remote areas in Zimbabwe and other low-income countries, many patients walk for many kilometres to get to a clinic [52]. This has forced them to rely on IHPs who are readily available and are also affordable.

Most patients also highlighted economic factors such as affordability and access as critical to their choice of therapy in indigenous healing [52]. Unlike the high costs of biomedicine that limit the access to treatment, many community members (16 out of 18) reported that IH was accessible to patients since one could pay according to one's means and still get the treatment [54]. In contrast, clinics demand cash even when their medication did not work. However, in IH one paid the healer after one had recovered from the illness [9]. A 46-year-old female community member who had a relative with the depression-like symptoms confirmed this:

With the IHP, you can pay what you are capable of paying, if you want to be seen by the IHPs. It may be as low as $10.00. You can plead that you have only $5.00 and once you put it in a plate, the healing process starts. You will then come to pay later when the mental illness is cured unlike with the BTPs where a session costs $100.00 or more (Community member, FGD 2).

It is affordability and accessibility which drive most patients to IHPs besides, of course, cultural beliefs [55]. However, not all visitors to IHPs are voluntary since some were referred from other sources as outlined in the section below.

Many patients (16 out 30) mentioned that they came to consult indigenous healers after a referral by someone who knew a patient who had been treated successfully or another healing agent who was either a faith healer, nurse, or a doctor, and was networking with the indigenous healers [46]. This was noted by a female patient, of 32 years of age who perceived her mental disorder as cultural *(chivanhu)*; "What happened was that when I went to hospital, I was told that Ms. X., it looks like your illness is *chivanhu* (traditional). Some nurses can tell you; this is *chivanhu* (traditional) go and see the IHP X or faith healer Y". This was good for the patients who enjoy holistic treatment [5]. The data, in revealing that some indigenous healers (but not all) refer their patients to the clinic, or the other healing providers if it was necessary, suggests that people using IHPs are ready to partner with the BT. However, the findings, where some IHPs did not allow their patients to mix their herbs with bio medicinal drugs, confirmed the results from the previous research which found some indigenous healers are not willing to refer their patients to hospitals [48]; [57]. In the past, spiritualists, patients and their relatives perceived mental illness as spiritual in etiology and they believe the treatment offered in hospitals for mental disorders was ineffective as a cure for spiritual problems [57]. Whatever the reason, the positive change in attitude towards the BT creates a vantage platform for the compatibility between the IH with biomedicine.

5. Conclusion and Recommendations

We aimed to assess perceptions and motivations of communities in seeking IH in cases of mental illness in Zimbabwe in order to understand health seeking behaviour of people in IHPs in mental health care in Zimbabwe. The paper revealed that the major reasons which lead the majority of Zimbabweans to rely IH are: that IHPs provide care for diagnosis which has no match in BTPs for the majority of Zimbabweans, similar to what happens internationally. The IHPs also address the patients' cultural concerns when dealing with the mental disorders as observed among the majority of the research participants which is similar to what obtains among the Australian Aborigines. This attracts many patients more than those who consult the BTPs. IHPs, in addition, use herbs to treat problems which BTPs fail to treat, and this could explain why the majority of the Zimbabweans depend on IHPs' approach concurrently with BTPs, or IHPs first, then BTPs or vice versa. The majority of Zimbabweans will continue to rely on IHPs in order to deal with the causes of their illnesses. The people's perceptions are critical to mental health service utilisation of IHPs and many people have come to utilise IHPs' services because their expectations are met. The role of conviction is a strong therapeutic element which drives patients to IHPs' treatment. In many remote areas in Zimbabwe and other low-income countries, many patients would walk long distances before accessing a clinic which forced them to rely on IHPs who are readily available. It is clear therefore that IHPs offered unique attractions to their patients. In providing the service that catered for supernatural factors, the approach met the cultural expectations of the patients unlike BT specialists who fail to cater for this service. The IHPs are an indispensable component of mental health care among the majority of patients in resource poor countries, including in Zimbabwe. IHPs should therefore be harnessed with BT specialists in order to create holistic therapy which cater for the mind-body and spirit. More research is required to establish the effectiveness of motivations.

Based on these conclusions, the study makes recommendations for practice and future studies detailed below.

1. The associations for the two approaches should organise training workshops and seminars on mental health care in Zimbabwe for these IHPs and BTPs. The workshops will help the mental health providers from the BT approaches to appreciate IH's input in mental health care. It is envisaged that health providers will then understand the strengths of IH approach in mental health care.
2. The BTPs should appreciate IH methods and allow them to practice within reasonable bounds, for example letting the IHPs treat common mental disorders,

including the interpersonal, cultural and spiritual conditions.

3. The government of Zimbabwe should create a department under mental health dedicated for IH systems of mental health care.
4. It is within the bounds of possibility that BT therapists be taught some IHP's positive skills and their helping techniques. For example, the rituals and prayers might be integrated into counselling if need be.
5. The therapists should try to understand mental health illnesses from a patient's cultural perspective which might help in the management of patients at the primary care level, for example the use of prayer and other rituals may be adopted in therapy.
6. Therapists should explore spiritual and cultural context of a patient to understand and appreciate the context of the patient's problems when a person develops mental disorders such as schizophrenia, depression or anxiety, if they are to manage the majority of Zimbabweans effectively.
7. Furthermore, the therapists should be encouraged to be non-judgmental, respect and allow patients to attend to their perceived supernatural factors, for example, respect for one's ancestors or making prayers to God, for this is likely to improve motivation of people with mental health issues to seek therapy in mental health facilities.
8. Nurses should provide adequate information to patients about side-effects of BTPs' medication of mental disorders and medical procedures should be properly explained to patients in order to avoid situations when patients develop unnecessary fears for BTPs' medical procedures. The information should be available at all levels where treatment is delivered. In their training, the nurses should include knowledge, attitudes and practices of communities in mental health care from the perspective of indigenous healing practices. IHPs should help in the process of training of nurses so they can input their approach. Nurses should work together with indigenous practitioners and tolerate IHPs within bounds of their capabilities.

The study has revealed that the IHPs should be recognized and integrated with BTPs in mental health treatment so that there is inclusion of indigenous healing values and beliefs in order to address patients' physical, mental and spiritual/cultural needs. The policy makers should develop policies and publish them in national guidelines to achieve holistic treatment which will improve on the practical aspects of mental health delivery services. Further studies will be needed to identify significant motivating features in IH in order to integrate them in therapy.

Conflict of Interest

All the authors do not have any possible conflicts of interest.

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