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The Practices of Indigenous Healing Practitioners in Mental Health Care at Community Level for Mental Disorders in Zimbabwe

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Abstract

We aimed to investigate perceptions of the IH practices in order to understand the role of the IHPs in mental health care. We recruited a total of 60 key informant participants, 30 IHPs, and 30 patients of the IHPs, at the IHPs' shrines in a settlement 16 kilometres north-east of Harare, in Zimbabwe. Gathered data were coded using constant comparison method with multiple members of the research team, enhancing validity and reliability. Our results revealed that there were many healing orders in Zimbabwe and the main ones were the herbalists, the spirit mediums, the diviners and the faith healers. The IHPs saw patients with mental disorders that were consistent with the BT diagnoses, and others with disorders that were non-existent in the BT. Common disorders to both IHPs and BTPs were the schizophrenia *(kurasikapfungwa)*, depression *(kusuruvara)*, anxiety *(kufunganya),* etc. Disorders unique to IHPs included supernatural, cultural or social problems and examples were *mamhepo* (bad airs), witchcraft *(zvehuroyi)* perceived to arise from evil minded people, and *ngozi* (aggrieved spirit). The IHPs used unique healing methods which included use of herbs, healing spirit, including counselling patients which involved use of rituals and prayer. On discharge and follow up, the patient was either given the medication to use later at their house; or a date to come for review; or a referral to a hospital for further management. In providing the service that catered for the supernatural factors, the approach met the cultural expectations of the patients unlike the BTPs who failed to cater for this service. The IHPs therefore, provided a unique therapy to patients in Zimbabwe. The IHPs should therefore be yoked with the BTPs in order to create a holistic therapy which cater for the body-mind and spirit. More research is required to test the IHPs' characteristics before their adoption into therapy.

Keywords

Indigenous Healing, Indigenous Healing Practitioners, Mental Health Care, Community Level, Mental Disorders

1. Introduction

Indigenous healing (IH) is a major resource in the management of mental health care in Africa and other resource poor settings [1]. In sub-Saharan Africa, 80% of the population continues to use IH as a resource for primary health care, including treatment of mental illnesses [2]. This is in spite of the presence of the evidence-based Biomedical Therapies (BT), who are accused of being culturally insensitive. The majority of people use Indigenous Healing Practitioners (IHPs) for their mental health care, but no one understands the IHPs' healing characteristics which attract so many people. This has created problems in the delivery of mental health service namely: patients' reluctance to use BT, shortage of specialists and side lining of IH because it is

unproven within the mental health service [3]. IH has potential to increase the uptake of mental health service once the healing characteristics are known. This paper therefore analysed the IH characteristics in order to help readers understand the role of IHPs in mental health care. First, the paper will define important terms, beginning with IHP.

There is no one definition of an IHP in Africa [4]. How an IHP is defined depends on the social, cultural and spiritual background of the person [5]. An IHP may be seen as a person who is recognized by the community in which one lives as competent to provide health care by using vegetable, animal, and mineral substances and certain other methods based on social, cultural and religious backgrounds, as well as the knowledge, attitudes and beliefs that are prevalent in the community regarding the physical, mental and social wellbeing and causation of disease and disability [6]. They may base their powers or practice on religion, the supernatural, experience, apprenticeship or family heritage [7]. IHPs may be males or females and are usually mature [8].

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, as well as to treat, diagnose or prevent illness [9]. In IH, ill health and other forms of misfortune are believed to be caused by either societal challenges (unemployment, poverty, etc.), or by supernatural causes (gods, spirits, ancestral spirits) or natural causes (accidents, weather, living environment, heritage, etc. [10]. IHPs are the major force driving mental health service in resource poor countries, but a lot needs to be known about what they do.

Mental disorders include a wide range of the mental health problems that present in primary care as an important source of burden worldwide, including Zimbabwe [11]. 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 [12]. Although primary care has an important role to play in the management of the more severe disorders, the common mental disorders are generally viewed as the main remit of the primary care [13]. In view of the mental health burden worldwide, the World Health Organization is appealing to countries to increase their support for the mental health treatment services and has made a key recommendation that the treatment be based within primary care [14]. In terms of disease progression, primary care treatment may be viewed as serving a preventive role to control the diseases from becoming severe long-term mental health disorders [12]. This is desirable because the preventive measures, apart from being better than cure, do not demand the services of specialists; they use readily available resources, including IHPs, and prevent the disease from progressing to the stages that attract specialist services [15].

1.1. Study Background

Studies suggest that there are high rates of psychopathology in Zimbabwe [16]. For example, even in the 1990s and prior to the worst of the decline in Zimbabwe, local studies have shown that the prevalence of psychological disorders such as depression and anxiety varied from 10.5% in primary care [17] to about 26% in rural and urban settings and 41% at two primary clinics in the suburbs of Harare [18]. In another study, 205 late term pregnant women were screened for mental disorders. Of these, 44 (46%) of 95 women who were considered as high risk and 9% of 110 women who were considered low-risk met criteria for depression [19]. The prevalence of depression in the rural community near Harare, the capital city of Zimbabwe, was 31% [20]. About 10-20% of patients from other provinces and health centres suffered from common mental disorders which included anxiety and depression [21]. 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. WHO representative in Zimbabwe, David Okello, has described the situation as a "crisis", which calls for urgent measures to reverse it. These are the gaps our paper is trying to address.

Currently, IH is being side-lined and there are problems in the delivery of mental health service in Zimbabwe namely: limited access for patients to mental health care due to the inadequate supply of mental health specialists, or people's reluctance to use BT since it is considered not culturally competent, and often patients resort to using alternative health care, leading to loss of statistics that also help in the surveillance studies to control the mental health disease burden [21]. In order to address the global burden of mental health issues in low-income countries (LICs), the World Health Organization has called for the optimization of all available resources to bolster the delivery of mental health treatment in primary care [11]. The mental health Global Action Program, which was launched in 2006 also focuses on forging strategic partnerships with local resources to enhance countries' capacity to combat stigma, to reduce the burden of mental disorders and promote health [22]. Unfortunately, IH has not been fully exploited in the delivery of mental health services.

Although IH has been studied in general in Zimbabwe and other LICs [5]; [23] and [24]; only a few studies have looked at IH characteristics,[25]. Once the information is known, it can be used to map out the role of IH which can be harnessed with BT in order to deliver a culturally appropriate mental health therapy. Despite some progress on evaluating IH therapies [26], the IHPs' work in mental health care is not known [31]. In addition, while it is generally known that many patients consult IHPs, IH characteristics are not known, or what characteristics may be adopted in therapy [27].

We analysed IH characteristics in order to understand the role of IHPs in mental health service. It is expected that in future research, the outcome will be twined with BT to make therapy culturally sensitive to users, thereby increasing the

user uptake of mental health service through the use of non-specialised IHPs and mental health workers in resource poor settings. Therefore, evidence from this research will be useful to inform future studies in order to help policy makers about the IH characteristics in the treatment of the common mental disorders in Zimbabwe to reduce the burden of disease.

1.2. Literature Review

In African Indigenous Healing (AIH), health care services are provided through tradition and culture prescribed under a particular philosophy, i.e. *ubuntu* or *unhu* [28]. These are norms, taboos, tradition and culture, which are the cornerstones of clinical practice of AIH, which are the major reasons for the acceptability of AIHPs in the community they serve [29]. The philosophical clinical care embedded in these customs, culture and taboos *(Ubuntu Philosophy)* have contributed to making AIH acceptable and hence highly demanded by the people [30]. This section will discuss the practices of AIH in mental health care.

1.2.1. Indigenous Healing in African Countries, Including Zimbabwe

Unlike the modern BTs which are based on empirical science, AIH practices are based on ancestry reverence and *ubuntu* [10]. *Ubuntu* is an African word depicting humanity and compassion. In *Ubuntu,* people hold the belief that the mental health of individuals as well as of the community is influenced by the ancestors [31]. Central to AIH is a view that there is a connection between the living and the dead. The rituals are the means of communication in the relationships [32]. In AIH people believe they connect with their ancestors via concrete literal means [33]. Examples are shown during the healing of an individual through community participation; and dancing and drumming which is thought to link the body and the mind. In addition, people also believe they can connect with their ancestors through dreams [6]. Before a full discussion of the practices of AIH, an overview of the aetiology and associated factors of mental disorders in Africa provides a springboard for that discussion.

1.2.2. The Etiology of Mental Disorders from an African Indigenous Healing Perspective

In African setting, the causes for mental illness include among other things, "*mamhepo*" (bad airs), natural objects, such as "*mweya yakaipa inopisa yakanaka*" (bad elements in the air that burn or overpower the good, "mheni" *(lightning)*, "*zvipotswa*" (a rheumatic and arthritic type of illness used to strike others), and *"mweya yakayipa"* (environmental air) [65]. The list also includes cognitive processes of evil-minded people. The next level of causes is spiritual which includes elements such as the devil, or demons, *mashavi,* (spiritual possession), *"varoyi"* (witches), and sorcerers [11]

1.2.3. A Consultation in Indigenous Healing

A consultation with a IHP is never done alone; the patient is always accompanied by at least one significant other [6]. Rituals, for an example, *intlombe*, are always performed with members of the affected individual's family and people from the community [24]. The *intlombe* can be regarded as special form of group psychotherapy, though with *intlombe* the focus for treatment is restricted to the client and not to any other person in the group. Sandlana and Mtetwa compare the African *intlombe* members with the biomedical group therapy process relationship, and point to the fact that the *intlombe* members are related [6]. While BT group processes are negotiated, the IHP has more control of group processes [10].

1.2.4. Diagnosis

The approach to diagnosis is generally methodical. In a study by Hewson (2010) of traditional healers in Southern Africa, it was shown that the most common means to diagnose was to observe for the signs of mental illness shown above [34]. In addition, other healers used spirit inspection, or bones [35]. While the traditional healer is in a trance or state of possession, he/she reveals the causes of the illness. While the diviners often used snuff and the medium spirits used the healing spirits in diagnosis, the herbalists used some herbs to diagnose patients' illnesses. The same herbs were used in treatment of mental problems [11].

1.2.5. Treatment Techniques

Based on the notion of supernatural causality, the treatment processes involved "freeing" the afflicted individual from the possession of evil spirits [36]. The IHP prescribes medication with herbs, head cleaning with potions, concoctions massaged into the affected parts, and symbolic sacrifices [37]. There are several other distinguishing features of African healing: oral legends, word-magic, abreaction (which takes different and complex cult forms such as rituals, symbolic sacrifices, suggestion, and dancing), detoxification, possession and shamanism (exorcism) [10]. However, in cross-cultural discussion of psychotherapeutic process, Frank in Berg [10] notes the vital role played by hope in achieving success in any therapeutic transaction [10]. Calestro and Frank in Berg [10] point to the expectant faith as another crucial element. The importance of hope and faith is fully recognized in African healing. According to Berg [10] (p.321), "faith…is half the battle toward cure" [10]. This idea is well illustrated in symbolic sacrifices.

Symbolic sacrifices or the sacrificial displacement of attack are prominent and involve the killing of designated animals to propitiate the deities. The theoretical underpinnings of the beliefs connected with sacrifices are clearly stated by Wittbower and Warns in Berg [10]:

Projection of internal badness unto vicious deities; displacement of internal badness, be it sin or sickness, on the scapegoat or any other sacrificial animal, displacement of attack, that is the killing of animal in lieu of a person; and penance by sacrifice [10 p.114].

The blood of sacrificial animals appeases the gods while the flesh is generally eaten by the people present during the sacrifice. This also ensures that a link between the

supernatural and the natural is maintained Green, E. C. (2000). Berg [10] further observed that rituals also help traditional people to manage satisfactorily their relations with gods, nature and fellow human beings. In African tradition, there are no set times for rituals as in the calendar year of religious system. The occurrence of rituals is individually determined and several occasions are marked by a ritual: life cycle rituals of birth, initiation, marriage and death; to thank the ancestors for the successful accomplishment of a task; and when illness strikes. Rituals also serve other functions in AIH [10].

Related to rituals is a process known as detoxification. Detoxification is used as treatment for specific physical and psychological ailments (Levers, 2006). Headaches are often treated by this method [38]. Another illustration is drawn from the Yoruba in Nigeria, who implicate bad blood in the onset of mental illness [7]. Letting the bad blood out of the victim through razor cuts (detoxification) is thus considered curative [38]. However, rather than let the patient merely bleed, herbs are usually rubbed into the cuts [10]. In contrast to pain inducing procedures such as detoxification, are pleasurable activities such as dance and music. According to Buhrmann (2001, 1991) and Kelly (1994), African traditional dance and music play a major role in the restoration of the equilibrium. Sandlana & Mtetwa (2008) describes the African traditional dance and music as central to the treatment of all clients especially those with *ukuthwasa* (a call by ancestor to be a traditional healer) [6]. Sandlana (2002) views it as a technique in which body, mind and spirit, and the conscious and the unconscious, are expressed [39]. The accompanying rhythm is seen as a way of projecting and expressing certain phenomena of the mind so as to organize and channel the life energy into forms of activity, whether mental or physical.

Central to most forms of traditional therapy is confession [40]. In Shona traditional medicine, confession (*kurewurura*) is required before certain kinds of healing service [36]. It is usually part of the cleansing ritual. Clients confess their misbehaviours. Despite these variations, there seems to be uniformity in terms of purpose and procedures. It is curious to note that therapy is drawn to a close in almost a similar fashion across the different AIHPs.

1.2.6. Discharge from Indigenous Healing

Once treatment has started, a long-standing relationship is established. However, therapy is terminated when the client feels well. Sometimes there is need for referral to other agencies. In their study, (Ovuga et al., 1999) found out that almost all the IHPs referred patients to district hospitals and many would refer them to other local IHPs if clients were failing to make progress in healing or became worse [41]. Only one IHP did not want any form of partnership with government workers and the same IHP was the only one who did not like to work with with other IHPs [41]. In the following chapter the thesis presents literature on the IAH potential to partner with BT in mental health care in the resource poor countries.

1.3. Conceptual Framework

This paper used the indigenous knowledge systems (IKS) to guide the study involving indigenous healing approach. Indigenous healing practices are formed and structured on the basis of knowledge systems passed through generations. The concept of IKS thus becomes an important prism through which to analyse the practices of IHPs. IH systems are deeply immersed in nature. Indigenous knowledge systems are a body of knowledge, or bodies of knowledge of the indigenous people of particular geographical areas that they have survived on for a very long time [42]. For rural and indigenous peoples, local knowledge informs decision-making about fundamental aspects of day to day life [43]. The emerging reality is that the complex ways of understanding nature is not restricted to science alone [44]. Societies from all parts of the world possess rich sets of experiences, understanding and explanations [45]. This knowledge is integral to a cultural complex that also encompasses language, systems of classification, resource use practices, social interactions, rituals and spirituality, including the indigenous healing [46]. These unique ways of knowing are important facets of the world's cultural diversity, and provide a foundation for locally- appropriate sustainable development [47]. The present section dwells on indigenous knowledge systems in order to contribute to the understanding of treatment by IHPs in mental health care.

2. Methods

From the 1st of June, 2018 to 31st December, 2018, we used 30 IHPs representing the indigenous healers of the different backgrounds; 6 herbalists, 6 spirit mediums, 6 diviners, 6 traditional birth attendants and 6 faith healers; including 30 patients of IHPs who were complaining of mental health problems to the IHPs for one on one interviews, making a total of 60 participants who represented the mixed views and came from the different regions of the country to settle in the seven wards of the Epworth community. The sample size was calculated using the information in Glaser & Strauss, 2009 and the participants were enrolled in the study [48]. This was done to minimize the sources of error in the subject selection and the comparability. However, the study would have some potential biases. The challenge was that out of the total participants that were approached, some accepted to take part as the key informants; but others declined because they were busy at the time, or for some other reasons. It was possible that the participants who declined to take part in the research would probably have some common characteristics which would affect the results [49]. However, such factors were born in mind when interpreting the results of the study.

We selected a qualitative design because this was appropriate in this study because little was known about the IH characteristics and a qualitative approach would allow for a deep, textured exploration of the perspectives on IH characteristics in Zimbabwe [50].

The study was conducted in Epworth, a large peri-urban settlement located 16 kilometres north-east of Harare. Epworth community is of very diverse cultural composition. In our study, understanding of the characteristics of IHPs emerged from the interviews with the participants and the direct observations of the IH practices. The study chose a case study because IH was of special interest and dealt with unique issues in the management of mental health [51]. This would help to understand the role of IH in the treatment of mental disorders within the local settings. A convenience sampling was used to recruit members of the IHPs while the snowballing was used to recruit the patients of the IHPs [52]. The participants were selected for the study if they spoke any of the indigenous language 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 the names of all of the indigenous healers in Epworth then tried to recruit those who were available with the assistance of the local community health workers [52]. As a result, the sample provided a nearly exhaustive coverage of the indigenous healers in Epworth. After locating the indigenous healers, the researcher explained the study objectives, procedures and obtained the informed consent from the indigenous healers before data was collected [48]. After the interviews with the indigenous healers, the researcher requested the indigenous healers for their permission to let the researcher recruit the patient participants at their healing shrines. To recruit the eligible patients, the researcher used the snowballing sampling strategy by first approaching one patient who had seen an IHP and requested them to link him to the next patient they knew had consulted an IHP [53]. The investigator explained the study objectives, procedures and obtained the informed consent from all the participants.

With two research assistants helping with notes taking and audio recording, the researcher made use of a number of data collection methods which included 30 key-informant interviews (KIIs) and 30 in-depth interviews (IDI) and observation for triangulation purposes. The researcher started collecting data by conducting the KIIs. The KIIs were conducted with 30 IHPs using the semi-structured interview guides on IH characteristics, the signs and symptoms of mental disorders, the mode of diagnosis and the treatment methods used in the IH and whether the IHPs would like to collaborate with the BT or not. The IHPs were included in the research because of their deep understanding of the indigenous medicine and would give details of the IH characteristics in the community.

The IDI were conducted with the 30 patients of the indigenous healers, using the semi-structured interview guides and the patients were chosen because they would give their perceptions on the use of the IH in the treatment of the mental disorders in Zimbabwe [53]. The interviews are often used to provide the context to the other data (such as the outcome data), offering a more complete picture of what happened in the program and why [54]. This study, explored the experiences of patients when they visited the IHPs and why they preferred the IHPs to BT specialists using the IDIs. The IDIs were used with patients of the IHPs in place of the focus groups because the patients consulting the IHPs 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. IDIs were conducted in the IHP's healing shrine and each interview lasted about an hour.

During the study period, the researcher made observations on the IHPs and their patients during their healing interactions. This was done in order to tap into issues that otherwise were hidden from insights of others. The researcher was involved in non-participant observations during the whole therapy process which lasted for about one hour and made thick descriptions of the whole process of the IH using an observation check list which included the different healing orders and the faith healers encountered, what happened during the process of spiritual possession, or in their induced state, and after the spiritual possession was over, the methods used for the diagnosis and the treatment, the healing tools used, how the treatment was drawn to a conclusion, if the IHPs collaborated among themselves or not, and whether they referred their patients to the biomedical providers or not, including any other relevant information [54]. The researcher also observed himself, in terms of his reactions during all the encounters [55]. This method was used to gain the first-hand information on IHPs' practices and the nature of mental disorders seen by IHPs and to triangulate the information with the other data obtained from the patients of IHPs; including the members of the community [52].

The KIIs and in-depth interviews were conducted in Shona, audio recorded, professionally transcribed, translated into English, and back-translated to Shona to check for consistency. The researcher pilot-tested the instruments using the interview guides and observational checklist. Data was collected from 5 IHPs and 5 patients of IHPs for the pilot study. After obtaining data from the respondents, the researcher then made some improvements to the interview guides and observational checklist [56]. 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 analysed using constant comparison method. The actual process of the data analysis usually took the form of clustering the similar data. In this study data was transcribed from the audio recorders and themes were developed from the transcripts. The analysis of the data was guided by the objectives.

The study was approved by the Chinhoyi University of Technology and the Medical Research Council of Zimbabwe (MRCZ). Approval was obtained from Kunaka District Hospital in Epworth and the ZINATHA before the start of the study. Informed consent was obtained from all the

participants, including permission to audio-record the interviews.

3. Findings and Discussion

We aimed to investigate perceptions of the IH practices in order to understand the role of the IHPs in mental health care, in a settlement 16 kilometres north-east of Harare. The results from direct observations by the investigator were fused with the responses from the KIIs of the IHPs and their patients. First, this section presents the demographics for the sample.

3.1. Characteristics of the IHPs, the Patients of IHPs, Community Members and Nurses

For the sample of IHPs, there was a total of 30 participants, 21 women and 9 men at the IHPs' shrines. The mean age for the 30 IHPs was 45years and the mean number of years of education was 10. There was a total of 30 patients of the IHPs, 20 women and 10 men at the IHPs' shrines. The mean age for the 30 patients was 45years and the mean number of years of education was 10 (Table 1). The study participants were similar to the people who normally consult in IH [11].

Table 1. *Sample characteristics.*

	No	% Males	% Females	Range	Mean education	Language Spoken	No declined	
IHPs' sub-sample	30	33	67	47years	31yrs-85yrs	Shona	0	1
Patients' sub-sample	30	30	70	18yrs-56yrs	10	Shona	1	

3.2. Types of the Indigenous Healers in Zimbabwe

From the observations made during the study period, the researcher noted that the patients consulted many different types of indigenous healers for their treatment of mental disorders similar to the results of the study by Patel et al., (2007) in Zimbabwe [11] or what Robertson (2006) found in South Africa [57], or Agara, Makanjuola & Morakinyo (2008) in Nigeria [58]. These were mainly herbalists, spirit mediums, diviners, traditional birth attendants and faith healers. Although faith healers were somewhat different from the other service providers, they were classified as the IHPs in this paper because of their similarities in their operations with the rest of the IHPs [6]. The researcher noted that many herbalists (5 out of 6), often called *vana godobori* (indigenous healers), reported that they were spiritually called to their profession, as they just received and administered the healing information in different ways on their patients. Many herbalists *(godobori)* (4 out of 6) reported they shared some of the functions of the diviners, but their concern was mainly with the healing of the illnesses. They prepared the concoctions, some of which had perceived protective value to ward off the evil spirits similar to the results of an international study in the United States of America [59]. For example, a 26-year-old male indigenous healer with 6 years' experience had this to say;

When a patient with (buka) anxiety disorder-like symptoms comes for the treatment, you mix the herbs and ask the patient to rub a little bit of the herbs on the fore-head to repel the evil spirits (Herbalist).

This implied the IHPs lacked an organised system of measurement of their herbs and the practice was likely to be a source of conflict with BTPs which would create some problems in the management of the mental disorders, if it was not resolved.

Unlike the herbalists, many spirit mediums *(masvikiro)* (4 out of 6) mentioned they were consulted for their guidance, management of misfortune and the treatment of mental illnesses [10]. They reported that they were "called" to their profession and were foretellers of the droughts, the diseases and the major events. They received the revelations from their ancestral spirits [35]. One 85-year-old male spirit medium *(svikiro)* seeing a patient with addiction problems observed; *"The spirit shows me the patient is losing his mind through abuse of alcohol (kurasika pfungwa nezvinodhakwa)"* (Spirit medium). The spirit mediums were useful in providing motivation therapy for those with alcohol abuse. The researcher also observed that a diviner carried a similar function to that of the spirit medium. The divination in *Un'anga* (IH) was a combination of astragyromancy, which was a method of reading dice marked with various symbols, numbers and letters, and cleromancy, or divination by lots, which was also called the interpretive divination [36].

In contrast to the above different groupings in IH, the researcher noted that all the faith healers (6 out 6) each belonged to a religious healing group. Unlike the indigenous healers who fell in the distinct healing orders, the researcher noted that all the faith healers from the Apostolic, the Pentecostal or the Independent churches referred to themselves as *muporofita* (faith healer), which like *n'anga* (IHPs), addressed both the physical and spiritual ailments as well as exorcising the evil spirits [34]. The patients reported that the faith healers were helping them effectively. While an IHP (*n'anga)* sought for a solution, which acceded to the demands of the spirits, a faith healer's solution was based on a belief in the healing power of the Christian God, which was above all other powers. The researcher observed that in addition to their different methods of diagnosis, a faith healer (*muporofita)* downplayed the role of the ancestral spirit (*mudzimu)* and rejected the indigenous and the biomedical medicine. Despite these differences, the faith healers (*maporofita)* were still grouped as the indigenous healers (*n'anga)* and were required to register with the Zimbabwe National Traditional Healers' Association (ZINATHA) [19]. Traditional birth attendants could be any member of any

healing order who specialised in assisting with delivery of pregnant women, or any member of the community who had experience in assisting deliveries [11]. The researcher found that the boundaries between the indigenous healers (*n'anga)* and the faith healers (*muporofita)* were extremely fluid. Many faith healers *(maporofita)* incorporated the ancestral spirits (*midzimu)* and numerous parishioners sought treatment from the clinics [6].

In religious healing, the faith healers mentioned they were responsible for the healing of the patients. The faith healers mentioned the religious healers in Zimbabwe were mainly influenced by the Christian missionaries, Arabic or Islamic teachings and indigenous cultures [10]. For example, the Zionist or African Apostolic Faith churches followed the customs of the indigenous rural society confirming the principles of IKS, but they had abandoned certain role boundaries and authority structures. All the faith healers mentioned that their difference with the IHPs was that their healing spirit was that of Jesus Christ and the Lord. For example, a 36-year-old female faith healer noted:

Only the Lord Jesus may direct us to pray for the patient's mental problem to go, or some water is given to the patient and the patient is freed from the evil spirits and blessed by the Lord (Faith Healer).

However, many faith healers mentioned that a few healers might practice witchcraft, in which case they were classed as witches. These were harmful people driven by the bitterness to hurt others (Helwig, 2010). They could be witches if they used their abilities for a wrong reason, such as killing people. The IHP's job in the past was to identify "who was the witch."

This was before the Witchcraft Suppression Act that prohibited folks from calling out a witch directly [60]. Their role was to identify this person but over time, the colonial government mislabelled them as witch-doctors and witches themselves. This reflected the polarisation of the two approaches with a bearing on the current negative tendency to refuse the adoption of IHPs as mental health providers (Sodi et al., 2011). In spite of the wrong labels of a witch doctor or a witch, many patients (25 out of 30) reported that they could choose to consult the indigenous healers for the different reasons [35]. This indicated that the patients had a strong belief and conviction in the IH system which in turn had a bearing on what should be considered in modifying mental health therapy for the majority of the patients in Zimbabwe [23].

3.3. The Mental Health Disorders Seen by the IHPs in Zimbabwe

Data suggested that the IHPs treated some mental disorders that were consistent with BT diagnoses, and other disorders that were non-existent in BT. The IHPs were complementing the BTPs in treating the common mental disorders which included schizophrenia *(Chirwere chepfungwa)*, depression *(kusuruvara)*, anxiety *(kufunganya),* post-traumatic stress disorder (PTSD), somatisation *(shungu)*, bipolar disorder *(mhengera mumba),* epilepsy *(tsviyo)* (Epilepsy is a physical disease in BT but the Shona people perceive it as a mental disorder), personality disorder *(kuzhangandira)* and substance abuse *(kuraradza nezvinodhaka)*, among others. However, there was a danger for the IHPs to treat epilepsy as a "spiritual issue" since it is a medical condition which requires specialists' services. There is a need to provide the IHPs with the right information so that they refer people with this condition to the specialists. The findings appear to corroborate many other studies done in low-income countries which demonstrate the role of IHPs in the treatment of the common mental disorders [11].

Data suggests that the IHPs are playing a unique but indispensable role which is complementary to BTPs in the treatment of mental disorders. These included some supernatural, cultural or social problems in IH. Therefore, the IHPs should not be side-lined as therapy was not complete without their input. A diligent search in the literature revealed no similar result. In addition, there was no suggestion that any one type of a healing order specialized on one type of a mental disorder as the patients simply went to an IHP depending on the focus of treatment i.e. whether they wanted to know the causes of their problems, in which case they went to a spirit medium or diviner or a faith healer; or simply wanted the herbs for treatment, and went to see an herbalist [36].

Data suggests that the IHPs commonly treated patients whose problems were mainly characterized by witchcraft/spiritual, and social or cultural factors, which were not recognised by BTPs. The results were similar to those obtained in other low-income countries [58]. Although these problems were refuted in BT as fiction, they were a reality in African settings. The mere rebuttal was not a solution because the issues were the source of the many common mental disorders and therefore needed attention. Measures were needed to address the issues which reflect the inferiority/superiority issues between IH and BT therapies [59]. The correction requires the balancing of power relations through mutual respect of each other's culture.

3.4. The IHPs' Assessment Methods of Mental Disorders in Zimbabwe

The methods used for the assessment of the patients' mental health problems depended on the healing order. However, all the IHPs used, in addition to their unique methods, similar diagnostic methods to the BT approach. The similar diagnostic methods of assessment to the BT approach focussed on the physical assessments of the patients using the experience and their knowledge about the physical conditions; and asking the visitors some questions about their mental experiences [34]. Almost all the IHPs (28 out of 30) reported assessing their patients*,* looking for the signs of mental distress such as grooming *(mapfekero),* looks*, mamiriro* (body posture) and asking questions about the patient's illness *(zvavainzwa)*. One 66-year-old female spirit medium who was seeing a patient with somatoform disorder-like symptoms noted: "*I examine the patient. I discuss with the patient in order to get a picture of the cause for the*

mental illness" (Spirit medium). The findings suggest that IHPs may be further trained with new methods in counselling. There is need for research in this area.

3.4.1. The Herbalists' Assessment Methods of Mental Disorders in Zimbabwe

All the herbalists (6 out 6) used some herbs to determine the patients' problem, or some medicine to direct the cause of the problem [11]. For example, a 26-year-old herbalist with 5 years' experience and was treating a patient with depression-like symptoms observed:

When we want to examine a person, we use some herbs for the diagnosis. We blow some water mixed with some herbs onto a patient's face sitting from a distance. I can tell from the patient's reactions, for example, feeling sulky or moody that the problem is [that their] *ancestors have turned against the patient* (Herbalist, 052).

The herbalists used some water mixed with some herbs and the product was blown onto a patient's face to interpret the patients' reaction for the diagnosis [36]. This probably sounded like the herbalist was basing the assessment from his knowledge and experience in assessment, which contrasted what the spirit mediums did.

3.4.2. The Spirit Mediums' Assessment Methods of Mental Disorders in Zimbabwe

To identify a patient's problem/s, the spirit mediums reported they used the power of the healing spirits or their ancestral spirits and they entered the experiential world of the patient and started feeling the problems as if they owned the patient's problems (*kuhakira)* [35]. While some spirit mediums were reading people's minds, or were given spiritual revelations through their eyes, or saw in one's mind; other spirit mediums were inspired to hear sounds or words about the type of illness or they used dream revelations [63]. For example, one 71-year-old female spirit medium seeing a patient noted;

I am given a diagnosis (chinetswa) in a dream (kurotswa). I am shown by an ancestral spirit (kuratidzwa nemudzimu) that a patient has fear (muchityu), palpitations (anorohwa nehana) and feels agitated (haana kudzikama). (Spirit medium)

The spirit mediums used the healing spirit to make a diagnosis of a patient's problems. However, it was not clear how the art could be transferable and if not, this might be of limited value to the mental health program in terms of continuity. Fortunately, the elders in the church were able to anoint a successor-faith healer. Similar to the role of spirit medium in assessment is the diviner.

3.4.3. The Diviners' Assessment Methods of Mental Disorders in Zimbabwe

Many diviners (5 out of 6) used the objects in the environment to guide their diagnosis, such as the money held by a team leader to inspect details about the problems; others threw some water with the medication mixed with snuff onto the visitor's face to determine the direction of the diagnosis [36]. The researcher noted that all the diviners (*vashoperi*) (6 out 6) used some physical tools, which were divining devices (*hakata*), to link with their healing spirits (*mudzimu or shavi*) to divine the cause/s of the illnesses [6]. The researcher observed there was enormous variation in the instruments and the techniques used for oracular divination, which included but were not limited to dreams, shells, stones, divination baskets, mirrors or even a glass of water. Unlike the medium spirit (*svikiro*), a diviner *(mushoperi)* did not enter a trance-like state. Instead, the researcher noted that a diviner *(mushoperi)* threw the divining devices (*hakata)* on the diving mat and examined how they fell to interpret messages from the healing spirits that answered the questions sought by a patient [11].

Most of the diviners (4 out of 6) mentioned using the environmental objects such as the shells, money, bones or herbs to guide their diagnosis depending on the training of the healer [38]. A healer, during his/her initiation ceremony, could train to use any one of the environmental objects [11] For example, many diviners (5 out of 6) mentioned they used the dice to determine the details about the patient's problems. A 26-year-old diviner with 5 years' experience and was throwing the dice in assessing a patient with depression-like symptoms observed:

...chitokadzi, chirume chinengwena chikadzi chirume kiya (Is this a female or male… Got the answer). *I can tell from the patient's reactions, for example, feeling sulky or moody that the problem is* [that their] *ancestors have turned against the patient and is depressed"* (Diviner, 053).

The diviners used the environmental objects such as the shells, money, bones or herbs to guide their diagnosis depending on the training of the healer and had to undergo a special training to be able to interpret the diving devices. We observed that patients' expectations were met as evidenced by their satisfaction with the explanations given by the IHP and they felt connected to their ancestral spirits. This was good potential for the partnership between the IHPs and the BTPs in the treatment of mental disorders.

3.4.4. The Faith Healers' Assessment Methods of Mental Disorders in Zimbabwe

To identify a patient's problem, all the faith healers (6 out 6) reported they used the power of God, or were shown the problems by the Holy Spirit and they entered the experiential world of a patient and started feeling the problems as if they owned the patient's problems (*kuhakira)*, or they were inspired to hear the sounds or words about the type of an illness, or they used the dream analysis [10]. For example, one 61-year-old female faith healer seeing a patient with anxiety-like symptoms chanted and noted;

Treasure Molia Vine Hrrrr Rabi…I am given this revelation (chiratidzo) in a dream (kurotswa). I am being shown by the Holy spirit (kuratidzwa nemudzimuunoyera) that this is the work of the evil spirits (mweya yakayipa) that has given rise to this psychosis (kurasha njere). (Faith Healer)

The faith healers used the spiritual powers and the process was awe-inspiring, naturally commanding respect to determine the diagnosis of a patient. Patients in turn expected a healer to talk about the spiritual world during the spiritual possession and faith healers' diagnosis was readily accepted. The next section addresses the IHPs' methods of treating mental disorders.

3.5. IHPs' Treatment Methods for Mental Disorders in Zimbabwe

The approach to Indigenous Healing (IH) was considered holistic because the approach focused on balancing the mind, body and the soul similar to what obtained in the international indigenous communities [60]. The treatment method used by the IHPs depended on the healing order whether it was the herbalist, spirit medium, diviner or faith healer and the treatment aimed at the restoration of the psychosocial equilibrium of the individual [64]. First, the thesis reports on the herbalists' methods of treatment.

3.5.1. The Herbalists' Treatment Methods for Mental Disorders in Zimbabwe

All the herbalists (6 out of 6) reported using a part of a tree, bush or grass for medicine. The parts used were the roots, bark, or leaves of a plant or a tree. The medicine was prepared by soaking the part into the water, burning the leaves or the bark into ashes, or grinding a plant part into powder [11]. Many herbalists (4 out of 6) reported using the herbs, to treat the mental disorders. For example, the Herbalists used the herbs to induce a patient to vomit (*kurutsisa*) in an effort to remove the dirt from the stomach, which they believed caused a mental disorder [61]. The herbs were administered through either the mouth, smoking, sniffing and rubbing the herbs on a patient's skin or inside a ritual incision (*nyora*). One herbalist (*godobori*) noted: *"When a patient comes for treatment, you ask him or her to rub a little bit of the herbs on the skin to ward off the evil spirits"* (Herbalist).

Furthermore, such instructions were vague, at least in terms of measurement and this was likely to attract some criticism from the BTPs. To administer the medicine, this was done through eating the food mixed with the powder or drinking some water that was mixed with the substance, or smearing the substance on the skin surface, smoking and sniffing, or steaming the herbs, or using the razor cuts to treat the different mental disorders [34]. Many different types of herbs were used and Table 2 below illustrates the herbs and the appropriate disorders that were used for the treatment of the different mental disorders. This was noted by an herbalist;

When a patient comes for treatment, you ask him or her to rub the herbs on the skin. Then we have herbs that we give them to eat which is in powder form to drive away the evil spirits which cause the mental illnesses (Herbalist).

Table 2. *Plants used in the treatment of mental disorders by indigenous healing practitioners.*

Disorder (Chirwere)	Local name	Scientific Name	Growth Form	Part Used	Purpose	Preparation	Area Source
Psychosis	Mushamba	Lannea discolor	Bush	Root	Mix with porridge	Soak roots in water	Mountains
Buka	Zinyamhunga	Prickly salvia	Bush	Leaves	Drinking water	Soak leaves	Waterlogged area
Kufunganya	Banana	*Musa acuminata*	Stalk	Flower bud	Drinking water	Soak in water	
Kurotomoka	Mutanda ngozi	psidium guajava	Tree	Bark	Smoking	Burning	mountains
Mhengeramumba	Mukunda n'anga	Batoka plum	Tree	Leaves	Steaming	Boiling water	Forest areas
Tsviyo	Mushamba	Lannea discolour	Bush	Root	Smearing face/ Mix with porridge	Soak roots in water	Mountains
Kuzhangandira	Muhacha and Mutondo	Mobola plum / Pterocarpus angolensis	Tree	Bark	Drinking	Grind and soak in water	Forest areas
Kuraradza	Potato	Solanum tuberosum	plant	tube	Mix drops with beer	Soak potato in water	
Chitsinga	Zinyamhunga	Prickly salvia	Tree	Fruits	Mix powder with porridge	Grind into powder	Forest
Ngozi	Mushamba and Mubayamhondoro	Lannea discolor and acacia karroo	Tree	Root	Mix 2 powders with porridge	Grind into powder	Forest
Mamhepo	Mukundan'anga	ectmih	Bush	Leaves	Mix with water for bathing	Grind into powder	Forests/Fields
Mweya Yakayipa	Mukunda n'anga		Bush	Leaves	Mix with water for bathing	Grind into powder	Forests/Fields
Zverudo	Mupfunye	Liquorice	Tree	Leaves	Mix with any food	Grind into fine power	Plains Liquorice
Munyama	Muvhereke		Bush	Roots and leaves	Mix powder with water and bath	Grind into fine power	Forests/Fields
Kuputsika	Any fallen branch of tree		Tree	Twigs and Leaves	Mix ashes with porridge	Burn into ashes	Forest

The herbalists had a deep repository of knowledge of the herbs which were used to cure the different mental disorders and therefore were a useful resource for mental health treatment. Many herbalists mentioned a situation similar to the effects of the drug interaction when using both the BT drugs and the IH herbs: if a patient was taking any BT medication (which was perceived to neutralize the power of the indigenous medicine) before they consulted the IH, they should stop that medication before using the indigenous herbs [7]. A 46-year-old healer noted; *"You don't mix my*

herbs (muti) with BT medicine; the healing spirit does not allow that, otherwise my herbs (muti) won't work" (Herbalist). While the herbalists were a source of the inspiration for the IHPs at least in terms of their use of the herbs for medicine, their practice of stopping the patients from using the BTPs' medicine was a risk for the patients and it required dialogue between the IHPs and BTPs. Next, the paper presents the spirit mediums' treatment methods.

3.5.2. The Spirit Mediums' Treatment Methods for Mental Disorders in Zimbabwe

Many spirit mediums reported were healing the patients using rituals such as the word power (where the healer commanded the perceived evil spirit to leave the patient) and bathing to prevent the evil spirits from following a patient [10]. In addition, the spirit mediums reported displaying what would be similar to "Rogerian" elements in biomedical counselling; kindness, giving a patient lots of time and letting a patient lead the conversation [62]. As an adjunct to counselling, the rituals play a significant role in indigenous healing and have a major role to play in therapy. Many healers reported they used *mhiko* (vows) in the treatment of mental disorders [6]. For example, once in a while, after a ritual at a river involving the killing of a goat or a chicken (the goat's blood was perceived to please the spirits *(mweya)* and the meat was shared by the group), they ordered the patients never to turn back before they reached their homes *(kusacheuka),* which was believed a symbol for respect for the spirits. Many healers exhorted if a patient adhered to a vow, the evil spirits would never touch him or her again.

Unlike the BTPs who acquired their expertise through training, many IHPs claimed to use the power of the healing spirits to treat the mental disorders [35]. Many IHPs reported they were possessed with a powerful spirit *(mhepo hobvu*) that fought and conquered the evil spirit in the patient, or they used the special powers to take over their patient's problems which they momentarily experienced as their own and drove the problems away [11]. (*kuhakira*). A 36-year-old spirit medium noted; *"If you are being led by a powerful spirit, that spirit will drive the evil spirits away"* (Spirit Medium). Their strong belief in spiritual protection was a major therapeutic factor in therapy. Unlike the spirits mediums who used mainly spiritual inspiration, the diviners used different approaches.

3.5.3. The Diviners' Treatment Methods for Mental Disorders in Zimbabwe

Many diviners (4 out of 6) made use of animal products in the treatment of mental disorders [10]. For example, to stop psychosis *(kupenga)*, the healers used the python fat *(mafuta eshato)* which they gave to their patients to smear on their skins. A 50-year old spirit medium observed:

If he is suffering from mental illness, I use mafuta eshato (the fat from a python). Pythons are viewed as calm creatures and python fat is perceived to calm an aggressive patient (Diviner).

In view of the fact that pythons were a protected species, there was need to find out how python farming could be encouraged to ensure continuous supply of IH medicine. Faith healers were more environmentally friendly than diviners in terms of what they used for treatment.

3.5.4. The Faith Healers' Treatment Methods for Mental Disorders in Zimbabwe

Similarly, most faith healers used the natural objects such as the stones, water, mobola plum (*muhacha)* leaves, honey, lemons, milk, as well as the horn-pod (*mutowa)* leaves and (powder-bark gardenia) *mutara* leaves to receive God's blessing; or the man-made products such as cooking oil or vaseline, and prayed over these before they gave them to their patients to eat, smear on the skin or drink to drive away the evil spirits [6]. A 49-year old faith healer observed; *"I am directed by the Holy Spirit. Sometimes I hear sounds/words directing me to use the stones, water and mutowa leaves to treat a mental disorder"* (Faith healer). The faith healers used the natural objects as treatment tools, but those objects had no therapeutic value in themselves except a to symbolize that the healer had faith in God. Faith played a central role in the treatment of mental disorders by faith healers. It was curious that all the IHPs used similar practices when it came to a termination of therapy.

3.6. Discharge from Therapy *(mhetamatare)* and Follow up

On discharge and the follow up, the patient was either given herbs to use later at their house; or a date to come for review; or a referral to a hospital for further management, e.g. where they would be given the herbs to calm them if they were violent since the indigenous healer was unable to do so; or the patient was referred to the other IHPs who were deemed more capable of treating the patient's condition [11]. For example, a 71-year-old female herbalist who was concluding the healing sessions with a patient who had been presenting with some cognitive impairment-like symptoms noted: *"I notice that your health is deteriorating a lot, I will send you to the hospital for some check-up" (Herbalist)* It was encouraging to note that the IHPs would turn to doctors for help, or advise that a patient needs to go to hospital when the problem was outside their area of expertise [63]. They found the 'severe mental complications' like schizophrenia and cognitive impairment more difficult to deal with and were naturally referred to the BTPs.

4. Conclusion

We aimed to investigate perceptions of the indigenous healing practices in order to understand the role of the IHPs in mental health care in Zimbabwe. The paper revealed that there were many healing orders in Zimbabwe and the main ones were the herbalists, the spirit mediums, the diviners and the faith healers. The IHPs treated some mental disorders that were consistent with the BT diagnoses, but others were non-existent in the BT. The findings therefore, revealed that the

IHPs used culturally appropriate diagnostic skills such as spiritual insights, dream analysis or environmental objects and their treatment techniques (herbal, spiritual, talking therapy, rituals, plant, animal products) were perceived tailor-made to address the supernatural conditions which were perceived to cause the mental disorders [11]. Although some of the techniques were regarded as unscientific by the academic and scientific communities, the approaches were appreciated by the patients. The IHPs perceived their approaches were beneficial and therapeutic to the mental health conditions of the indigenous patients, consequently, IHPs offered an important resource for psychosocial care among the participants. They appeared to contribute immensely to the management of the mental health burden in Zimbabwe, at least in terms of the high numbers of patients seen, and participants in this study expressed satisfaction with the care they received. The IHPs therefore, provided an indispensable part of therapy among the majority of the patients in Zimbabwe and in Africa. The IHPs should therefore be harnessed with the BTPs in order to create a holistic therapy which cater for the mind-body and spirit. More research is required before implementing IHPs' healing characteristics to establish the effectiveness their effectiveness.

5. Recommendations

Based on these conclusions, we made recommendations for practice and future studies. These are detailed below.

5.1. Recommendation for Indigenous Practitioners

There is need to train IHPs to appreciate BTPs' methods of healing to reduce the contradictions that exist between the two approaches. Indigenous practitioners too, must be trained to appreciate bio-medication. 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 two approaches to appreciate each other's input in mental health care. IHPs are encouraged to continue to refer patients requiring medical attention to BTPs. BTPs should in turn refer patients with perceived cultural and spiritual needs to IHPs. IHPs should desist from conflicting practices, such as stopping patients from taking BTPs' medication. 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.

5.2. Recommendation for Practice

The therapists should try to understand the 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. Therapists should explore the spiritual and cultural context of a patient to understand and appreciate the context of the patient's problems when a person develops the mental disorders such as schizophrenia, depression or anxiety, if they are to manage the majority of the Zimbabweans effectively. The BT therapists might also benefit from knowing that the herbs, talking and performing the rituals are important healing processes among the majority of the patients in Zimbabwe. 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 would likely improve the motivation of people with mental health issues to seek therapy from the mental health facilities.

The paper argues that the two approaches should partner in a relationship which should benefit the patient to access holistic therapy which is culturally sensitive. Since the strengths and weaknesses for each approach off-set each other to result in a culturally appropriate therapy when the two are merged, the paper argues that IHPs should partner with BTPs in a complementary way, with IHPs specializing on the issues which normally were not addressed by BTPs, for example, cultural/spiritual problems. The nurses and other mental health providers should embrace IHPs in order for them to incorporate local traditions and beliefs into the management of mental disorders.

5.3. Recommendation for Policy Makers

The paper has revealed that the IHPs should be recognized and integrated with the BTPs in mental health treatment so that there is inclusion of indigenous healing characteristics in order to address patients' physical, mental and spiritual/cultural needs. The policy makers should develop the policies and publish these policies in the national guidelines to incorporate the cultural and the spiritual needs of a patient to achieve holistic treatment which will improve on the practical aspects of the mental health delivery. The resources should be channelled towards the national programs such training the IHPs in counselling to empower the indigenous healers to address the spiritual, family and the social issues on a higher level.

5.4. Recommendation for Future Study

The paper demonstrated the role of the IHPs but there was need to know more detail about the IHPs' methods in terms of their efficacy. Quantitative studies should be done to establish the efficacy of the healing herbs and techniques before the partnership takes place.

Author Contributions

Conceptualized the study: LK; Designed the interview: LK; Conducted the interviews: LK; Participated in data analysis: LK; Drafted the manuscript: LK; Gave manuscript input: LK, MKC, JM.

Conflict of Interest Statement

All authors agree with the content of the manuscript and there are no conflicts of interests between/among them.

No material from other publications is reproduced in the manuscript.

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References

[1] Cross, T. L. (2003). Culture as a resource for mental health. *Cultural Diversity and Ethnic Minority Psychology*, *9* (4), 354.

[2] Machinga, M. (2011). Religion, health and healing in the traditional Shona culture of Zimbabwe. *Practical Matters*, *4*, 1–8.

[3] Liverpool, J., Alexander, R., Johnson, M., Ebba, E. K., Francis, S., & Liverpool, C. (2004). Western medicine and traditional healers: partners in the fight against HIV/AIDS. *Journal of the National Medical Association*, *96* (6), 822.

[4] Oliver, S. J. (2013). The role of traditional medicine practice in primary health care within Aboriginal Australia: a review of the literature. *Journal of Ethnobiology and Ethnomedicine*, *9* (1), 46. https://doi.org/10.1186/1746-4269-9-46

[5] Shoko, T. (2008). Karanga traditional medicine and healing. *African Journal of Traditional, Complementary and Alternative Medicines*, *4* (4), 501–509.

[6] Sandlana, N., & Mtetwa, D. (2008). African traditional and religious faith healing practices and the provision of psychological wellbeing among amaXhosa people. *Indilinga African Journal of Indigenous Knowledge Systems*, *7* (2), 119–131.

[7] Elujoba, A. A., Odeleye, O. M., & Ogunyemi, C. M. (2005). Review-Traditional medicine development for medical and dental primary health care delivery system in Africa. Retrieved from https://tspace.library.utoronto.ca/handle/1807/9189

[8] Ahmed, I. M., Bremer, J. J., Magzoub, M. M., & Nouri, A. M. (1999). Characteristics of visitors to traditional healers in central Sudan. Retrieved from http://apps.who.int/iris/handle/10665/118687

[9] Madiba, S. (2010). Are biomedicine health practitioners ready to collaborate with traditional health practitioners in HIV & AIDS care in Tutume sub district of Botswana. *African Journal of Traditional, Complementary and Alternative Medicines*, *7* (3). Retrieved from http://www.ajol.info/index.php/ajtcam/article/view/54779

[10] Berg, A. (2003). Ancestor reverence and mental health in South Africa. *Transcultural Psychiatry*, *40* (2), 194–207.

[11] Patel, V., Araya, R., Chatterjee, S., Chisholm, D., Cohen, A., De Silva, M., … van Ommeren, M. (2007). Treatment and prevention of mental disorders in low-income and middle-income countries. *The Lancet*, *370* (9591), 991–1005.

[12] Michaud, C. M., Murray, C. J., & Bloom, B. R. (2001). Burden of disease—implications for future research. *Jama*, *285* (5), 535–539.

[13] Watts, S. C., Bhutani, G. E., Stout, I. H., Ducker, G. M., Cleator, P. J., McGarry, J., & Day, M. (2002). Mental health in older adult recipients of primary care services: is depression the key issue? Identification, treatment and the general practitioner. *International Journal of Geriatric Psychiatry*, *17* (5), 427–437.

[14] Woldetsadik, M. A. (2015, March 10). Mental Health Care in Sub-Saharan Africa: Challenges and Opportunities. Retrieved April 5, 2018, from https://www.rand.org/blog/2015/03/mental-healthcare-in-sub-saharan-africa-challenges.html

[15] Cohen, A., Organization, W. H., Organization, W. H., & others. (2001). *The effectiveness of mental health services in primary care: the view from the developing world*. Mental Health Policy and Service Development, Department of Mental Health and Substance Dependence, Noncommunicable Diseases and Mental Health, World Health Organization.

[16] Chibanda, D., Mesu, P., Kajawu, L., Cowan, F., Araya, R., & Abas, M. A. (2011). Problem-solving therapy for depression and common mental disorders in Zimbabwe: piloting a task-shifting primary mental health care intervention in a population with a high prevalence of people living with HIV. *BTC Public Health*, *11* (1), 828.

[17] Reeler, A. P., Mbape, P., Matshona, J., Mhetura, J., & Hlatywayo, E. (2001). The prevalence and nature of disorders due to torture in Mashonaland Central Province, Zimbabwe. *Torture*, *11*, 4–9.

[18] Patel, V., Todd, C., Winston, M., Gwanzura, F., Simunyu, E., Acuda, W., & Mann, A. (1998). Outcome of common mental disorders in Harare, Zimbabwe. *The British Journal of Psychiatry*, *172* (1), 53–57.

[19] Patel, V., Musara, T., Butau, T., Maramba, P., & Fuyane, S. (1995). Concepts of mental illness and medical pluralism in Harare. *Psychological Medicine*, *25* (3), 485–493.

[20] Broadhead, J. C., & Abas, M. A. (1998). Life events, difficulties and depression among women in an urban setting in Zimbabwe. *Psychological Medicine*, *28* (01), 29–38.

[21] Patel, V., Simunyu, E., & Gwanzura, F. (1997). The pathways to primary mental health care in high-density suburbs in Harare, Zimbabwe. *Social Psychiatry and Psychiatric Epidemiology*, *32* (2), 97–103.

[22] Weine, S., Danieli, Y., Silove, D., Ommeren, M. V., Fairbank, J. A., & Saul, J. (2002). Guidelines for international training in mental health and psychosocial interventions for trauma exposed populations in clinical and community settings. *Psychiatry*, *65* (2), 156–164.

[23] Chitindingu, E., George, G., & Gow, J. (2014). A review of the integration of traditional, complementary and alternative medicine into the curriculum of South African medical schools. *BTC Medical Education*, *14* (1), 40.

[24] Patel, V., Todd, C., Winston, M., Gwanzura, F., Simunyu, E., Acuda, W., & Mann, A. (1997). Common mental disorders in primary care in Harare, Zimbabwe: associations and risk factors. *The British Journal of Psychiatry*, *171* (1), 60–64.

[25] Gunda, M. R. (2007). Christianity, Traditional Religion, and Healing in Zimbabwe: Exploring the Dimensions and Dynamics of Healing Among the Shona. *Swedish Missiological Themes*, *95* (3), 232.

[26] Nortje, G., Oladeji, B., Gureje, O., & Seedat, S. (2016). Effectiveness of traditional healers in treating mental disorders: a systematic review. *The Lancet Psychiatry*, *3* (2), 154–170. https://doi.org/10.1016/S2215-0366(15)00515-5

[27] Pienaar, A. (2014). Mental Health Care in Africa: An Evidence-based Approach. - Google Search. Retrieved from https://www.google.com/search?client=firefox-b&biw=1366&bih=604&ei=qYnxWYS3Cs7RwQKLr5zwDA&q=+Mental+Health+Care+in+Africa%3A+An+Evidence-based+Approach.+&oq=+Mental+Health+Care+in+Africa%3A+An+Evidence-based+Approach.+&gs_l=psy-ab.12...923009.928855.0.932392.2.2.0.0.0.0.608.608.5-1.2.0....0...1.1j2.64.psy-ab..0.1.892.6..35i39k1.894.OrGxgP9Tj5Y

[28] Mhame, P. P., Busia, K., Kasilo, O. M., & Mhame, P. P. (2010). Clinical practices of African traditional medicine. *The African Health Monitor*, 32–39.

[29] Cumes, D. (2013). South African indigenous healing: how it works. *Explore (New York, N.Y.)*, *9* (1), 58–65. https://doi.org/10.1016/j.explore.2012.11.007

[30] Ngoma, M. C., Prince, M., & Mann, A. (2003). Common mental disorders among those attending primary health clinics and traditional healers in urban Tanzania. *The British Journal of Psychiatry: The Journal of Mental Science*, *183*, 349–355.

[31] Sodi, T., & Bojuwoye, N. (2011). Cultural embeddedness of health, illness and healing: Challenges for integrating traditional healing and western oriented health care systems. *Journal of Psychology in Africa*, *21* (3), 349–356.

[32] Sobiecki, J.-F. (2012). Psychoactive ubulawu spiritual medicines and healing dynamics in the initiation process of Southern Bantu diviners. *Journal of Psychoactive Drugs*, *44* (3), 216–223.

[33] Maluleka, J. R., & Ngulube, P. (2017). The preservation of knowledge of traditional healing in the Limpopo province of South Africa. *Information Development*, 026666691772395. https://doi.org/10.1177/0266666917723956

[34] Hewson, M. G. (1998). Traditional healers in southern Africa. *Annals of Internal Medicine*, *128*, 1029–1034. doi: 10.7326/0003-4819-128-12 [CrossRef], [PubMed], [Web of Science ®], [CSA]

[35] Helwig, D. (2010). Traditional African Medicine. *Encyclopedia of Alternative Medicine*.

[36] Chavunduka, G. L. (1994). Traditional medicine in modern Zimbabwe. *Zimbabwe: University of Zimbabwe Publications 115p. ISBN*, *908307403*. Retrieved from http://kbd.kew.org/kbd/detailedresult.do?id=107336

[37] Chigora, P., Masocha, R., & Mutenheri, F. (2007). The role of indigenous medicinal knowledge (IMK) in the treatment of ailments in rural Zimbabwe: The case of Mutirikwi communal lands. *Journal of Sustainable Development in Africa, 9*, 26–43.

[38] Green, E. C. (2000). The WHO forum on traditional medicine in health systems, Harare, Zimbabwe, February 14-18, 2000. *The Journal of Alternative and Complementary Medicine*, *6* (5), 379–382.

[39] Sandlana, N. S. (2002). *The Use of Traditional African Dance and Music as a Therapeutic Technique: An Exploratory Study in Search of Psychological Wellbeing*. University of Fort Hare.

[40] Mokgobi, M. G. (2014). Understanding traditional African healing. *African Journal for Physical Health Education, Recreation, and Dance*, *20* (Suppl 2), 24–34.

[41] Ovuga, E., Boardman, J., & Oluka, E. G. (1999). Traditional healers and mental illness in Uganda. *Psychiatric Bulletin*, *23* (5), 276–279.

[42] Mapara, J. (2009). Indigenous knowledge systems in Zimbabwe: Juxtaposing post- colonial theory. *The Journal of Pan African Studies, 3*, 139–155.

[43] Emeagwali, G. 2003. African Indigenous Knowledge Systems (AIK): Implications for the Curriculum, in Toyin Falola (ed), Ghanain Africa and the World: Essays in Honor of Adu Boahen. http://www.africa history. Net Retrieved on 08 May 2009.

[44] Hammersmith, J. A. 2007. Converging Indigenous and Western Knowledge Systems: Implications for Tertiary Education. Unpublished Doctoral Thesis. Pretoria: University of South Africa (UNISA).

[45] Kunnie, J. 2000. 'Developing indigenous Knowledge and Technological systems' in Chiwome, E. M. etal. (eds)

[46] Gelfand, M. (1985). *The traditional medical practitioner in Zimbabwe: his principles of practice and pharmacopoeia*. Mambo Press.

[47] McKenzie, K., Patel, V., & Araya, R. (2004). Learning from low income countries: mental health. *BMJ*, *329* (7475), 1138–1140.

[48] Glaser, B. G., & Strauss, A. L. (2009). *The discovery of grounded theory: Strategies for qualitative research*. Transaction Publishers. Retrieved from https://books.google.com/books?hl=en&lr=&id=rtiNK68Xt08C&oi=fnd&pg=PP1&dq=The+discovery+of+grounded+theory:+Strategies+for+qualitative+research&ots=UVwUTlVJZP&sig=Su95_tyfwesd8nXv9dja3ZuX7Ao

[49] LeCompte, M. D., & Schensul, J. J. (2010). *Designing and conducting ethnographic research* (Vol. 1). Rowman Altamira. Retrieved from https://books.google.com/books?hl=en&lr=&id=xa7oIOlCUGwC&oi=fnd&pg=PR5&dq=Designing+and+conducting+ethnographic+research&ots=n_ryshLuck&sig=qo9ymoTOj_PzbCW9-vOmhD_i0EM

[50] Pope, C., & Mays, N. (2009). Critical reflections on the rise of qualitative research. *BMJ*, *339*, b3425. http://doi.org/10.1136/bmj.b3425

[51] Kumar, S., & Phrommathed, P. (2005). *Research methodology*. Springer. Retrieved from http://link.springer.com/content/pdf/10.1007/0-387-23273-7_3.pdf

[52] Ritchie, J., Lewis, J., Lewis, P. of S. P. J., Nicholls, C. M., & Ormston, R. (2013). *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. SAGE.

[53] Parahoo, K. (2014). *Nursing Research: Principles, Process and Issues*. Palgrave Macmillan.

[54] Paltved, C., & Musaeus, P. (2012). Qualitative Research on Emergency Medicine Physicians: A Literature Review. *International Journal of Clinical Medicine*, *03* (07), 772–789. https://doi.org/10.4236/ijcm.2012.37A136

[55] Patton, Michael Quinn (2000). *Qualitative Research & Evaluation Methods. 3rd* Sage Publications, London.

[56] Huberman, A., & Miles, M. (2002). *The Qualitative Researcher's Companion*. 2455 Teller Road, Thousand Oaks California 91320 United States of America: SAGE Publications, Inc. https://doi.org/10.4135/9781412986274

[57] Robertson, B. A. (2006). Does the evidence support collaboration between psychiatry and traditional healers? Findings from three South African studies. *African Journal of Psychiatry*, *9* (2), 87–90.

[58] Agara, A. J., Makanjuola, A. B., & Morakinyo, O. B. (2008). Management of perceived mental health problems by spiritual. *African Journal of Psychiatry*, *11* (2), 113–118.

[59] Ware, F. (2008). African American Folk Healing. *Pneuma*, *30*, 367–368. https://doi.org/10.1163/157007408x346717

[60] Taylor, T. N. (2010). "Because I was in pain, I just wanted to be treated": Competing Therapeutic Goals in the Performance of Healing HIV/AIDS in Rural Zimbabwe. *Journal of American Folklore*, *123* (489), 304–328.

[61] Zakaria, F., & Zainal, H. (2017). Traditional Malay medicine in Singapore. *Indonesia and the Malay World*, *45*, 127–144. https://doi.org/10.1080/13639811.2017.127515

[62] Appiah, B. (2012). African traditional medicine struggles to find its place within health care. *CMAJ : Canadian Medical Association Journal*, *184* (16), E831–E832. https://doi.org/10.1503/cmaj.109-4277

[63] Chikara, F. & Manley, M. R. (1991). Psychiatry in Zimbabwe. *Psychiatry Services*, *42*, 943–947. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/1743667 [CrossRef]

[64] Labhardt, N. D., Aboa, S. M., Manga, E., Bensing, J. M., & Langewitz, W. (2010). Bridging the gap: how traditional healers interact with their patients. A comparative study in Cameroon. *Tropical Medicine & International Health*, *15* (9), 1099–1108.

[65] Mutambirwa, J. (1989). Health problems in rural communities, Zimbabwe. *Social Science & Medicine*, *29* (8), 927–932.