

## Why Do People Use Traditional Healers in Mental Health Care in Zimbabwe?

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### Abstract

**Introduction:** In sub-Saharan Africa, including in Zimbabwe, 80% of the population continues to use African Traditional Medicine (ATM) as a source of primary health care that includes the treatment of mental illnesses, but little is known about what motivates their health seeking behaviour. The study aimed at understanding why patients use ATM treatment of mental disorders.

**Methods:** Using exploratory qualitative methods in a semi-urban community near Harare, we conducted 30 in-depth interviews with patients from ATM sites using convenience sampling, and three focus-group discussions with 18 participants from the community recruited from three food distribution depots in the settlement. Data were coded and analysed using the constant comparative method to identify key themes.

**Results:** We found that patients preferred the use of ATM for witchcraft, religious, psychological and psychosocial conditions and believed the causes of their sickness stemmed from witchcraft. Many patients reported high levels of confidence and satisfaction with the ATM received.

**Conclusion:** The findings suggest that supernatural and psychosocial factors play a major role in health seeking behaviour of the communities. Therefore, ATM is a relevant point of referral and rehabilitation for mental health patients and ATM should be integrated with BM.

**Keywords:** African traditional medicine, Mental illness, Health-seeking behaviours.

### Introduction

In sub-Saharan Africa, 80% of the population continues to use African Traditional Medicine (ATM) as a source of primary health care that includes the treatment of common mental illnesses [1]. 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 [2]. The recently launched mental health Global Action Program also focuses on forging strategic partnerships to enhance countries' capacity to combat stigma, reduce the burden of mental disorders and promote health [3].

Health care in Zimbabwe, like most African countries, is provided by both biomedical and traditional health care providers [4]. Treatment seeking behaviors in Zimbabwe can be characterized as a system of alternate treatment paths that intersect and overlap [5]. For patients (though not all), the first assumption is that an illness is natural and normal and can be treated with standard remedies, such as over the counter medications or herbal remedies. When conventional efforts fail to relieve normal symptoms, patients might then suspect that their illness is not normal or natural, and turn to traditional medicine, known as Hun'anga in Zimbabwe, to identify the underlying cause or culprit for sickness and disease [6]. In general there is a paucity of research available concerning health seeking behaviour in traditional healing for mental illness [7].

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Very little is known about why patients continue to use Hun'anga, in parallel or in conjunction with western psychotherapy [8,9]. The objective of this study was to characterize why patients and community seek therapy in hun'anga in the treatment of common mental disorders at community health care. An understanding of the treatment seeking behaviors of patients who use Hun'anga will help identify aspects of traditional medicine that need to be integrated into mainstream therapy, and make traditional medicine a relevant point of referral and rehabilitation for mental health patients.

In this paper, we sought to explore, using qualitative research methods, why some Shona people in Zimbabwe use Hun'anga for the treatment of common mental disorders. Findings from this study will be used to develop more culturally appropriate mental health training for both lay and professional Zimbabwean health providers.

## Methods

### Purpose and objectives

This study aimed to explore, using qualitative research methods, why some Shona people in Zimbabwe use Hun'anga for the treatment of common mental disorders. The study was conducted in a settlement located 16km Northeast of Harare. A qualitative design was selected because this was an exploratory study [10].

### Sampling and Measures

We conducted 30 in-depth interviews and three focus group discussions, using a semi-structured questionnaire to guide the process. A total of 68 participants from seven wards of the Epworth community were enrolled in the study. The in-depth interviews were conducted with the patients of traditional healers and the three focus group discussions sessions were held with the general members of the community.

We recruited patients from traditional healers who were registered with Zimbabwe National Traditional Healing association (ZINATHA). The traditional healers were recruited using community health workers. Community Health Workers approached all eligible healers and explained the study objectives, procedures and obtained informed consent to use their healing offices (matare) to recruit patients. Investigators used a convenience sampling strategy to recruit eligible patients from the healers' offices. Community members were recruited at general mass gathering points which were food distribution depots in the community. The Community Health Workers also explained the study objectives, procedures and the investigator obtained informed consent from the participants.

Participants were excluded from the study if they did not speak the Shona language and if they were: minors, prisoners, mentally disabled or severely mentally ill individuals who had severe psychosis, severe depression, or those who were hyper manic. We excluded the aforementioned special populations because of their vulnerable status as human subjects. Recruitment continued until substantive saturation, or the point at which new data did not

produce more findings.

### Data collection

From January of 2013 to December of 2013, we conducted 3 focus group discussions (FGD) with community members and 30 in-depth interviews (IDI) with the patients of traditional healers. All interviews were conducted in a private room. The investigator facilitated the discussion. Two research assistants were available; one was helping with notes taking while the second was helping with recording of information during focus group discussions and in-depth interviews. Each FGD discussion lasted about one hour. We used a semi-structured interview questionnaire to explore the community's views about healing practices, about visiting traditional healing, and the causes of illness among the people visiting traditional healers, and the reasons for choice of traditional therapy over conventional medicine.

The in-depth interviews were conducted one-on-one in a private room and lasted approximately one hour. The investigator conducted the interviews with the aid of two research assistants. To guide the interviews we used a semi-structured interview questionnaire, to explore the patient's views about what caused their illness, the treatment strategies used, the changes in health as a result of therapy, the patients' attitude toward traditional therapies, their personal feelings toward the treatment received, the levels of improvement as a result of therapy, the patient's satisfaction with the therapy, and the limits of the approach. Some key questions were provided in the table. The researcher asked further probing questions to generate more discussion before closing questions. A summary of the major points was given in the end. The focus group discussions and in-depth interviews were audiotaped and professionally transcribed.

### Ethical concerns

Written permission was obtained from Kunaka District Hospital before the study was started and concern was also obtained from all participants. Permission was acquired to conduct the interviews and audio-recording of the interview was allowed. The interviews took place in the healer's shrine.

### Data analysis

Data were analysed using the constant comparison method [11]. Essential concepts were coded and compared to extract recurrent themes across data. While the principal investigator was leading the process in writing, the other members of the research team reviewed coded transcripts to validate the outcomes. This process of refining codes and describing the properties of each code continued until no new concepts emerged. An analysis comparing and contrasting the themes was made across the two groups of participants. Data was manually coded and translated into English. It was then back translated and checked for consistency. Analysis of the interviews and focus group discussions explored the subjective meaning of mental illness and treatment seeking behaviours. Quotations used throughout this paper reflect participants' typical comments unless otherwise noted.

## Results

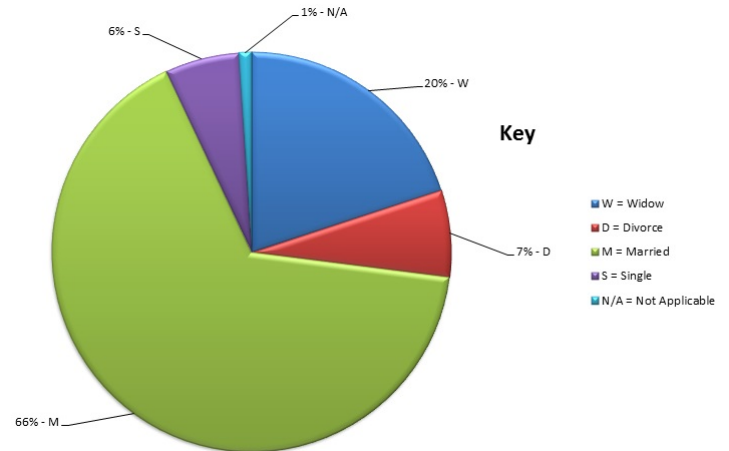
Sample characteristics of the in-depth interview and focus group participants.

Table 1 and Figure 1 present selected socio-demographic variables used to characterize the sample of in-depth and focus group participants. Women (70%) were the majority and the men were only 30%. Focus group discussions were held at 3 food distribution depots and each focus group had 7, 6 and 5 participants, respectively. The mean ages for the 3 groups were 43, 28 and 29, 2 respectively, while the mean for the 3 groups was 34, 17 years (SD: 13, 63). The mean number of years of education was 9.28years (SD: 2, 89) for all participants in the 3 groups.

		In-depth interviews N= 30	Focus groups N= 18
		M (SD) or %, N	M (SD) or % (N)
<b>Age</b>		40,40 (SD: 13,61)	34,17 (SD:13,63)
<b>Gender</b>	Female	68,97% (20)	32% (6)
	Male	31,03% (9)	68% (13)
<b>Ethnicity</b>	Muzezuru	33,33% (10)	27,78% (5)
	Munyika	3,33% (1)	11,11% (2)
	Mukaranga	20% (6)	5,56% (1)
	Mundau	13,35% (4)	11,11% (2)
	Malawi	23,33% (7)	16,67% (3)
	Zambian	3,33% (1)	5,56% (1)
	Mozambican	3,33% (1)	16,67% (3)
<b>Education</b>		6,97 (SD: 3,6)	9,28 (SD: 2,89)
<b>Marital status</b>	Divorced	10,34% (3)	16% (3)
	Married	72,4% (21)	74% (14)
	Single	3,45% (1)	1% (2)
	Windowed	13,79% (4)	
<b>Religion</b>	Christian	55,17% (16)	84% (16)
	Traditional	13,79% (4)	16% (3)
	NR	31,03% (9)	
<b>Number of people living in household</b>	2	16,67% (5)	-
	3	16,67% (5)	27,78% (5)
	4	16,67% (5)	11,11% (1)
	5	16,67 (5)	16,67% (2)
	6	16,67 (5)	-
	7	10,00 (3)	5,56% (1)
	8	3,33% (1)	11,11% (2)
	11	3,33% (1)	-
	14		5,56% (1)
<b>Number of children</b>	1	16,00% (16)	16,67% (3)
	2	28,00% (28)	16,67% (3)
	3	18,00% (18)	11,11% (2)
	4	16,00% (16)	11,11% (2)
	5	10,00% (10)	5,56% (1)

<b>Number of children</b>	6	2,00 (2)	5,56% (1)
	9	1,00% (1)	-
<b>Number of people earning income</b>	0	60% (18)	27,78% (5)
	1	40% (12)	72,22% (13)
<b>Occupation</b>	Employed	2	32% (6)
	Self-employed	3	16% (3)
	Unemployed	24	48% (9)

**Table 1:** Characteristics of the in-depth interview and focus group participants.



**Figure 1:** Marital status, Demographic Characteristics of Patients of Traditional Healers.

## Emergent topics

From the focus group discussions and in-depth interviews emerged two topics: patients' explanatory models for mental illness and why Zimbabwean patients use Hun'anga (traditional healing) for common mental health disorders.

### Shona Explanatory Models for Mental Illness

The main causes of illnesses that emerged from data analysis of participants were supernatural factors. This response was further categorized into illnesses caused by perceived spiritual causes (zvemweya), or witchcraft (zvouroyi), or culture (zvemagariro), and illnesses affecting mental health with unidentified causes (zvisinganzwisiki kuchipatara).

### Description of causes and symptoms of illness

Both groups of participants attributed the causes of mental illness to spirituality "zvomweya". Nearly all participants reported causes due to ancestral spirits (zvemidzimu), or possession by evil (kusvikirwa nemweya yetsvina) or an aggrieved spirit (kubatwa nengozi), and people who had been beaten by goblins (vakarohwa nezvidhoma).

Many of the participants reported cultural issues (zvechivanhu) as the causes of mental illness. Many patients mentioned the pains which were perceived to have arisen from unidentified traditional

practices (zvemadzinza). For example, when relatives are believed to have been inciting ancestral spirits (midzimu) to stop extending protection and as a result, the sufferer becomes a victim of bad airs (mamhepo) and become psychotic.

Almost all community members reported the causes of illness as when people had stopped observing their cultural prescriptions (tarasa tsika nemagariro) resulting in their ancestors withdrawing their protection from them (midzimu yafuratira) and thereby, making them prone to illness. However, some of the community members believed illness was a form of request from ancestors, asking the living to perform cultural rituals on their behalf. Many community members mentioned that mental illness in a family member was believed to be a sign an ancestral spirit (mudzimu) was seeking to talk through a host (patient); a 30-year-old community member whose friend had depression had this to say;

*“The healing spirit (mudzimu) first makes its host ill as a way of alerting the relatives so that they may find out what the problem is all about, you see, my friend doesn’t want to talk with anyone and looks sad all the time with tears all over the place”* (community member FGD).

Many community members spoke about witchcraft issues as causing a number of mental health problems. Examples given were: those who are bewitched (vakaroyiwa) and may become depressed, patients presenting with psychosis (kupenga) and confusion (kuvhiringika) through witchcraft (huroyi), some are struck by witchcraft birds (zvishiri) and become unconscious, some patients were inserted witchcraft objects (zvipotswa) in their bodies which would make them suffer from untold pain, and many similar issues.

### **Patients’ reasons for the use of Hun’anga**

From our data, we identified specificity as the main reason why Zimbabwean patients use Hun’anga for common mental health disorders.

### **Specificity**

Most participants reported that they used Hun’anga because mental illness with a supernatural cause can only be fixed by Hun’anga. This means conditions which were perceived to derive from culture or witchcraft could be treated only in traditional healing. A community member observed,

*“Those people with bad luck and finding it difficult to get married (munyama) for them to go to the hospital complaining that they need to get married, is not possible* (Community member, FGD)”.

The aetiology of mental illness was strongly linked to spiritual factors by both study groups. Most of the community members believed that the spiritual problems (matambudziko ezvemweya) were believed to respond more positively to methods of traditional medicine rather than in western medicine when, generally, doctors failed to make a diagnosis. This was noted by a 37-year-old female

community member, who was living with a 42-year old female patient suffering from mental psychosis,

*“When we went to see the doctors, we were told the diagnosis was not clear, when the person was molested by evil spirits”*  
(Community member).

Many participants mentioned their choice of treatment was determined by the perceived causes of illness. Many patients mentioned they visited traditional healers because they perceived only traditional medicine (chivanhu) could resolve witchcraft (huroyi) problems, as one 47 years old female patient suffering from hysteria (mamhepo) observed;

*“Because people thought that my illness was due to black magic (mishonga yechibhoyi) which could only be treated in traditional medicine”* (Patient).

Nearly all community members reported supernatural causes for unidentified illnesses (zvisinganzwisiki) where nobody understood the illness affecting the patient. A 40-year-old female community member observed,

*“If the illness is arising from (mushonga wechibhoyi) black magic, or after getting beaten by goblins (varohwa nezvidhoma), a person may go to a western trained doctor who may fail to see what happened”* (Community member).

Almost all the community members who used traditional medicine and patients felt they were consulting traditional medicine because the healers provided holistic care—healing the mind, body and spirit (kushandirwa zvose nemweya). A 26-year-old female community member who uses traditional medicine for her anxiety noted,

*“Some traditional healers may start by chanting (kudeketera) to your ancestral spirits (midzimu) for their support in the treatment before they start healing. This is different from the hospital set up where ancestors (midzimu) are not recognized and no nurse will refer to any of your ancestors (kudeketera kumudzimu) for their protection. It feels good to be connected with your ancestors and I feel better”* (Community member, FGD).

However in assessing the impact of traditional therapy they had received, many participants had different feelings. Many patients reported they derived complete satisfaction, but a few patients thought they’d only experienced partial satisfaction or even no satisfaction. However many participants felt traditional healing was better than no treatment.

### **Discussion**

This was the first study of why Zimbabwean patients use traditional healing (Hun’anga) for common mental health disorders. The findings in this study are limited by difficulties in selection of traditional healing sites that represent diverse backgrounds and viewpoints, scheduling interviews with hard to reach respondents and the study site which was a peri-urban settlement and

commonalities may differ in other areas, particularly in low and middle income countries. There was also a risk the validity of the data was (or could have been) compromised because respondents did not answer the questions openly and honestly. To minimize biases and sources of error, we took certain precautions and the steps outlined above regarding the selection of subjects, their comparability, and a calculation of sample size. In spite of the above, some important findings are noteworthy.

Explanatory models for mental health illness were largely supernatural. Our results supported a Nigerian study which found supernatural reasons to be the most popular explanations for mental illness amongst carers and patients, a notable difference from psychosocial issues found in international findings [12].

The study showed that witchcraft played a central role in the causation of mental health problems. Although witchcraft is outlawed in Zimbabwe, this category continues to be used as an important way of explaining misfortune and requires attention. A similar result was established in Sub-Saharan Africa [13-15]. The problems created by witchcraft were not identifiable to practitioners of conventional medicine, and could only be identified in Hun'anga. What was surprising from our data was that traditional healers served both the roles of providing therapy for those affected as well as being used to cause illness when requested by their patients to do so, for example, they cast bad spells on their patient's enemies. This implies that some traditional healers (but not all) practise unethical behaviours. There is need to train traditional healers the ethics of preventing public harm.

In addition, our study showed people who sought Hun'anga were perceived to have developed mental health problems from their lack of following their culture or their relatives were perceived to have incited ancestral spirits to turn against them to either withdraw their perceived protection from bad spirits, or cause bad spirits to inflict harm on them. Our result corroborated previous studies [16,17]. Their study found spiritual possession is believed to influence the brain directly. What was surprising, however, was that most of the illnesses that arose, including those with apparent physical causes, were often attributed to the supernatural factors.

The implication of the findings is that patient treatments in Zimbabwe should focus beyond the physical manifestations of the problems to include the underlying spiritual issues, which is the mind. It is important to inform clinicians, policy makers and other stakeholders that the understanding of the aetiology of mental health illness from a Zimbabwean traditional healing perspective may inform the management of patients at the primary care level. This can be tackled by involving both the healers who are well versed in the traditional approach and training nurses at the primary health care level. More research should focus on exploring this possibility. Our findings corroborate the previous research findings.

Our findings reveal that attending to perceived supernatural factors should improve motivation of people with mental health issues to

seek therapy. However, further research is required to establish how to integrate cultural and spiritual context of a patient in therapy.

What was surprising was, while community members mentioned seeing patients with the more florid psychotic symptoms, the patients reported benign symptoms of mental illness. This could probably be a result of the stigma associated with mental illnesses where people do not open up about their mental illness, and this implies there should be deliberate effort to fight stigmas surrounding having a mental illness.

Our study further revealed that participants made a choice to use Hun'anga because they rated traditional healers' skills high. Participants also felt secure traditional healers would refer them to other healing agents if it was necessary. Our findings contradicted results of previous research which found traditional healers were not willing to refer patients to biomedical practitioners [18]. Perhaps the difference was because we used a more robust qualitative design as opposed to the quantitative methods used in previous research.

Finally, our findings suggested that people were satisfied by using hun'anga. Our results supported previous research [6,19,20]. The implication is that hun'anga indeed helps in the treatment of some people (but not all) with mental health problems. Two questions that remain to be answered are: how Hun'anga works for different types of patients and how it can complement biomedicine in the treatment of mental health problems [21,22].

## Conclusion

We conclude that in our study location in Zimbabwe (and potentially in most developing countries) community health seeking behaviour is motivated mainly by supernatural factors. Therefore, we are suggesting, in order to plan for a holistic, culturally appropriate mental health programme, efforts must be made to address these factors. Specifically for the purpose of incorporating cultural and spiritual needs in order to cater for physical and spiritual being of a patient. Such an approach could make traditional medicine more relevant as referral point as well as rehabilitation and after care. Above all there must be continuous mental health education for both mental health and mental illness. Furthermore, research is needed to identify efficacy of traditional methods and incorporate them into mainstream therapy. These findings can be used to optimize the health choices available in low-income countries (LICs).

## Author Contributions

Conceptualized the study: LK; Designed the interview: LK; Conducted the interviews: LK; Participated in data analysis: LK, CW, DC, TT, HJ; Drafted the manuscript: LK; Gave manuscript input: LK, CW, DC, TT, HJ.

## Ethical approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the University of Zimbabwe and Parirenyatwa Joint Research Ethics Committee

(JREC) and the Medical Research Council of Zimbabwe (MRCZ); and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

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