

Compatibility between Indigenous Healing and Biomedical Therapy for Mental Disorders in Zimbabwe

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Abstract: -There is an increasing demand for collaboration between the Indigenous Healing Practitioners (IHPs) and the Biomedical Therapists (BTPs) to mitigate barriers in the delivery of mental health service in resource poor countries, including Zimbabwe. In Africa, many countries have resorted to different models of collaboration between IHPs and BTPs, but there is little or no studies on their compatibility in Zimbabwe. This study sought to examine the perceptions of health service providers and IHPs on the compatibility of IHPs and BTPs in the treatment of mental disorders in a settlement north-east of Harare using an exploratory qualitative methodology in order to establish compatibility between IH and BT. Thirty key informant interviews with IHPs and one focus group discussion with nurses were conducted. Gathered data were coded using the Constant Comparison Method with multiple members of the research team, enhancing the validity and the reliability. The results of the study show that IHPs and BTPs were ready to collaborate, with potential benefits in the partnership. IHPs mainly treated common mental disorders, social problems and culturally specific problems perceived to have supernatural causality, which BTPs did not address and IHPs provided supportive and palliative care to BTPs' patients who had chronic conditions. However, the study also found some IHPs' practices with either health risks or were counterproductive to the partnership. For example, the IHPs ordered patients to stop taking BTPs' medication and they changed the diagnosis which patients were given by BTPs. Although they viewed some IHPs had flaws in the delivery of mental health care, the participants suggested that the partnership would resolve the problems. The study found IHPs and BTPs compatible and therefore should redistribute the tasks in mental health treatment in Zimbabwe. The IHPs should be integrated with the BTPs in order to increase the coverage of mental health care in resource poor countries. Policies on collaboration of IHPs and BTPs must be drawn and published in national guidelines. This is expected to initiate a wider, holistic, therapy. More research is needed to establish how the two approaches may collaborate in Zimbabwe.

Key Terms:- Compatibility; indigenous healing; biomedical therapy; mental disorders; resource poor countries

I. INTRODUCTION

There is a growing body of evidence on the importance of compatibility between Indigenous Healing (IH) and Biomedical Therapy (BT) to mitigate the burden of disease in the delivery of mental health service in resource poor countries (Atilola, 2016). This is because IH serves 80% of

the population for their primary health care needs while the majority of the people are reluctant to use the formalised BT in sub-Saharan Africa (Appiah, 2012). The World Health Report 2006, "Working together for health", highlights the importance of human resources for health and the shortage of trained health professionals as among the main obstacles to strengthening low-income countries' health systems (The World Health Report 2006). In Africa, different countries have resorted to different models of collaboration between IH and BT but in Zimbabwe there is little progress of this work. This paper will analyse the views of the different stakeholders in the mental health care in Zimbabwe in order to establish compatibility between IH and BT. First, the paper will define compatibility; indigenous healing; biomedical therapy; mental disorders and motivate on the importance of compatibility, before examining the different models in Africa.

Compatibility means the increase of health care coverage through communication, harmonization and partnership-building between the indigenous and biomedical systems of medicine, while ensuring the protection of intellectual property rights and indigenous knowledge (Busia, 2005).

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 (Sandlana & Mtetwa, 2008), as well as to treat, diagnose or prevent illness (World Health Organization, 2011). Although there is some work to formalise IH, there is no work to establish compatibility of IH with BT in mental health services (Mhame et al., 2010).

Mental health services are the means by which effective interventions for mental health are delivered. The way these services are organized has an important bearing on their effectiveness. Typically, mental health services include outpatient facilities, mental health day treatment facilities, psychiatric wards in a general hospital, community mental health teams, supported housing in the community and mental hospitals (WHO, 2003). These have to be inclusive of local knowledge systems, if they are to appeal to the indigenous people.

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 (Patel et al., 2007). 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 (Michaud, Murray, & Bloom, 2001). An understanding of the management of mental disorders from cultural perspective is vital towards their management, which entails collaboration between IHPs and BTPs.

Currently there is tension between Indigenous Healing Practitioners (IHPs) and Biomedical Therapy Practitioners (BTPs) mainly due to a lack of mutual trust and understanding because the BTPs do not know what the IHPs can do (Chitindingu et al., 2014). To reduce the tension, in 2002, the WHO recommended that the IH be included in national responses to mental health problems, thus prioritizing the idea of the compatibility between the IH and BT specialists (Cohen, Organization, Organization, & others, 2001).

Unfortunately, BTPs were sceptical of the role of IHPs in therapy, accusing the IHPs among other things, of lack of adequate scientific proof, imprecise diagnosis and dosage, non-tested medicines and occultist practices, because little was understood about the IH services (Elujoba, Odeleye, & Ogunyemi, 2005) However, IH still attracts the majority of patients because of the perceived advantages namely, low-cost, affordability, ready availability, accessibility and acceptability and perhaps low toxicity (Shoko, 2008b) and IHPs have been generally acknowledged excellent at primary health care levels (Bower & Gilbody, 2005).

Unfortunately biomedical specialists cannot stand alone in therapy because they are not culturally appropriate, and they give access to only a few people because they are expensive, limited in numbers, and only available, mainly in urban areas and they need to partner with the IHPs in order to offer a more comprehensive mental health service (Chitindingu et al., 2014).

Presently, the increasing burden of physical and mental disorders in low income countries, including Zimbabwe, confirms the need to involve all the available resources, including the indigenous health approach (Robertson, 2006). The increasing demand for the IH globally, necessitates that BTPs and other healthcare personnel collaborate with IHPs to deal with common mental disorders (Pienaar, 2014). Two main reasons why such collaboration is important stand out. First, the BT specialists and other health personnel should understand all health services their patients may be accessing, including that of IHPs and their products. Secondly, all health personnel (especially the general practitioners, nurses and the pharmacists) are often used by patients as an information source for all health and health-related issues (Busia, 2005). An understanding the role of IH will therefore enable them to advise their patients accordingly.

Functional collaboration between the IHPs and the BTPs researchers is also required for the validation of the claims of IHPs (K. Kofi & Kasilo, 2018). Such collaborations will facilitate the assessment of the quality, safety and efficacy of the plant raw materials and the finished medicinal products. In addition, with the increasing burden of various mental disorders on health systems of Member States, it is imperative that any primary health care (PHC) delivery plans draws on the skills and knowledge of IHPs especially because of their close proximity to the community (Cohen et al., 2001). The WHO has provided some guidelines on the collaboration.

Since the early 1970s, the WHO has repeatedly advocated for the recognition of IHPs as Primary Healthcare (PHC) providers and for the integration of IH in national health systems (Krah, de Kruijf, & Ragno, 2018). Several calls have been made on governments to take responsibility for the health of their people and to formulate national policies, regulations and standards, as part of comprehensive national health programmes to ensure appropriate, safe and effective use of IH medicine (Appiah, 2012). One of the priorities of the African Regional Strategy on Promoting the Role of IH in Health Systems is promotion of collaboration between the practitioners of IH and BT (K. Kofi & Kasilo, 2018).

Currently most people suffering from a mental disorder do not receive treatment and have less than positive attitudes towards mental health services (Patel et al., 2007). The problem may be resolved if innovative strategies that would promote mutually-beneficial collaboration should be pursued. This is the gap that this study is helping to plug.

II. LITERATURE REVIEW

The study draws its literature review from a collection of models of collaboration between IHPs and BTPs from selected countries in Africa to give an insight of the collaborative work on health in resource poor countries.

In Africa, innovative strategies on compatibility between IHPs and BTPs have mainly involved organizing training programs for IHPs, and establishing protocols for laboratory testing of traditionally used herbs (King, 2005). Successful collaboration in some countries, such as Kenya and Tanzania, where hospitals tested traditional herbs to establish their efficacy have resulted in willingness of some hospitals and clinics to provide onsite practice facilities to IHPs, combined with training programs (Kayombo et al., 2007a). Specific examples are provided below.

Senegalese Case

In Senegal, IHPs and BTPs have established a centre for collaboration called “The International Centre for Traditional Medicine in Fatick (B. Kofi, n.d.)”. The role of the BTPs at the centre is to check vital signs such as blood pressure, pulse respiratory cycle, temperature, weight etc. and make a diagnosis after laboratory tests. The BTP does not take part in the treatment. After making a diagnosis, the BTP sends the

patient to a qualified IHP for treatment. After the treatment, the IHP sends the patient back to the BTP to measure the treatment impact of IHP. The physical examinations therefore, are done before and after IH treatment. The impact of IH treatment is measured by comparing pre-and the post-treatment laboratory results, vital signs and physical examinations findings (K. Kofi & Kasilo, 2018). Collaboration has helped to reduce health workers doubt about the effectiveness of IHPs and has strengthened mutual appreciation, understanding and respect between IHPs and BTPs (Busia, 2005). While collaboration between IHPs and BTPs in Senegal focused on all health conditions, Uganda model of collaboration concentrated on one area in health.

Uganda case

In Uganda, collaboration between the IHPs and the BTPs has had an impact on the fight against HIV/AIDS. The IHPs and the BTPs began collaborating in 1992. Collaboration started with AIDS support organization (TASO) Uganda Limited and San Frontiers' (Doctors without Borders), an international organization (Kayombo et al., 2007b). The focus for BTPs was on evaluating the effectiveness of local herbal treatment for selected AIDS-related diseases. The project achieved its goals and collaboration escalated onto the level of HIV/AIDS education, counselling and patient care. Collaboration then had a special focus on supporting children orphaned by HIV/AIDS scourge. In spite of its success, this important collaborative project operates with very little resource support and under harsh conditions. Nevertheless, the number of children benefitting from the project keep on increasing, suggesting the importance of collaboration between IHPs and the BTPs in Uganda (Ovuga, Boardman, & Oluka, 1999).

Malian Example

For Mali, collaboration between IHPs and BTPs under the Department of Traditional Medicine in the Ministry of Health's Public Health Research Institute and is by mutual respect and awareness of the limits of the competence and voluntarism (Busia, 2005). The parties collaborating receive no remuneration and they collaborate in research and patient referrals. The collaboration that is achieving success is Bandiagra, near Timbuktu, which is a centre for excellence in collaborative work. Consequently, collaboration has resulted in the decline of the rate of mortality caused by serious malaria from 5% in 1997 to 2% in 1998; in 2008 severe malaria dropped from 38% to less than 10%; and finally referrals of tuberculosis patients to health centres by the trained IHPs increased by 18% (K. Kofi & Kasilo, 2018). This demonstrates the importance of collaboration between IHPs and BTPs. A study in South Africa below may help to further amplify compatibility between IHPs and the BTPs.

The South African Experience

In South Africa, a controlled study of HIV/AIDS/STI/TB intervention with IHPs in two rural and two urban areas in Kwazulu-Natal was conducted to determine whether IHPs

can reduce the risks of their practices and encourage them to provide appropriate information and referral to STI/HIV and TB care (Peltzer, Mngqundaniso, & Petros, 2006). Their findings corroborated the previous findings as they reported significant improvement of HIV/AIDS knowledge among the IHPs after training. Their study concluded that there was a need to devise interventions that will enable women to provide more support to other women in their communities. The study highlighted the importance of compatibility between IHPs and BTPs in resource poor countries. The study also raised the issue of the possibility of involving IHPs in areas where they are respected by the community and attend to clients at risk of HIV, STI and TB. In addition, the study pointed out to the need for better interventions to be developed to change the actual risk practices and encourage IHPs to work with BTPs. However, studies on the compatibility between the IHPs and the BT specialists in the area of the delivery of mental health service were not done.

The case for Zimbabwe.

In Zimbabwe there are some collaborative activities between the IHPs and the BTPs, mainly in the area of the Human Immune Deficiency Virus (HIV/AIDS) (Willms, 1996) However, the work is outside the formal health structures, and the lack of compatibility is primarily thought due to academics' and BTPs' lack of knowledge of IHPs' services (Chavunduka, 1994) and the view that IH negatively affects public health delivery, among other things (Gunda, 2007). Several authors e.g.(Chitindingu et al., 2014).; Simmons, 2012; Chavunduka, 1994), however, suggest that it is possible for IHPs and BTPs to collaborate and they should begin to take measures aimed at enhancing understanding between them with active interaction and mutual learning; and making referrals from IHPs to BTPs and the other way around (Chikara& Manley, 1991). Although a number of studies suggest that the idea of collaboration is sound, the problem relates to whether IHPs are ready to collaborate with BTPs when IH differs in theories on causation and management of mental disorders (Madiba, 2010). This paper seeks to analyse health providers' and IHPs' views on the compatibility between IHPs and the BTPs in order to develop a collaborative strategy to improve on the delivery of mental health care in Zimbabwe.

Conceptual framework

The aim of the paper was to investigate the compatibility of the IHPs with the BTPs in order to understand the role of the IHPs in mental health care. n Zimbabwe. This section is dedicated to the theoretical frameworks that may help to explain health-seeking behaviour in a health facility, either indigenous practices, or biomedical care, or both, in the treatment of mental disorders in Zimbabwe. It provides an account of the theoretical frameworks that back the research study and gives justification for the use of these theories. The theories selected include the health belief model, which is a psychological health behaviour change model developed to

explain and predict health-related behaviours, the reasoned action and planned behaviour which are psychological health models developed to explain and predict health-related behaviours, particularly in regard to making decisions of health services, the indigenous knowledge systems, which becomes an important prism through which to analyse the practice of IHPs and the explanatory model of illness which postulates that health-seeking behaviour and utilization of health facilities is best understood using EMI which gives the physician knowledge of the beliefs the patient holds about his/her illness, the personal and social meaning he/she attaches to his/her disorder, his/her expectations about what will happen and what the doctor will do, and his/her own therapeutic goals (Hark & DeLisser, 2011), because they help to explain decision making processes and this was useful for the study which explored the compatibility between IHPs and BTPs in the management of common mental disorders. These theories provided a framework that assisted in the development of the study tools, data analysis and a discussion on the implications of the research findings.

III. METHODS

A total of 36 participants (30 IHPs and 6 nurses) was enrolled in the study, representing the indigenous healers of the different backgrounds; 6 herbalists, 6 spirit mediums, 6 diviners; traditional birth attendants; and 6 faith healers; who represented the mixed views and came from the different regions of the country to settle in the seven wards of the Epworth community. A qualitative design was selected because this was an exploratory study (Taylor, 2010). In this study, the understanding of the views on compatibility between the IHPs and the BTPs emerged from the interviews with the participants and the direct observations of the indigenous healing practices and nurses. The study chose a case study because IH was of special interest and used the unique methods in the management of mental health (Pop & Mays, 2013). This helped to understand the IH in relation to their activities within the local settings (Ritchie, Lewis, Lewis, Nicholls, & Ormston, 2013b).

The study was conducted in Epworth, a large peri-urban settlement located 16 kilometres northeast of Harare, and was selected because of its mixed population with the urban and the rural characteristics with potential for diversity of a broad range of ideas and issues in IH, which would increase the credibility of the results. The study targeted all the consenting male and female IHPs at their healing shrines, and nurses at three clinics in Epworth Community during the study period. This study used a sample of 30 for one on one interviews and six for a focus group discussion, using the rule of thumb (Glaser & Strauss, 2009a). A non-probability sampling method which is selective sampling was used to recruit IHPs, and to select nurses (Ritchie et al., 2013a). The participants were selected for the study if they spoke any of the indigenous languages in Zimbabwe (i.e. Shona or Ndebele); and if they were 18 years of age or above. The participants were excluded

from the study if they were minors (under 18 years of age); including those with severe cognitive impairments.

The researcher examined the Zimbabwe National Traditional Healers Association (ZINATHA) records to determine the names of all of the IHPs in Epworth; then tried to recruit those who were available with the assistance of the local community health workers. As a result, the sample provided a nearly exhaustive coverage of IHPs in Epworth. After locating IHPs, the researcher explained the study objectives, procedures and obtained the informed consent from IHPs before data was collected. The nurses were selected from three Epworth clinics through a convenience sampling strategy. The investigator explained the study objectives, the procedures and obtained the informed consent from all the participants. The researcher managed to achieve a sample size of six participants for the focus group sub-sample in a relatively fast and inexpensive way, because the researcher did not need many participants. The sampling approaches allowed the researcher to gather the useful data and the information that would not have been possible using the probability sampling techniques, which required the more formal access to lists populations (Pope & Mays, 2013). To improve on the credibility of the results, the researcher made sure that the sample was exhaustive and would include all the indigenous healing orders (Ritchie et al., 2013a).

From January of 2018 to December of 2018, the researcher conducted interviews in Epworth. The researcher made use of a number of data collection methods which included 30 key informant interviews (KII), one focus group discussion and observation for triangulation purposes. Two research assistants helped with notes taking and audio recording. The researcher started collecting data by conducting the key-informant interviews with the IHPs, followed by the focus group discussions with nurses to assess the acceptability of the IH service and the compatibility of the IH and the BT in mental health work. During the study period, the researcher made observations on IH approach when interacting with the participants.

Key informant interviews

KIIs were used because the interviews let the researcher explore the IH in depth. Accordingly, 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 IH and whether IHPs would like to collaborate with BTPs 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 focus group discussions

This paper used the FGDs to allow the participants to agree or disagree with each other so that it provided some insights into how nurses thought about the IH, about the range of opinions

and ideas, and the inconsistencies and variations that exist in Epworth in terms of their beliefs and their experiences with IH practices. An FGD of six participants was held with the nurses drawn from three clinics in Epworth representing the BT specialists using an open ended FGD guide. The nurses were included in order to discuss their views about the IH practice and their attitude towards collaboration with IHPs. The information was required to check for compatibility with information from IHPs.

Observation

The researcher made observations and thick descriptions of the whole process of IH, including 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, methods used for diagnosis and treatment, the healing tools used, how treatment was drawn to a conclusion, if IHPs collaborated among themselves or not, and whether they referred their patients to BTPs or not, including any other relevant information. The researcher also observed himself, in terms of his reactions during all the encounters. This method was used to gain first-hand information and to triangulate information with other data obtained from IHPs, including, nurses. The key-informant and focus group discussion interviews were conducted in Shona, audio recorded, professionally transcribed, translated into English, and back-translated to Shona to check for consistency.

IV. DATA MANAGEMENT AND ANALYSIS

Data was analysed using constant comparison method where researcher moved back and forth between data sets to discover differences, similarities as well as complimentary 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. On data analysis, the study was guided by the Framework Method to the management and analysis of qualitative data in health research. The researcher adopted the Framework Method because the study was multi-disciplinary, involving the clinicians, patients and lay people (Charmaz, 2006).

Ethical Issues

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 the permission to audio-record the interviews. The dignity, rights, safety and wellbeing of the participants were paramount in any research project. The ethical principles of respect for persons, beneficence and justice were observed in this study. The ethical issues that were of concern to the present study were the informed voluntary consent, confidentiality and anonymity, including

the permission to use any electronic pictures or videos from the internet.

Informed Consent

Written informed consent was obtained before any study-specific procedures were performed. The next section presents the findings and discussion.

V. FINDINGS AND DISCUSSION

5.1 INTRODUCTION

This section sought to establish the compatibility of the indigenous healing with the biomedical therapy in the treatment of mental disorders in a settlement north-east of Harare. The data was obtained from all the two study groups (the IHPs and the nurses). From the key informant interviews emerged three topics: the compatibility of the IHPs with the BTPs specialists in the treatment of the mental disorders, the perceived barriers for IHPs to partner with the BTPs and how the IHPs think they could work together in mental health work.

This study revealed marked similarities of the responses among the different IHPs, and the nurses to readiness of the IHPs to partner with BM and their proposed strategies for the partnership in the treatment of the mental illness. The study found cross-cutting themes among the study groups.

5.2 *The providers' attitudes towards their compatibility in the treatment of the mental disorders*

5.2.1 *IHPs' attitude towards the partnership*

Almost all the IHPs (26 out of 30) reported positive attitudes towards the partnership in the delivery of the mental health service and said they would feel very happy to work with the biomedical specialists. The IHPs said they would be dealing with the special issues in the community (Cohen et al., 2001). The IHPs believed they were able to treat the cultural and the spiritual aspects of a person which the BM did not treat, in addition to treating the common mental disorders similar to the international findings (Hastwell, 2014). A 31-year-old male community member, who had a sick relative diagnosed with psychosis from the hospital but was consulting an herbalist noted,

For example, when we have a relative in hospital, we run around in indigenous healing and bring herbs to the patient. We hide the herbs in our handbags to avoid detection by the authorities and give the herbs to our sick relative. We also pray for a sick relative to recover during the visiting hour (FGD).

5.2.2 *Nurses attitudes towards partnership*

Similarly, many nurses (5 out of 6) mentioned that they would be happy if both IHPs (*n'angas*) and BM specialists (nurses) were found at the clinic (Pienaar, 2014). The nurses mentioned that the IHPs and the BTPs should collaborate,

since people were already using both approaches, anyway, in line with WHO (2003) strategies.

Data suggests that the fact that the participants had positive attitude towards the partnership and that they would feel very happy to work together in a complimentary way set the scope for the allocation of the roles and responsibilities for the partnership between IHPs and biomedical specialists (Teuton et al., 2007).

5.3 HEALTH PROVIDERS' AND IHPs' PERCEPTIONS ON COMPATIBILITY IN THE TREATMENT OF MENTAL DISORDERS

5.3.1 The IHPs' perceptions on compatibility

The IHPs saw some potential benefits in collaborating with the biomedicine (Shoko, 2008b). The IHPs stated that they benefited from the mutual exchange of the information through the partnership with the BTPs; and they perceived a broadened scope for the choice of the therapy for their patients. The IHPs perceived a holistic treatment of the patients through complementary efforts of the two approaches (Krah, de Kruijf, & Ragno, 2018). IHPs claimed that they would be dealing with the special issues such as the cultural and the spiritual issues of a person (Pienaar, 2014). These special issues were perceived to result in the mental disorders which were not known in BM, but the IHPs claimed were able to fix them. A 56-year-old male spirit medium who was treating a patient with somatisation disorder-like symptoms noted, *"Only the indigenous healer can deal with spiritual problems in mental health"* (Herbalist).

The nurses' perceptions on compatibility

The nurses reported that the partnership was necessary to control the IHPs immoral issues of the false claims on the treatment where they could not help, for example HIV/AIDS cure (K. Kofi & Kasilo, 2018). The nurses claimed the IHPs could not make a clear diagnosis and they might disadvantage some patients economically. They reported that the IHPs were mainly the source of the compliance problems among their patients at the clinic and the partnership was needed to deal with the issues in the delivery of the mental health. In addition, the nurses reported that the partnership was important because the IHPs exposed some patients to some health risks, including stopping the patients from seeking treatment from biomedicine. However, the nurses noted that the IHPs provided the palliative care to their patients who had chronic mental illnesses and there was need for the partnership (Cohen et al., 2001).

In addition, many nurses (5 out of 6) reported there were some potential benefits in collaborating with the biomedical specialists such as the improved performance that resulted from the division of labour in the mental health treatment; the broadened scope of treatment choices; and making more medication available (Shoko, 2008b). Many nurses mentioned that the collaboration would allow the different approaches to cater for the different needs of the patients (holistic care). A 32-year-old female nurse who often counselled patients with

the mental health disorders observed, *"For me I think it's alright for them to collaborate with us because the dosage will be under control and no one will be hurt by any drugs (Nurse)"*.

Data suggests that most of the study groups concurred that there would be some potential benefits to patients in the partnership. The IHPs perceived a holistic treatment of the patients through the complementary efforts of the two approaches. However, the result that parties to collaboration would take advantage of the mutual exchange of information contradicted the previous work which found that the BM specialists perceived had nothing to learn from IHPs (Madiba, 2010). The findings probably suggest that more people are gradually learning to appreciate the role of the indigenous healers in mental health care. This meant that the IHPs were becoming more compatible with BTPs. The IHPs would benefit under the supervision of the BTPs and BTPs' burden would be lighter, and the patients would receive a holistic therapy (Busia, 2005). Although the nurses mentioned the IHPs' barriers to the partnership, they acknowledged the benefits and corroborated the need for the IHPs to partner with the BT specialists to bridge the gap in the delivery of mental health service in Zimbabwe.

5.4 THE PERCEIVED BARRIERS IN THE PARTNERSHIP BETWEEN THE IHPs AND THE BTPs

5.4.1 The IHPs' perceived barriers in compatibility

The study revealed the IHPs had malpractices which were barriers in the compatibility between the IHPs and BTPs (Madiba, 2010). An example of these barriers included; where IHPs were perceived to cast a spell on the perceived enemies of their visitors which resulted in mental health problems; A 60-year-old male diviner who was treating a patient with anxiety-like symptoms noted,

"It is like when a person steals something. A person may complain that his maize, chicken or anything has been stolen. This person decides to go and see an "n'anga" (an IHP) to help them to fix the "nyanya" culprit with "kupinga" magic or juju so that the "nyanya" (culprit) becomes psychotic or ill with some disease. Another visitor might demand that the culprit should die while another might say the culprit should go psychotic". However, there was no evidence for this except for the bare claims.

In addition, a few IHPs (6 out of 30) reported the information that had some health risks in mental health. The IHPs either reported ordering a patient with a life-threatening condition to stop taking medication from the clinic; A 76-year-old male herbalist who was treating a patient with depression-like symptoms noted,

"It does not help to insist that the patient should continue with this medication because I see a lot of problems where a patient is put on medication for example, epilepsy. A person is on medication for 8

years, the patient ends up with side effects such as getting fat” (Herbalist).

A few indigenous healers (5 out of 30) claimed they had no limitations in healing because they always had the treatment success; and the IHP believed they could cure everything being led by a water spirit (njuzu).

I don't know what I can't treat in mental health problems. I don't know what it is because for the 3 years that I have been practising healing, my work was progressing so well. My work is good because I have never seen a person back at my healing shrine complaining that things did not work for me. After one is assisted you don't see him/her anymore (Spirit medium).

There is a chance that those patients who do not return to the healer might have decided to change the healer, or had given up, or at worst, they might be dead. Such remarks were too bold and exposed the patients to risks. Again, the above was an instance that required the two approaches to partner with each other so that the IHPs would appreciate their limits and this would cascade down to the clients in the form of their improved health. Many IHPs (13 out of 30) identified further limits to the partnership mentioning that the IH and the BT used the different medications for the same condition (Elujoba, Odeleye, & Ogunyemi, 2005). This was observed by a 26-year-old male spirit medium with 5 years' experience as an IHP: *“It will not be possible to work together because we will be using the different medications”* (Spirit medium).

What was more worrisome in mixing the different drugs would be the drug interaction.

To sum up, IHPs' approach was little known, were interfering with BTPs' practice and made false claims. Further examples of these barriers included; IHPs were perceived to cast a spell on the perceived enemies of their visitors which resulted in mental health problems; or the IHPs either ordered a patient with a life-threatening condition to stop taking the medication from the clinic; or an IHP offered a diagnosis that did not tally with the one given at the clinic (Elujoba et al., 2005). Furthermore, IHPs and the BTPs used the different medications for the same condition. Some of the problems were ethical issues and required the engagement of the two approaches to share information on what worked and what did not work. However, IHPs believed the partnership would resolve the problems (Chitindingu et al., 2014). There was need for dialogue to resolve this between the two approaches.

5.4.2 The nurses' perceived barriers

The nurses reported that the partnership was necessary to control the IHPs immoral issues of the false claims on the treatment where they could not help, for example HIV/AIDS cure (K. Kofi & Kasilo, 2018). The nurses claimed the IHPs could not make a clear diagnosis and they might disadvantage some patients economically. They reported that the IHPs were mainly the source of the compliance problems among their

patients at the clinic and the partnership was needed to deal with the issues in the delivery of the mental health. In addition, the nurses reported that the partnership was important because the IHPs exposed some patients to some health risks, including stopping the patients from seeking treatment from biomedicine. However, the nurses noted that the IHPs provided the palliative care to their patients who had chronic mental illnesses and there was need for the partnership (Cohen et al., 2001).

The nurses complained that IHPs offered a diagnosis that did not tally with the one given at the clinic (e. g. witchcraft for psychosis) (Elujoba, Odeleye, & Ogunyemi, 2005)

The nurses raised further concerns against the IHPs. Almost all the nurses (5 out of 6) reported the IHP's counterproductive practices which they perceived could discourage them from collaborating with the IHPs (Elujoba, Odeleye, & Ogunyemi, 2005). For example, the patients lacked clarity on how to use the prescribed herbs because there was no measurement of the dosage. Data revealed that the nurses were complaining about IHPs' unethical practices that were interfering with the administration of therapy to their patients and the results supported the previous research findings that suggests some IHPs demonstrate unethical behaviours in their practices, gave the treatment that contradicted the BM prescriptions, and they caused barriers for patients from receiving adequate treatment (Elujoba et al., 2005). There is need to create dialogue between the IHPs and the BTPs. More research is required to establish how this could be done.

The nurses further claimed that the continued use of the herbs by the IHPs might lead to the development of the health-related problems (Ovuga, Boardman, & Oluka, 1999). A 60-year-old male patient who was treated for the depression-like symptoms noted

My depression did not go away. This was despite the fact that the indigenous healer continued to encourage me to come to him for more herbs. I ended up having the stomach problems (Patient).

The above observations suggest that the IHPs lack the idea of the side effects of the herbs. In addition, Many nurses reported that the IH was not considered hygienic at times and that people in IH might continue to use the same herb despite the fact that the disorder was not improving (Elujoba, Odeleye, & Ogunyemi, 2005). The problem might be resolved if refresher courses were organised for them for sharing information and this could easily be done through the partnership with BTPs.

Data suggests that the nurses complained about IHPs' unethical practices that were interfering with the administration of therapy to their patients and the results supported the previous research findings that suggests some IHPs demonstrate unethical behaviours in their practices, gave the treatment that contradicted the BTPs' prescriptions, and they caused barriers for patients from receiving adequate

treatment (Elujoba et al., 2005). There is need to create dialogue between the IHPs and the BTPs. More research is required to establish how this could be done. There were so many similar examples of contradictory activities in the parallel systems of the mental health service (between the IHPs and the BTPs) and many believed the partnership between the two approaches would eliminate the problems and protect the patients.

Data suggests that the partnership was needed to deal with the IHPs' flaws in the delivery of the mental health in order to protect the patients from harm. Data shows that the IHPs should allow the BTPs to study their herbs, and the IHPs should learn to appreciate the new methods of treatment so that they would not interfere with BTPs' treatments. The results were similar to the findings in the international communities (Labhardt et al., 2010). More research with regard to the specifics was needed.

5.5 Suggested partnership model between IHPS and BTPS in the treatment of mental disorders.

IHPs on partnership

The IHPs suggested some strategies on how IHPs might partner with the BTPs in the treatment of mental disorders. Many IHPs (10 out of 30) reported that they expected to work with the BTPs in a multi-disciplinary team similar to the Ugandan case where the BTPs were evaluating the effectiveness of local herbal treatment (Kayombo et al., 2007b). For example, many IHPs reported that partnership could be done most adequately through mutual division of labour where each approach focused on the different but complimentary roles. They suggested the IHPs would, for example, be dealing with the cultural and the spiritual issues while the BM specialists would deal with the specialists' issues requiring drugs. A 56-year-old male spirit medium who was treating a patient with somatisation disorder-like symptoms noted,

Sometimes the disease might be caused by the evil spirit and when the patient is treated at the hospital, the disease won't heal. If they try to take a patient's temperature, it will be normal despite the fact that the patient was ill. At that point one then suspects that the disorder can be treated in IH (Spirit medium).

The task sharing was the key issue to the problems and the two healing approaches were playing complementary roles therefore the approaches were compatible in the delivery of the mental health service similar to the Senegalese case findings (K. Kofi & Kasilo, 2018). Many IHPs (15 out of 30) reported the partnership would be done through sharing of tasks (Watts et al., 2002). A 56-year-old male diviner who was treating a patient with somatisation disorder-like symptoms noted, *"The conventional medicine can help to pre and post-test our patients when they come and when they leave our treatment"* (Herbalist).

Furthermore, some IHPs (8 out of 30) further reported that they would focus on the psycho-social issues which normally caused the common mental health problems. A 65-year-old male herbalist who was treating a patient with depression disorder-like symptoms noted; *"In our culture, the marital issues and relational issues can't be taken to hospital. The problem requires the indigenous healing solutions. Bad luck is best treated using an IH approach"*

The IHPs were addressing the perceived causes of the mental illnesses and this was useful for preventive measures against the development of mental disorders.

However, a few IHPs (3 out of 30) reported that the partnership between the IHPs and the BTPs was doubtful. A 47-year-old female herbalist who was treating a patient with PTSD-like symptoms noted; *"What I might want to add is that, I am not quite sure how things will be like, will nurses not be surprised that they are working with an herbalist, is that possible?"* (Herbalist).

Nurses on partnership

Almost all the nurses (5 out of 6) reported that the professionals in biomedicine should acknowledge what the IHPs do in order to collaborate with BM systems (Krah, de Kruijff, & Ragno, 2018). They reported that there should be an exchange of information on healing among the different therapies in order for the parties to understand their strengths and limitations of each approach (Gunda, 2007). Many nurses felt there was need for a discussion on the roles and responsibilities of each approach in mental health treatment and the nurses should lead the process and determine what the IHPs would do (Simmons, 2012). This was observed by a 34-year-old female nurse.

The nurses should lead the process and we support them. If we are satisfied that the IHPs can also treat some mental health conditions effectively, we should allow them to help the people" (Nurse).

The nurses supported the partnership between the IHPs and the BTPs. This was paramount to bridging the gaps in the delivery of mental health service in Zimbabwe.

There was an attitude of intolerance among the providers of the mental health service from the two opposing approaches. Despite the tolerance, the nurses expressed optimism to work with the IHPs and therefore, the partnership was possible. Many IHPs mentioned the need for the mutual understanding and the acceptance of each other in the treatment of mental illness (Busia, 2005). A 51-year-old male herbalist who had 12 years' experience as an IHP noted,

"We feel that nurses should respect our work and we will accept what they do because as indigenous healers we do not object to be taught the other ways of healing that were not known to us in mental health treatment" (Herbalist).

The IHPs were open to learn new ways healing. This was a vantage point for the partnership which would aim to share the healing information. Again, there was a need for tolerance for each other and the IHPs were ready to do that.

VI. SUMMARY AND CONCLUSION

This paper discussed the possibility of a partnership between the IHPs and the BTPs in the care and treatment of mental disorders in Zimbabwe.

The study found opportunities and challenges in the potential for a partnership. The opportunities for collaboration which emerged were: people in IH are ready to collaborate; and the study found potential benefits in the partnership. The study can illustrate that IHPs mainly treated common mental disorders (*zvitenda*), social problems and culturally specific problems perceived to have supernatural causality, which BTPs did not address and IHPs also provided supportive and palliative care to BTPs' patients with chronic conditions.

However, the study also found IHPs presented some potential barriers; practices with either health risks or that were counterproductive to the partnership. IHPs ordered patients to stop taking BT medication and they changed the diagnosis which patients were given in BT. Furthermore, some IHPs often used counterproductive practices which caused illnesses in some people. While this might have been true at face value, the findings may be viewed as a reflection of the superiority and inferiority issues relating to IH and BT where IH was viewed negatively due to the impact of the colonization (Illich, 1995). This scenario is not helpful towards the partnership of therapies which could result in a culturally appropriate therapy.

The findings further highlighted the strengths and weaknesses of the BT and the social models of disease causation and the treatment often presented in the discourse around the indigenous knowledge systems and the modern scientific knowledge (Illich, 1995). Therefore, the partnership between the IH and BT might be considered a tool that could be used to correct the imbalances (where IHPs were downplayed and BTPs were considered a superior) between the indigenous knowledge systems and the modern scientific knowledge in the developing countries. The thesis is an attempt to reconstruct the IH as a useful therapeutic approach which can be used together with the BT to establish a culturally appropriate mental health treatment.

The IHPs, and nurses accepted to have the partnership because they perceived some potential benefits. Although they viewed the IHPs had some flaws in the delivery of mental health care, they suggested that the IHPs were compatible with the BTPs. The IHPs should be integrated with the BTPs in order to increase the coverage of mental health care in resource poor countries. More research is required.

VII. RECOMMENDATIONS

The IHPs should have dialogue with their national association, ZINATHA to improve on their ethical behaviour and the BTPs should assist them to improve on ethical issues in mental health care.

The BTPs should acknowledge the IHPs' modes of diagnosis and treatment of mental disorders that talk to a patient's cultural and spiritual world and tap into problems which otherwise were not recognized in biomedicine.

The study found people have misconceptions about some mental condition, e.g. epilepsy. There should be awareness programmes through training, education and advocacy.

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.

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 paper demonstrated the potential for a partnership between IHPs and BTPs, but there was need to know more detail about the strategies for partnership developed by this paper. Quantitative studies should be done to establish the efficacy of the techniques before the partnership takes place. The results from the studies would be expected to lead to the development of effective strategies that closes the gaps in the delivery of mental health care by increasing the coverage of mental health care through the use of non-specialised IHPs and the nurses in Zimbabwe.

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