


Collaboration Between Biomedical and Complementary and Alternative Care Providers: Barriers and Pathways

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Abstract

We examined the scope of collaborative care for persons with mental illness as implemented by traditional healers, faith healers, and biomedical care providers. We conducted semistructured focus group discussions in Ghana, Kenya, and Nigeria with traditional healers, faith healers, biomedical care providers, patients, and their caregivers. Transcribed data were thematically analyzed. A barrier to collaboration was distrust, influenced by factionalism, charlatanism, perceptions of superiority, limited roles, and responsibilities. Pathways to better collaboration were education, formal policy recognition and regulation, and acceptance of mutual responsibility. This study provides a novel cross-national insight into the perspectives of collaboration from four stakeholder groups. Collaboration was viewed as a means to reach their own goals, rooted in a deep sense of distrust and superiority. In the absence of openness, understanding, and respect for each other, efficient collaboration remains remote. The strongest foundation for mutual collaboration is a shared sense of responsibility for patient well-being.

Keywords

caregivers, caretaking, culture, cultural competence, religion, spirituality, traditional, folk, medicine, mental health and illness, well-being, qualitative research, focus group discussion, Africa

Introduction

Complementary and alternative care providers (CAPs), including traditional and faith healers, are important stakeholders in mental health care in developing countries (Gureje et al., 2015; Nortje, Oladeji, Gureje, & Seedat, 2016), serving many with mental health problems (Galabuzi, Agea, Fungo, & Kamoga, 2010; Kurihara, Kato, Reverger, & Tirta, 2006; Latypov, 2010; Mbwayo, Ndeti, Mutiso, & Khasakhala, 2013; Varghese, Gopal, & Thomas, 2011). Traditional healers share worldviews and belief systems (Campbell & Amin, 2014; Thornton, 2009) with their patients, and are generally more accessible and affordable than biomedical health care (Farooqi, 2006; Gureje et al., 2015; Nortje et al., 2016). Many patients seek the help of biomedical psychiatric services in addition to receiving care from traditional healers (Chitindingu, George, & Gow, 2014; Nortje et al., 2016), therefore necessitating shared knowledge and collaboration between the different providers (Chitindingu et al., 2014). The World Health Organization has advocated for increased involvement of traditional healers in the provision of general health care since 1978 (World Health

Organization, 2000), and a few countries have started to facilitate collaboration through incorporating traditional care into formal health care systems (Kurihara et al., 2006; Macfarlane & Alpers, 2009; Manson, 2000; Sorsdahl, Stein, & Flisher, 2013). Previous collaborative efforts have focused mostly on the prevention and treatment of HIV/AIDS (United Nations Programme on HIV/AIDS, 2006), with little focus on mental health care. Both specialist and nonspecialist care providers have called for the recognition and mobilization of traditional and faith

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healers to facilitate the improvement of mental health care (Kakuma et al., 2011; Saraceno et al., 2007), in the context of the human resource shortage in low- and middle-income countries (LMIC). Some previous collaborative efforts were possibly undermined by tensions between biomedical and traditional care providers, as well as unfavorable attitudes toward alternate healing systems (Green, 1988). Such efforts suggest that traditional healers, faith healers, biomedical care providers, patients and patient caregivers, and the government need to cooperate in order for collaboration to succeed.

Studies examining stakeholder views on collaboration have primarily focused on biomedical care providers. These studies suggest that biomedical care providers are generally open to collaboration, acknowledging that traditional healers, with their skills in the spiritual and psychological treatment of patients (Upvall, 1992), are an important resource for patients (Addis, Abebe, Genebo, & Urga, 2004). However, most biomedical care providers endorse only limited collaboration (Addis et al., 2004; Barbee, 1986; Campbell-Hall et al., 2010; Pearce, 1982; Peltzer & Khoza, 2002; Tolera et al., 2011), demanding conditions of control, regulation, and supervision of traditional healers by biomedical services (Addis et al., 2004; Bishaw, 1990; Kahn & Kelly, 2001; Ojanuga, 1981; Pearce, 1982), as well as training traditional healers in the biomedical paradigm (Addis et al., 2004; Campbell-Hall et al., 2010; Chipolombwe & Muula, 2005; Ojanuga, 1981; Tolera et al., 2011; Upvall, 1992). Biomedical care providers are often dismissive (Chipolombwe & Muula, 2005; Kahn & Kelly, 2001; Upvall, 1992) or ambivalent (Barbee, 1986; Campbell-Hall et al., 2010) about collaborating with traditional healers. They often cite differences in worldview, erratic dosages of herbs, delays in referrals (Chipolombwe & Muula, 2005), lack of evidence, and potential harms (Addis et al., 2004; Campbell-Hall et al., 2010; Tolera et al., 2011) as the main obstacles.

Conversely, traditional and faith healers have been more willing to collaborate and integrate with biomedical care providers in the provision of primary health care (Addis et al., 2004; Bishaw, 1990; Burnett et al., 1999; Hillenbrand, 2006; Puoane, Hughes, Uwimana, Johnson, & Folk, 2012). Traditional and faith healers have also suggested parallel care provision as a method of collaboration (Hillenbrand, 2006), stating a need for support (Addis et al., 2004) and supplementary training from government (Addis et al., 2004; Bishaw, 1990; Burnett et al., 1999; Ragunathan, Tadesse, & Tujuba, 2010). Some have requested biomedical training (Hillenbrand, 2006). Qualitative studies conducted in South Africa and Cameroon suggest that traditional and faith healers are unhappy with the lack of recognition from government and the lack of respect from biomedical care providers. They express concern about

potential exploitation of their herbal knowledge (Campbell-Hall et al., 2010; Hillenbrand, 2006; Sorsdahl, Stein, & Flisher, 2010). Some traditional and faith healers are hesitant to refer to Western medical care, as they believe the latter might be unable to treat the effects of witchcraft (e.g., when a curse has been placed on a person) or the real cause of mental illness. They are also reluctant to refer patients due to Western medicines' perceived incompatibility with traditional remedies (Awodele, Agbaje, Ogunkeye, Kolapo, & Awodele, 2011). On a deeper level, the attitudes of healers from all traditions, as well as patients, are framed within an ongoing cultural struggle between old traditional values and modern Western aspirations (Del Casino, 2004). Ambivalence between the two systems and what they represent may undermine the will to bring them together in collaboration.

While previous studies indicate mixed attitudes toward collaboration, empirical exploration of collaboration between conventional and complementary mental health providers, especially from the perspectives of different cultures and nationalities, is lacking. In this report, we present the results of a study exploring the views of biomedical providers, complementary alternative providers (CAPs), mental health service users and caregivers regarding the feasibility, boundaries of as well as perceived barriers and facilitators to such collaboration in three sub-Saharan African countries.

Materials and Methods

Sample

Data were collected in Ghana, Kenya, and Nigeria as part of formative studies conducted to inform the design and implementation of a single-blind cluster randomized controlled trial (RCT). The goal of the RCT was to evaluate the effectiveness of a collaborative shared care intervention package delivered by CAPs and primary health care providers (PHCPs) in improving the outcome of patients with psychosis presenting to CAP facilities compared with patients presenting to CAP facilities offering enhanced usual care. The RCT, known as COSIMPO (Collaborative Shared Care to Improve Psychosis Outcome), hypothesizes that patients presenting to CAP facilities engaged in collaborative shared care with PHCPs will have better psychosis outcomes compared with patients in enhanced usual care at 6 months, as measured by a significant mean reduction in symptoms as rated by the Positive and Negative Syndrome Scale (PANSS). In addition to the aforementioned primary outcome, a hypothesized secondary outcome is that patients in the collaborative care arm will be significantly less likely to receive harmful treatment or be subject to human rights abuses (e.g., chaining, beating, starving, exposure to natural elements, scarification, locking up, fasting) than those in

enhanced usual care. Data from the formative studies were to inform the implementation of COSIMPO by providing an understanding of (a) existing patterns of interaction between different care providers, (b) the clinical practice profile of CAPs and their treatment approaches, (c) lay idioms and terms used for the disorders of interest, (d) experience of users of traditional and faith healing approaches and their caregivers, and (e) feasibility, boundaries, potential barriers, and facilitators of collaboration between conventional and complementary providers in the care of persons with severe mental disorders. While an earlier report has dealt with one aspect of the formative studies (Makanjuola et al., 2016), the present report is based on data exploring collaboration.

A mapping exercise was conducted in each country to determine the number, distribution, and practice profile of complementary and primary health care facilities in defined catchment areas in the three countries. A snowballing approach was used such that every CAP who provided treatment to patients with mental disorders and who practiced in the selected catchment area was identified. The search was continued in each segment of the catchment area until no additional CAP facilities could be identified.

Based on the mapping exercise, purposively selected faith healers (FH), traditional healers (TH), patients and their caregivers (PCG), as well as biomedical care providers (BM) were constituted in each country for focus group discussions (FGD). The healers and biomedical care providers (BM) were identified and approached during engagement meetings and the mapping exercise. Patients and their caregivers were approached and selected from among those who had recently been in the care of traditional and faith healers. Ethical approvals were obtained from the relevant institutional review boards (including Kwame Nkrumah University of Science and Technology, Ghana; University College Hospital and University of Ibadan, Nigeria; and Kenyatta National Hospital and University of Nairobi, Kenya). Participants provided informed consent after being ensured about the confidentiality of the research data and the purpose of the research study. All recordings and transcriptions were kept in a locked office and/or password protected. No identifiable information was used in the article writing process. Participants ($N = 194$, male 61.9%) ranged between 19 and 71 years (average age = 43.31 years). On average, biomedical care providers (BM) were the youngest (37.59; range = 24–56 years), followed by patients and their caregivers (PCG) (39.30; range = 19–64 years), faith healers (FH) (46.27; range = 29–68 years), and traditional healers (TH) were on average the eldest at 51.37 years old (range = 33–71 years). The Ghanaian sample ($n = 72$) consisted of 15 faith healers (FH), 16 traditional healers (TH), 16 patients and their caregivers (PCG), and 25 biomedical care providers (BM). The Kenyan ($n = 61$) sample consisted of 12 faith healers (FH), 15 traditional healers (TH),

18 patients and their caregivers (PCG), and 16 biomedical care providers (BM). Last, the Nigerian sample ($n = 61$) consisted of 14 faith healers (FH), 15 traditional healers (TH), 16 patients and their caregivers (PCG), and 16 biomedical care providers (BM).

In this article, for the purpose of clarity, we refer to the three provider groups as *biomedical care providers* (BM), *faith healers* (FH), and *traditional healers* (TH). The patient and caregiver group (PCG) refers to the group of mental health service users and caregivers.

Instruments and Procedures

We qualitatively explored the nuanced perceptions and experiences of current and/or future collaboration. A total of 25 semistructured FGD were conducted in Ghana (9), Kenya (8), and Nigeria (8). Separate FGDs were held with faith healers, traditional healers, patients and caregivers, and biomedical care providers, respectively; with an average of seven participants per group. Discussions were held in the local languages (Yoruba in Nigeria, Twi in Ghana, and Swahili in Kenya) and facilitated by trained research assistants with a social sciences background. Audio-recorded FGD was transcribed and translated to English (and back-translated) by the research assistants. The thematic framework approach (Braun & Clarke, 2006) was used for data analyses; coding was both inductive and deductive. The following steps were followed during data analyses: (i) Van der Watt and Nortje familiarized themselves with the data prior to initiating the analysis process; (ii) Nortje created initial primary codes from the discussion guide, including those relating to the nature of existing collaboration (where such existed), perceived barriers to collaboration, and possible pathways to collaboration; (iii) the initial primary codes were applied to the transcriptions (using MAXQDA11) where appropriate, and additional and subcodes for unexpected emerging themes were created and applied; (iv) Nortje critically reexamined and simplified the additional and subcodes, merging identical or similar codes, and removing redundant codes; and (v) thereafter, Van der Watt and Nortje validated and collapsed the subthemes into the themes presented below. Differences in interpretation were resolved by consensus. Van der Watt and Nortje's social sciences and biomedical backgrounds, respectively, influenced the aforementioned analysis process.

Results

Although various themes emerged from the data, the present article focuses on the main barriers to collaboration and identifying pathways toward better collaboration (including the respective subthemes).

Barriers to Collaboration

Several barriers to collaboration were identified, including the limited number of biomedical care providers, geographical constraints, and financial concerns. These barriers were overshadowed by an overall sense of distrust.

“It did not help at all...” (Ghanaian patients and their caregivers (PCG)). A strong distrust in biomedical care providers’ general abilities was evident. A Kenyan patients and their caregivers (PCG) states, “When I was taken to hospital I stayed for . . . over six months and I was not getting better . . . he [herbalist] treated me and within one month I got better.” Similarly, a Ghanaian patients and their caregivers (PCG) said, “When I took my patient to the hospital, it did not help at all.” One Nigerian TH sent his patient to “your hospital . . . This was to test your ability, for I know he will be given tablets and tonic instead of directing such a patient to where he would be healed.” Two participants made it clear it was the “Whites” and the “English doctors” whose treatment could not be trusted:

The English doctors, those that inject people, they should release people because someone sees there is no sign of this person becoming better but still continues to inject this person, they have refused to let them go. (Kenyan FH)

Some Whites came to my place sometime ago and I asked them why their drugs and injections have a lot of side effect[s] and they said theirs is to reduce the aggression but not to heal it completely. . . . I wouldn’t want a patient to be injected before I start my treatment . . . (Ghanaian TH)

More specifically, participants had a distrust of biomedical care providers (BM)’s ability to treat mental illness, stating that taking the patient “to the hospital which [*sic*] will worsen the case, for mental illness does not require injections or the use of any modern medical equipment” (Nigerian traditional healers (TH)). Similar to the above, participants spoke of the inability of the orthodox medicines: “all those orthodox medicine[s] cannot treat the illness” (Ghanaian faith healers (FH)), “orthodox medications [are] not efficacious on the jinns or spirits causing his madness. I have mentioned it earlier that Westerners do not believe in the fact that a patient can be charmed” (Nigerian patients and their caregivers (PCG)). A Ghanaian patients and their caregivers (PCG) also stated that the “Whites don’t have medicine for madness therefore they resort in having several operations on your head, which I wouldn’t have allowed . . . if I knew there is a man in Ghana who can cure this illness.” Similarly, a Ghanaian traditional healers (TH) stated, “Some Whites came to my place sometime ago and I asked them why their drugs and

injections have a lot of side effects and they said theirs is to reduce the aggression but not to heal it completely.”

Biomedical care providers were, however, trusted to diagnose patients. Thus, “when this person leaves the hospital with the report or card that he is given . . . we take a look at this report and then give him medication accordingly” (Kenyan traditional healers (TH)). Patients are “first [*sic*] taken to [the hospital] after which several tests will be conducted. If it is not germ caused, the traditional medical approach may be adopted” (Nigerian patients and their caregivers (PCG)). Biomedical care providers were also trusted to treat physical ailments (such as dehydration or anemia) using physical interventions:

. . . a case that was brought to me that I refused to take; the patient’s relatives had to take the patient to UCH [University College Hospital] where the patient was treated . . . it was caused by the untreated wound on the patient’s body. (Nigerian FH)

Trust in the biomedical system was thus limited to diagnoses and the treatment of physical ailments using physical interventions.

It was not only the biomedical care providers who were not trusted. Some biomedical care providers, patients, and patient caregivers distrusted the efficacy of non-biomedical healers’ treatment of mental illness and requested “the government should test the efficacy of their [non-biomedical healers] products” (Nigerian patients and their caregivers (PCG)). Similarly, two biomedical care providers stated,

We can’t uh [pause] point a finger at them and say they should be removed from the system . . . we can actually do a bit of research . . . and see if it is truly the medication from the traditional healers that helped. (Kenyan BM)

. . . if they can give us the evidence-base of their intervention and how they work, when they should work. Then, I think we will be convinced [pauses and laughs]. (Ghanaian BM)

While non-biomedical healers were generally open to their treatments undergoing testing, stating that “people will know more about the drugs since it will be tested in the laboratory” (Nigerian traditional healers (TH)) and “my herbal medicine . . . let them be tested and get approved” (Kenyan traditional healers (TH)), none of the participants volunteered suggestions on how this testing should proceed.

“One barrier is the feeling of superiority...” (Ghanaian biomedical care providers (BM)). Rivalry and perceptions of superiority appeared to influence the distrust between the

respective groups. Each group perceived their own treatment to be superior to that of the other, as stated by a Ghanaian faith healers (FH): “. . . [we] form a group but any time we form it collapses because each of us thinks of himself as the best.” Similarly, a Nigerian patients and their caregivers (PCG) stated: “. . . when someone is using akocity [superiority], I am boss, you are boss, it may lead to break down.” Another Ghanaian faith healers (FH) stated:

. . . though the doctors are very much aware of the effectiveness of our drugs but they don't want to admit it because they think it is a kind of threat to their job. I have known clearly that they don't want to give us any chance.

The biomedical care providers also noted the barrier of superiority:

One barrier is the feeling of superiority, they don't accept ours, we don't accept theirs, we try to condemn them, they also don't appreciate us. (Ghanaian BM)

I think it is also our own attitude . . . if we stop condemning them and praise them . . . let us correct them. (Ghanaian BM)

In addition, where education in the biomedical paradigm of non-biomedical healers was mentioned as a pathway to collaboration, an underlying sense of superiority is evident:

. . . public education, it is very important, once you are able to let people understand the causes, the signs and symptoms then you have tak[en] a step that will allow us to provide the kind of service we want . . . they will know what to do when it [mental illness] comes rather than quickly just sending the person to the prayer camp. (Ghanaian BM)

If these spiritual leaders, if they are going to [pause] if they are educated on the importance of medical care maybe like hospital care; if they can be brought about [pause] if they can be educated to understand about medical care . . . (Kenyan BM)

“...You have brought another religion that is not ours” (Kenyan faith healers (FH)). Various belief systems might influence the distrust between different groups. For example, some participants mentioned that Muslim and Christian healers cannot work together due to their different religions:

. . . we faith healers in helping such a person is that you can find a person who is Muslim and you are Christian . . . you can rebuke them [evil spirits] and they leave him but now his people can then take drastic steps on you to report you that we are Muslims and now you have brought another religion that is not ours. (Kenyan FH)

In addition, faith healers are perceived as reluctant to work with traditional healers: “. . . if you tell them now

that spiritual person collaborates with the traditional healer, he'll say now that is evil you telling me to collaborate with that person” (Kenyan biomedical care providers (BM)). Similarly, a Kenyan patients and their caregivers (PCG) said, “. . . there is a barrier, between the pastor and herbalist because pastor believes in faith. He believes that without anything everything is possible. And the herbalist, he is also under a different kingdom.” Along the same lines, a Ghanaian traditional healers (TH) highlighted that Ghana has “. . . different religions we associate ourselves with . . . if a doctor is a Christian; he wouldn't like to visit our facility. So this can be a barrier that will prevent the collaboration from working.”

Moreover, non-biomedical healers hold beliefs regarding causes such as “. . . a person can have a nightmare and as soon as he wakes up he gets attacked of mental illness” (Ghanaian faith healers (FH)), or “. . . some people do money rituals and abandon the prescribed sacrificial rites hence resulting in madness” (Nigerian patients and their caregivers (PCG)), which are in conflict with the biomedical paradigm. This also included beliefs that “this illness is brought by spirits of ancestors” (Kenyan traditional healers (TH)), and practices where “our fathers will consult the oracle first to know the kind of madness it is” (Nigerian traditional healers (TH)). Similarly, some treatment methods are in conflict with the biomedical paradigm: “. . . [herbal medicine] causes them to be sneezing and releasing phlegm. While he is releasing the phlegm, he is becoming normal” (Ghanaian traditional healers (TH)).

“... It is possible for us to be cheated” (Nigerian faith healers (FH)). Some non-biomedical healers expressed their distrust of biomedical care providers' intentions: “If always you invite use, we come but we don't see anything. Is like you are gaining knowledge from us to enrich your [sic] and career but you people are not interested in helping us” (Ghanaian faith healers (FH)). Specifically, non-biomedical healers voiced concern that biomedical care providers want to gain from the knowledge of non-biomedical healers without any compensation of the latter:

. . . even you doctors we will show you the medicine that we work with and then after you come and take it . . . the medicine I showed you for free and . . . I remain with . . . my poverty. (Kenyan TH)

Similar to previous sections above, non-biomedical healers emphasized the “Whites” who will be stealing their knowledge:

I agree with him because we the Blacks have the knowledge that is how come the Whites come down to learn from us, take our herbs and go back to transformed them which they have exported to us. (Ghanaian FH)

... he was seeing that the Whites were coming to Africa for herbs and then sell them. (Ghanaian FH)

I have seen recording being done here. So is this ... going abroad to the Whites? (Kenyan PCG)

Pathways to Better Collaboration

Participants provided insights on possible solutions for the barriers to collaboration.

"We want the government to recognize us ..." (Nigerian faith healers (FH)). Non-biomedical healers requested recognition, "permits" (Kenyan traditional healers (TH)), "letters" (Kenyan traditional healers (TH)), and "certificates" (Kenyan traditional healers (TH)) needed for protection, from government. One Kenyan traditional healers (TH) stated "... that is why we want to work together ... sometimes I am even scared to enter into certain areas because we don't have a letter." Another Kenyan traditional healers (TH) also mentioned the protection of having "those letter do [*sic*], they prevent the bad name calling of being referred to as witches ... that is how we have protected ourselves." Non-biomedical healers wanted "the government to recognize us and accord us our due respect. They should stop harassing us with the police" (Nigerian faith healers (FH)).

A request was also made for financial assistance from the government in terms of salaries: "... for the doctor collects his or her salary on a monthly basis unlike the traditional medical practitioner. The government too should help the traditional medical practitioner in this regard" (Nigerian patients and their caregivers (PCG)), and a space to work: "... you [should] create a budget and find somewhere in your hospital where those healers could be sitting down and doing their job" (Nigerian traditional healers (TH)). Much like the request to receive recognition, respect, and protection, financial assistance was identified as a solution; yet financial assistance was also seen as the end while collaboration was the means:

What is more important is financial assistance. Some of the parents do abandon their patients on you because they are poor and cannot take care of them. There is one I am still caring for at the secondary school level. ... The collaboration is not all that important if we don't get support because of abandonment. (Ghanaian FH)

If the government will back us like it is backing the doctors, nothing will prevent us from working together. There are some of them [patients] who do not even have money to feed themselves and I feed them. So, if the government would support us with food and shelter like how it supports the hospitals, we can work together. (Ghanaian TH)

"... We should have boundaries ..." (Kenyan traditional healers (TH)). All the groups shared statements such as "... the need for each party to know their limit" (Nigerian biomedical care providers (BM)); and "there is a point a doctor shouldn't cross and there is a point a herbalist shouldn't cross [pause] yes, it should [be an] association with respect" (Kenyan traditional healers (TH)). Similarly, a Nigerian faith healers (FH) stated, "There can be a collaboration between doctors and faith healers given that it is not everything that can be treated in the hospital, especially the mentally ill." Thus, there was an emphasis on the limits of caregivers' capabilities:

... the role each has to play in the life of the patient. Because if I know that this man is going to do the spiritual aspect and I'm going to [do] the physical aspect [pauses and laughs] then I will know how we can share the outcome of the roles. (Ghanaian BM)

When everybody knows his or her role and appreciates others role then it will be possible and it starts from understanding each other. ... if the patient goes to him [pastor], he would first ask if he [has] been to the hospital before he starts with his [treatment], if not, then he will come to the hospital with the patient for us to give him medicine, then he continues with the spiritual aspect. This means that we can all work together. (Ghanaian BM)

Thus, if a patient's illness falls outside of the capability (or role) of the care provider, then the care provider should recognize this and refer the patient appropriately.

"Their main objective is to treat the sick person" (Kenyan patients and their caregivers (PCG)). One pathway to better collaboration, even if not explicitly identified as such by the participants in this study, is "... their main objective is to treat the sick person" (Kenyan patients and their caregivers (PCG)); "the benefit that they can get when they work together is better outcome for the patient. We pray God will grant the patient total healing" (Nigerian patients and their caregivers (PCG)). Collaboration will "... solve a lot of the problems of this country" (Ghanaian faith healers (FH)) and it will "... help to reduce the number of people with mental illness" (Ghanaian faith healers (FH)). Thus, there was a clear sense of shared responsibility toward the wellness of the patient and society in general:

It is the welfare of the patient[s] that we are looking out for not for our personal satisfaction. So, if we work with the doctors, it will speed up the patient's rate of recovery. If two people are traveling and both can drive, the other can drive when the one driving wants to sleep and it is better that way. So, it will help greatly, if we work together with doctors. (Ghanaian TH)

Discussion

We explored the views of healers, patients, and caregivers on biomedical and non-biomedical collaborative mental health care. Various barriers to collaboration emerged, dominated by an overall sense of distrust within and between groups. The hampering effect of lingering mutual distrust between traditional and biomedical care providers in Africa has been noted in previous research (Abdullahi, 2011). Rivalry and feelings of superiority, where each believes their own skills and/or paradigm to be superior, fueled distrust. Furthermore, divergent belief systems and conflicting philosophies appeared to influence the belief that the other group's treatment of mental illness is inferior. Unsurprisingly, differences with respect to diagnosing and treating mental illness existed both within and between treatment providers. These differences appeared to discourage mutual trust, which in turn impedes collaboration.

Barriers to Collaboration

Biomedical care providers were mostly only trusted to diagnose and treat physical ailments using physical interventions. This echoes previous findings that biomedical care is sought for physical (Shaw & Middleton, 2013) or *visible* (Ypinazar, 2006) illnesses, and not for mental illness. However, some biomedical care providers, patients, and patient caregivers distrusted non-biomedical treatments and requested proof of their efficacy. Within the biomedical paradigm, evidence-based practice refers to "clinical practice that is informed by evidence about interventions, clinical expertise, as well as patient needs, values, and preferences; and their integration in decision making about individual care" (Kazdin, 2008, p. 147). If the patient's "needs, values, and preferences" are understood purely from a biomedical perspective, it is unclear how evidence could be provided that could convince biomedical care providers of the value of non-biomedical treatment. Previous research expounded that the incorporation of indigenous healing methods was dictated and controlled by biomedical regimes of regulation and as such remained asymmetrical (Del Casino, 2004). Importantly, even though some biomedical care providers acknowledge that they may be "convinced" (Ghanaian biomedical care providers (BM)) that traditional medicine is effective, this acknowledgment was accompanied by laughter, calling its sincerity into doubt.

Rivalry and perceptions of superiority appeared to influence the distrust between the respective groups. This became evident when the *solution* of educating society and non-biomedical healers was mentioned; at closer inspection, phrases such as ". . . allow us [biomedical care providers (BM)] to provide the kind of service we want"

(Ghanaian biomedical care providers (BM)) and ". . . if they [non-biomedical healers] can be brought about" (Kenyan biomedical care providers (BM)) suggest education is useful for *converting* non-biomedical healers to what biomedical care providers believe to be a superior paradigm. This is in accordance with findings from a previous study where traditional healers are expected to learn from and adapt their practice to the principles of biomedicine (Wreford, 2005). Even while recognizing the role played by perceptions of superiority, biomedical care providers tended to position themselves as authoritative, confirming the tensions of power affecting collaboration. Some have suggested that not seeing traditional healers as equals or incorporating them into the health care system is a missed opportunity to improve population health (Shaw & Middleton, 2013).

Educating biomedical and CAPs about each other's discipline and clinical approaches may facilitate collaboration through careful yet deliberate efforts to bring the aforementioned philosophies closer to each other. While the addition of the non-biomedical paradigm to biomedical education has been discussed elsewhere (Chitindingu et al., 2014; Fenton & Morris, 2003; Hollenberg, Zakus, Cook, & Xu, 2008; Kim et al., 2012; Nxumalo, Alaba, Harris, Chersich, & Goudge, 2011), it was all but ignored by participants in the current study. In view of the well-known practice by patients to seek care from both biomedical and CAPs concurrently, the value of biomedical care providers understanding non-biomedical methods is clear (Chitindingu et al., 2014; Nortje et al., 2016). The apparent lack of such insight among participants is striking.

Various belief systems appeared to influence the distrust between proponents of different paradigms. Non-biomedical treatment methods are often in conflict with the tenets of biomedicine and subsequently labeled as witchcraft (Hollenberg et al., 2008). In so doing, they fail to ". . . appreciate the layers of indigenous knowledge possessed by various members of a community and the ideational basis of the system's approach . . ." (Konadu, 2008). Biomedical care providers consequently perceive traditional, complementary, and alternative modes of treatment as an illegitimate source of knowledge (Ernst, De Smet, Shaw, & Murray, 1998; Shaw & Middleton, 2013) and the use and reliance of such treatments as regressive and backward (Broom & Doron, 2013).

A strong perceived and experienced power imbalance is evident throughout the data. The non-biomedical healers (including the patients and caregivers who hold the non-biomedical views) appear careful to highlight how "the Whites" and "the English" treatments do not work, and that "Westerners" do not take their traditional beliefs seriously. One should also consider the level of resentment and the defensive language utilized by non-biomedical healers

throughout the data. This can possibly be inferred as a reaction to the predominant discourse that Western medicine is superior and that traditional treatments are outdated and/or not worthy of consideration. In addition, it often appears as if the non-biomedical healers simply want to be *seen*, recognized, or taken seriously by the biomedical care providers. They appear to have a desire for their non-Western practices to be recognized as real, meaningful, and not to be exoticized. This is similar to research by Del Casino (2004) who noted the discourses used by traditional Thai healers to legitimize their healing methods to that of global, conventional practices. In contrast, it seems as if the biomedical care providers want to *confirm* the superior position of the biomedical paradigm. Here, the way in which each party approaches the other, the power imbalance is also evident. This possibly suggests that the after effects of colonialism may have a strong impact on the non-biomedical healers' perceptions of biomedical medicine and trust in biomedical doctors, in general. Previous research has also underscored the negative impact of colonialism and the introduction of Western medicine in Africa, which has created an unequal power relation (Abdullahi, 2011; Konadu, 2008) and the marginalization of traditional healers and medicine (Richter, 2003). This unequal power relation "practically undermined and stigmatised the traditional health care system in Africa" (Abdullahi, 2011, p. 116).

It is important to take cultural differences into account as the provision (Broom & Doron, 2013) and meaning of health and health care are inextricably linked to the complexities of social relations (Del Casino, 2004) within the particular place and society. These cultural differences are important in delivering culturally sensitive health care (Ypinazar, 2006). In addition, "healers have an intense association with the culture in which they work" (Popper-Giveon & Weiner-Levy, 2014, p. 33). Even though participants did not mention cultural differences explicitly, the variety of cultures in Kenya, Ghana, and Nigeria cannot simply be ignored. Within Africa, non-biomedical healers are specifically valued for sharing worldviews and belief systems with their patients (Campbell & Amin, 2014; Gureje et al., 2015; Thornton, 2009). However, non-biomedical healers are not a homogeneous group either. Differences in philosophy as well as cultural practice may be highlighted through the processes of certification and registration. Therefore, any efforts toward collaboration from the biomedical community should be flexible and open to these differences.

Pathways to Better Collaboration

Although government recognition was suggested as a vehicle to better collaboration, closer scrutiny revealed that collaboration is seen as a means to an end. Collaboration was a means for non-biomedical healers to receive recognition,

respect, and protection, instead of working together with biomedical doctors to provide care for patients. In addition, non-biomedical healers were eager to collaborate to obtain government funding. These requests for government involvement have been documented previously (Pinkoane, Greeff, & Koen, 2012). Indeed, there is a suggestion that visits by government officials to places of traditional healing may help legitimize traditional healers and ultimately provide a secure platform from which they can collaborate with less fear of exploitation (Del Casino, 2004).

Mirroring previous research (Konadu, 2008), care providers emphasized awareness of their own limits and boundaries. Given the existing distrust between groups (especially in treating mental illness), the implication is that both groups believe the other group should *always* refer a mentally ill patient to them. Collaboration thus remains asymmetrical and unidirectional. One pathway to better collaboration is the shared responsibility toward the wellness of the patient and society in general.

Conclusion

Collaboration among participants was often seen as a means rather than an end. First, it is a means to *convert* the other to *our* paradigm. Second, it is a means for protection, recognition, and financial aid. Finally, it is a means for the *other* to know their role and limits in treating illness. Within the current sample, this quintessentially meant that the *other* should *not* treat mentally ill patients. All of this is rooted in a deep sense of distrust and perceptions of superiority. Without a mind shift to openness, understanding, and respect for each other's differences and beliefs, collaboration is moot. It appears as if the strongest foundation for mutual collaboration is a shared responsibility for the welfare of the patient. It can be argued that each care provider's sense of responsibility to the welfare of the patient might be influenced by their sense of wanting to *protect* the patient from other *inferior* care providers. However, further research is needed to explore the true meaning of the shared responsibility for the welfare of the patient. In addition, future research should utilize and emphasize this foundation to foster trust between different mental health providers and this may increase the likelihood of success of collaboration. The current research provides insight into the existing pattern of interactions between different care provider groups. This knowledge and understanding can be applied to future research and collaborative models to be sensitive to the differences between various care provider groups and the barriers to collaboration.

Limitations

As per the aim of this article, the current findings give a valuable insight into the shared perceptions of collaboration

across three countries and four stakeholder groups. However, presenting the data as such may have compromised the depth of the data analyses in terms of the perceptions of specific stakeholders or country-specific findings. Therefore, it would be valuable for future papers to explore some of the emerging themes in greater depth and detail to answer subsequent research questions, for example, exclusively exploring the perceptions of Christian Faith Healers in Kenya as compared with the Muslim Faith Healers.

The use of FGD can highlight the degree of consensus, promote dialogue and exchange, and help participants to clarify their own ideas and opinions (Morgan & Krueger, 1993), yet there is a risk of “group think” and “group polarization” (Robbins & Judge, 2011). It is thus possible that some participants may have suppressed, withheld, or modified their true feelings and/or beliefs if these were different from the majority in the group. Future research utilizing individual interviews may compensate for potential biases arising from group dynamics.

University trained researchers whose worldviews are arguably more biomedical facilitated the FGD. While practical, it created a power dynamic that possibly influenced non-biomedical healers’ willingness to talk freely (Lesch & Scheffler, 2015). The discussion guide served to direct conversation toward the research question, yet adherence to the guide with limited in-depth exploration by some facilitators may have limited data richness. Ideally, further interviews and/or FGD with less rigorous adherence to the discussion guide should be conducted that can lead to more nuanced insights.

Finally, the authors, who are from a biomedical and social sciences background, cannot purport to have approached the data in a value-free and neutral manner. While it has been essential to understand the perspectives of all participants as fully as possible, our goal was ultimately not phenomenological. We aimed to understand the possibility of collaboration from a predominantly biomedical perspective, with a particular goal in mind. These factors influenced what we have taken from the data and how we interpreted it. Nevertheless, we attempted to limit bias and prejudice as much as possible.

Authors’ Note

Soraya Seedat supervised data analyses and preparation of the first draft both of which were conducted by Alberta S. J. van der Watt and Gareth Nortje. All other coauthors participated in discussions to interpret the results and in revisions, and approved the final version of the manuscript for submission. The views expressed are those of the authors and do not necessarily represent those of the National Institute of Mental Health, the National Institutes of Health, the Department of Health and Human Services, or the U.S. Government.

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