Sacred Texts and Public Health: Interpretive Traditions, Bodily Ethics and Health-Seeking Behaviour in African Contexts

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ABSTRACT

Across much of sub-Saharan Africa, the Bible is not a private devotional object but a working public-health document. It supplies the categories through which illness is named, the vocabulary in which symptoms are disclosed or concealed, and part of the reasoning by which people decide where to go first when a child convulses, or a cough will not stop. This review asks a narrower question than the religion-and-health literature usually poses: not whether faith helps or harms, but how particular ways of reading healing texts translate into particular patterns of care-seeking, and which of the resulting delays are tractable. Three arguments are developed. First, African Christian communities do not share one hermeneutic. Mission-church, African Instituted Church, Pentecostal-charismatic and African biblical-hermeneutic readings differ in what they take a healing narrative to be, and those differences predict behaviour more reliably than intensity of belief does. Second, biblical texts carry an implicit bodily ethics, a set of assumptions about contagion, visibility, ritual boundary, gender and personhood, that continues to shape stigma and disclosure in African clinics, most visibly around HIV, epilepsy and disability. Third, therapeutic itineraries are sequential and legible. Mozambican patients who consulted multiple healers before testing waited a median of nine months against two for those who consulted none; Ghanaian cancer patients typically reached hospital after spiritual and herbal care; yet cluster-randomised evidence from Nigeria, Ghana and Tanzania shows that collaboration with religious and traditional practitioners can improve outcomes without displacing them. The review argues that therapeutic pluralism is a rational response to health systems that are variously inaccessible, culturally unintelligible or impersonal, and that the useful public-health target is referral design rather than displacement. Comparative material from the United States, Latin America and Asia is used to locate the African case against settings of stronger biomedical dominance. Literature published through 2025 is synthesised.

Keywords: African biblical hermeneutics, health-seeking behaviour, medical pluralism, stigma and disclosure, therapeutic itineraries, faith healing

1. INTRODUCTION

1.1 Scripture as a Public-Health Variable

A woman in Soweto keeps her antiretrovirals in a drawer and a bottle of church water on the shelf above them. She uses both. In the ethnographic record from that neighbourhood, this is unremarkable: prayer, church attendance and blessed water sit alongside clinic attendance in the accounts people give of managing chronic illness, and the two are not experienced as rival claims requiring adjudication (Bosire et al., 2022). Public-health analysis has generally treated such arrangements as noise around a signal, or as a health-literacy deficit awaiting education. Both readings are wrong, and the error is consequential.

The Bible functions in African health decision-making as a source of classification. It offers names for conditions that biomedicine describes without explaining; it distinguishes afflictions that can be borne from those that must be fought; it specifies who may touch whom, and under what conditions a person may re-enter the congregation. Togarasei (2025) puts the point bluntly in reviewing the field: health promotion in Africa that ignores the place of the Bible in how illness is understood, sought and provided for is working without a variable it cannot afford to omit.

That variable is not uniform. The scholarship has too often spoken of "religion" as though it were a single dial, turned up in some populations and down in others, with health outcomes varying accordingly. Koenig's (2012) influential synthesis of the religion-health field frames the relationship in terms of belief, coping and social support: categories that travel well but flatten the differences that matter most in African settings. What matters is less how strongly a community believes than what it believes a healing text to be. A narrative read as a closed historical record generates one set of behaviours; the same narrative read as an available promise generates another.

This review takes that difference as its subject. It asks how interpretive traditions, the bodily ethics encoded in the texts themselves, and observable patterns of health-seeking connect to one another across Nigeria, Ghana, Kenya, South Africa, Zimbabwe and their neighbours.

1.2 The Question and the Argument

The dominant public-health framing of African religious healing is a subtraction problem. Faith healing causes delay; delay costs lives; therefore reduce faith healing. The framing has the advantage of being partly true. Symptomatic HIV-positive adults in rural Mozambique who consulted no traditional healer before presenting at a health facility were tested after a median of two months; those who consulted one waited three; those who consulted several waited nine (Audet et al., 2014). Ghanaian cancer patients in an Akan-majority sample commonly reached the teaching hospital only after traditional and spiritual care, which is one reason so many present at advanced stage (Asante, Tuck & Atobrah, 2023). These are real harms, measured in months.

But the subtraction framing mistakes a symptom for a cause. People do not consult healers because they are ignorant of clinics. In southwestern Uganda, Sundararajan et al. (2020) found patients moving toward traditional practitioners because those practitioners gave them time, treated them respectfully and explained themselves, and away from biomedical facilities where they reported neglect and where diagnostic procedures were feared as invasive. The pull factor was care; the push factor was the manner of the clinic. Neither has anything to do with health literacy.

This article therefore argues the following. Therapeutic pluralism in African contexts is a rational response to institutions that are variously inaccessible, culturally unintelligible or impersonal. Religious healing is one of the forms that response takes, and it is neither uniformly harmful nor uniformly benign. The public-health question worth asking is not how to displace it but which specific delays it produces, in which conditions, and which of those delays can be shortened by designing referral relationships instead of policing belief. Where religious healing causes harm that referral design cannot reach -- the chaining of people with psychosis, the withdrawal of antiretrovirals on a pastor's instruction -- it should be named as harm and regulated as such. The distinction between these two categories is the practical work this review attempts.

1.3 Scope, Sources and Method

This is a narrative review, and its evidence base is uneven by design. Empirical material is drawn from sub-Saharan Africa, with Nigeria, Ghana, Kenya, South Africa and Zimbabwe carrying the argument; interpretive material is drawn from African biblical scholarship and from the wider exegetical literature on Hebrew and Gospel healing texts. Comparative material from the United States, Latin America, India and East Asia appears in section 5, where it does analytical work rather than decoration.

Biblical healing accounts are treated here as culturally embedded representations rather than as proto-clinical reports. The condition rendered "leprosy" in Leviticus 13 is not Hansen's disease; the demoniac of Mark 5 is not a psychiatric case file. What these texts supply is a set of assumptions about bodies and belonging, and those assumptions have an afterlife in how contemporary communities respond to visible illness.

Three questions organise the review. How do distinct African Christian reading traditions construe healing texts, and with what behavioural consequences? What account of the body do those texts transmit, and how does it bear on stigma, disclosure and care-seeking? And what does the empirical record actually show about therapeutic itineraries, their delays, and the interventions that alter them?

A caution about the evidence is owed at the outset. The interpretive literature is rich and the empirical literature is thin, and they are rarely produced by the same people. Claims about how hermeneutics shapes behaviour are therefore usually inferential rather than demonstrated. Where that is the case, this review says so.

2. INTERPRETIVE TRADITIONS: HOW AFRICAN CHRISTIAN COMMUNITIES READ HEALING TEXTS

2.1 Mission-Church Readings: The Text as Record

The oldest Christian reading tradition in Africa arrived with the mission station and its dispensary. It construes biblical healing narratives as historical testimony to a completed revelation: Jesus healed, the apostles healed, the canon closed, and what continues is not the miracle but the compassion that motivated it. On this reading, the hospital is the legitimate successor to the healing ministry. Divine action is real but ordinarily mediated through medicine, and the believer's duty is to seek competent care and pray for its success.

The tradition's institutional footprint is large. Faith-based providers deliver a substantial share of biomedical care across sub-Saharan Africa, running hospitals, training staff and reaching communities that state provision does not, though the evidence on their comparative reach and cost remains patchier than advocates usually concede (Olivier et al., 2015). Christianity in these settings is not an alternative to biomedical modernity. It is frequently the infrastructure through which biomedical modernity arrives.

Its hermeneutic came at a cost, and the cost was paid in indigenous therapeutic knowledge. Missionary Christianity in Zimbabwe denounced African traditional medicine as incompatible with Christian faith, a judgement that did not eliminate the knowledge so much as drive it out of speech; postcolonial scholarship has since had to recover what mission theology had ruled unspeakable (Rugwiji, 2019). The same logic operated across the region. What was suppressed was not only a set of remedies but a set of aetiologies, and aetiology is precisely what patients need when biomedicine explains the mechanism of a disease without explaining why it has come to them.

The mission-church reading survives most strongly among educated urban Christians and among clinicians, where it underwrites a comfortable division of labour. It is also, for that reason, the reading tradition least likely to generate delay, and least likely to be the tradition of the patient arriving at the clinic in month nine.

2.2 African Instituted Church Readings: The Text as Ritual Script

The churches founded by African prophets from the early twentieth century onward read the healing texts differently. Where the mission reading takes a narrative as a record of what happened, the Aladura, Zionist and Apostolic traditions take it as a script for what should be done. The text prescribes procedure.

Ademiluka's (2023) analysis of *eto* -- the sacred preparations made by Aladura prophets for their clients -- shows the mechanism precisely. Consecrated water, ritual bathing in flowing streams, recitation of psalms, fasting, candles and blessed cloths constitute a therapeutic repertoire that draws simultaneously on Yoruba medicine and on a literalist appropriation of Gospel practice. The Johannine account of Jesus making clay with saliva is not read as a datum about first-century healing technique; it is read as authorisation for material mediation. Ademiluka

concludes that the practice is defensible as Christian so long as its more occult borrowings, including midnight sacrifices at road junctions, are abandoned. That conclusion is contestable, but the observation underlying it is not: these churches generate ritual from exegesis.

The Psalms occupy a particular place in this tradition, and here African biblical scholarship has done the most useful work. Adamo (2018) argues that Psalm 23 is read in African contexts not through the pastoral imagery that dominates European exegesis but as a text about protection, provision, healing and success, which are the four concerns that bring people to prophets in the first place. The psalm is used rather than merely interpreted. Dada's (2021) assessment of Adamo's method makes the underlying claim explicit: the Yoruba cultural elements are not illustrative addenda to an exegesis conducted on other grounds; they constitute the interpretive frame.

Kenyan evidence indicates that these churches are the ones most attentive to healing as a pastoral function, and that their members move fluidly among faith healing, African traditional healing and biomedical care rather than inhabiting separate therapeutic worlds (Boyo et al., 2021). Asamoah-Gyadu (2014) documents the corresponding move in Ghana, where herbs once associated with shrine priests have been relocated rather than abolished: the substance remains, the mediating authority shifts from ancestral agency to the Christian God, and the prophet's prayer performs the transfer. Christianisation did not erase indigenous pharmacopoeia. It rebranded its warranty.

2.3 Pentecostal-Charismatic Readings: The Text as Contemporaneous Promise

The fastest-growing reading tradition treats the healing narratives as neither record nor script but as promise, presently available and personally addressed. The grammar is one of entitlement: what Jesus did, he does. Folarin's (2017) study of Christ Apostolic Church theology shows divine healing understood not as an extraordinary irruption into ordinary life but as the normal expression of divine power within it, a framing that removes the category of the exceptional and thereby raises the expected frequency of cure.

This hermeneutic is not naive about evidence, and it is a mistake to treat it as pre-modern. Brown (2015) demonstrates that Pentecostal healing claims are increasingly advanced *against* biomedical evidentiary standards rather than outside them: the testimony is corroborated by the scan, the healing is verified by the discharged patient's file. Wabyanga, Nyamnjoh and Ugba (2021) show African Pentecostal divine-healing practice continually reinventing itself in response to religious competition, migration and secular medical cultures. These are traditions that know exactly what a laboratory result is and have decided to enlist it.

The behavioural consequences are genuinely mixed, and the honest summary is that they depend on the pastor. Azia et al. (2025) interviewed twenty Pentecostal pastors in a Cape Town suburb and found two incompatible positions held within the same movement. One group treated HIV as a demonic affliction or divine punishment, held that God heals without medical mediation, and counselled congregants to focus on God rather than on treatment; several of these pastors could not correctly describe HIV transmission or what antiretrovirals do. The other group held that

God heals through doctors, that antiretroviral therapy extends life, and that medication and prayer belong together. The difference between a congregation led by the first sort of pastor and one led by the second is, in aggregate, a difference in viral suppression.

That finding is the clearest available evidence for this section's central claim. The two groups of pastors were equally devout, equally Pentecostal and equally committed to divine healing. They differed in how they read the relationship between divine agency and secondary causation, and that hermeneutical difference, not their piety, determined what they told sick people to do.

2.4 African Biblical Hermeneutics: Reading Through Indigenous Therapeutic Categories

The fourth tradition is scholarly rather than congregational, and it has been the most theoretically ambitious. African biblical hermeneutics reads Hebrew and Gospel healing texts through the therapeutic categories of African cultures, on the argument that those categories are closer to the texts' own world than the categories of post-Enlightenment European exegesis.

Adamo (2021) anchors the approach. Reading the declaration of Exodus 15:26 that YHWH is Israel's healer alongside Yoruba understandings of therapeutic mediation, he shows that divine causation in the Hebrew text does not exclude practical treatment; healing belongs ultimately to God and is routinely mediated through prophets, substances and human agents. The Yoruba framework, in which a herbalist's preparation and an *orisha*'s favour are not competing explanations, turns out to make better sense of the Hebrew material than a framework that must choose between miracle and medicine.

The Hebrew material supports the reading more than sceptics allow. Cranz (2020) shows that the Chronicler's account of King Asa does not condemn physicians; the criticism falls on a king who consulted them and did not seek YHWH, which places medicine inside a hierarchy of dependence rather than outside the circle of legitimate action. That is a structure African therapeutic thought already recognises, and it is the structure that the Cape Town pastors who endorsed antiretrovirals had arrived at independently.

The method generalises. M'bwangi (2021) reads the healing of the leper in Matthew 8:1-4 through ethnomedical anthropology, recovering the social-diagnostic work the episode performs. Berman (2016) reads Naaman's healing in 2 Kings 5 postcolonially, showing how the narrative dismantles the prestige of the Aramean commander by routing his cure through an enslaved girl, a servant's advice and an unimpressive river. Kim (2022) tracks the politeness strategies in the same chapter to expose how access to therapy is rationed through social hierarchy. Behera (2014) performs the analogous operation for the Mizo of northeast India, and Moetara (2016) builds a Maori trauma-recovery framework from the Joseph narrative without requiring indigenous identity to dissolve into Christian interpretation. What unites these is a refusal to treat the European reading as the neutral one.

The approach has been criticised, not unreasonably, for occasionally sliding from "these categories illuminate the text" to "these categories are the text's own". Dada (2021) notes the difficulty in Adamo's corpus without abandoning the project. The criticism matters less for present purposes than the fact that this scholarship supplies congregations and seminaries with an

intellectually serious warrant for reading healing texts through African therapeutic logic, which is what the Instituted and Pentecostal churches were doing anyway, now with academic cover.

2.5 What Follows From the Differences

Four traditions, four construals, four behavioural profiles. The mission reading directs patients to clinics and treats prayer as accompaniment. The Instituted reading generates ritual therapy that runs in parallel with biomedicine and rarely forbids it. The Pentecostal reading generates expectation of cure, and depending on how it handles secondary causation, either supports treatment or licenses its abandonment. The scholarly tradition supplies the vocabulary in which the other three increasingly justify themselves.

The counter-argument deserves a hearing. One might object that these are ideal types, that real congregations blend them, and that individual patients switch between them within a single illness episode. All true. The Soweto respondents who used church water and clinic medication together were not selecting a hermeneutic; they were managing an illness (Bosire et al., 2022). But the fact that individuals improvise does not make the traditions analytically idle. Pastors do not improvise in the pulpit; they teach a position, and the Cape Town data show that the position taught has consequences (Azia et al., 2025).

A second objection is more serious: that the causal arrow runs the other way, and that people select the reading tradition that licenses what they already wanted to do. This is likely true some of the time and cannot be excluded on present evidence, which is correlational throughout. The claim defended here is therefore modest. Hermeneutics is not reducible to piety; it varies systematically across African Christian traditions, and it is the more tractable variable for anyone designing an intervention. You cannot make a congregation less devout. You can change what its pastor thinks Exodus 15:26 implies about a prescription.

3. BODILY ETHICS: PURITY, STIGMA, PERSONHOOD AND THE BODY IN SCRIPTURE AND CLINIC

3.1 Contagion and Boundary: The Logic of Leviticus 13-14

Leviticus 13 and 14 constitute the most sustained treatment of a visible bodily condition in the Hebrew Bible, and they are widely misread. The chapters do not describe a disease and do not prescribe a cure. They describe a procedure of examination and classification, conducted by a priest, whose output is a ritual status and whose consequence is a location: inside the camp or outside it.

Feder (2021) makes the decisive observation. There is no healing ritual in these chapters. The rites of Leviticus 14 are performed for a person already recovered; impurity management and physical cure are adjacent processes, not the same process. The priest is a boundary official rather than a physician. Rooke (2020) situates the material within the wider ritual world of Hebrew Scripture, where sickness and restoration are understood as movements within a network

of relationships encompassing body, household, sanctuary and deity. Restoration means readmission.

What these texts transmit to later readers, then, is not a theory of infection but a habit of thought: that certain bodily conditions are legible on the skin, that legibility triggers classification, and that classification determines belonging. That habit survives the collapse of the ritual system that produced it. It is the deep structure of stigma.

The condition in question was almost certainly not Hansen's disease, and the translation "leprosy" has done a century of damage. But the mistranslation is itself instructive about what the category was doing. A term denoting a heterogeneous set of skin abnormalities, unified by visibility rather than by pathology, was read by later communities as naming a specific dreaded disease, and the social exclusion attached to the ritual category migrated intact onto the clinical one.

3.2 Lament, Complaint and the Right to Protest

If Leviticus supplies the logic of exclusion, the Psalms and Job supply the vocabulary of the excluded. Southwood's (2018b) analysis of Psalms 88 and 102 shows illness narrated through metaphors in which somatic distress and threatened personhood are inseparable: the sufferer's bones, breath and social standing fail together. Bodily weakness, estrangement from the community and the felt absence of God arrive as a single event. Healing in these texts accordingly cannot mean symptom removal alone. It means restored speech, recognition and a place in worship.

Job pushes further, and does so against the grain of the tradition it sits in. Van der Zwan (2022) reads Job's deterioration as encompassing pain, disability, disgust and the loss of a recognisable self. The comforters' insistence on retributive explanation illustrates how a spiritual account of illness can intensify suffering by converting the sufferer into the cause of his own condition; Southwood's (2018a) study of Job 13 draws the direct line to contemporary practice, where moralised aetiologies do the same work. Daliman et al. (2022) note that the book's unresolved theodicy preserves the sufferer's right to question and protest rather than requiring acquiescence.

This is a genuinely useful resource, and it is underused. African Christian communities that possess a developed theology of lament have a scriptural warrant for refusing the equation of illness with sin, the equation that does most of the stigmatising work. Kaminsky (2021) makes the complementary point that the Hebrew Bible's frank treatment of mortality and bodily limit resists defining good care as maximal intervention, and treats accompaniment as the standard of good care.

The counter-evidence should be registered. Religious meaning-making is not uniformly protective. Kent et al. (2022), following American adults with chronic illness across three waves, found greater subjective suffering associated with subsequent religious and spiritual struggle: faith did not insulate believers from rupture in their relationship with the sacred. Brazilian cancer patients show religious coping and spiritual distress coexisting in the same person (Silva et al., 2019). Fatima et al. (2022), surveying respondents in India and Nigeria during the COVID-19

pandemic, found religious coping rising with uncertainty, which tells us when such resources are recruited but not whether they help. Pargament and Lomax (2013) are right that religion supplies meaning and self-regulation to people facing illness; they are also right that it supplies material for self-condemnation.

3.3 Touch, Boundary-Crossing and the Gendered Body in the Gospels

Gospel healing narratives are structured around the deliberate violation of the boundaries Leviticus established. This is their most consistent formal feature and their most underexploited ethical resource.

M'bwangi (2021) reads Matthew 8:1-4 as an episode in which Jesus's willingness to touch a person classified as impure is the therapeutic act, prior to and more consequential than the physical cure; the touch restores the possibility of community membership. Culpepper (2016) argues that distinguishing biomedical cure from culturally constructed illness experience is necessary to see what the Gospel accounts are doing at all, since so much of what they repair is social identity. Chae (2017) connects Matthew's healing material to covenantal renewal, locating individual restorations within a corporate recovery. Moles (2011) shows how thoroughly healing constitutes Jesus's identity across the Gospel and early Christian traditions.

The gendered material is the sharpest. Mark's haemorrhaging woman suffers a condition that is simultaneously physical, financial and ritual: twelve years of bleeding, a fortune spent on physicians, and a permanent state of impurity that makes ordinary social contact an offence. Oke (2017) reads the episode as a model for confronting HIV-related stigma, and the analogy is exact in its structure. The woman approaches from behind because disclosure is dangerous. Jesus's insistence that she identify herself converts a furtive private transaction into public recognition, which is the part that heals the stigma rather than the haemorrhage. The Canaanite woman's appeal in Matthew 15 makes the ethnic boundary explicit and then crosses it; Love (2002) shows the narrative extending therapeutic access beyond Israelite identity through the persistence of a woman with no standing to persist.

What these texts assume about bodies can now be stated. Bodies are porous to social judgement; visible conditions attract classification; classification governs belonging; and the reversal of exclusion requires a public act, not a private one. That last element is what contemporary anti-stigma work keeps rediscovering.

3.4 From Text to Clinic: Stigma, Disclosure and Personhood in African Settings

The connection between this bodily ethics and contemporary African health behaviour is not speculative, though it is less well evidenced than it should be.

Consider disclosure. Campbell, Skovdal and Gibbs (2011), reviewing thirty-six studies of church responses to HIV across sub-Saharan Africa, found congregations operating in both directions at once: perpetuating stigma through moralised framings that read HIV as sin and punishment, reinforcing patriarchal norms that constrain women's sexual health autonomy, and simultaneously providing the care and support networks that people living with HIV most rely

on. Their most acute finding concerns speech. Anchoring HIV within existing religious frameworks renders it, in their phrase, literally unspeakable outside the language of morality. A congregation that possesses only a moral vocabulary for a disease cannot discuss it as a disease, and a person who cannot discuss a disease cannot disclose it.

Consider disability. Chisale (2020), working with Ndebele communities in Zimbabwe, argues that supernatural interpretations of impairment produce a fear that separates disability from personhood: the disabled body is read as evidence of something, and the woman inhabiting it is diminished accordingly. Her proposal, an African women's theology of disability grounded in *ubuntu*, is a direct attempt to replace one bodily ethics with another -- to make fragility universal and belonging unconditional rather than contingent on bodily form. This is Leviticus being answered by the Gospels, conducted in a Zimbabwean register.

Consider visible, episodic illness. Winkler et al. (2010), interviewing 167 people in a rural northern Tanzanian community, found 44.3% holding that traditional healing could treat epilepsy and 34.1% that Christian prayer could cure it or its cause. Belief in traditional efficacy was markedly higher among people with epilepsy and their relatives (57.6% and 48.4%) than among unaffected villagers, higher among men than women, and higher in rural than semi-urban settings. The pattern is revealing: those closest to the condition were the most convinced of non-biomedical efficacy, which is hard to explain as ignorance and easy to explain as accumulated experience of biomedical services that did not control their seizures.

The clinical consequence of these bodily ethics is a gradient of disclosability. Conditions that are invisible and morally neutral are disclosed; conditions that are visible or morally coded are managed by concealment, and concealment operates at exactly the point where public health needs information. Aja (2019) argues from Nigerian chaplaincy experience that hospitals need spiritual care precisely because patients interpret bodily illness within moral and relational frameworks that clinical technology does not address. Zambezi, Emmamally and Mooi (2022), studying families in a KwaZulu-Natal intensive care unit, found substantial interest in nurse-provided spiritual care alongside markedly varied preferences about specific interventions such as chaplain visits. The lesson is that responsiveness beats protocol.

The payoff of this section is a reframing of stigma interventions. Most are designed as information campaigns, on the theory that stigma is a factual error. The scriptural genealogy sketched here suggests it is instead a classification practice with deep textual roots and a ritual grammar, and that it is therefore more likely to yield to the mechanism the Gospel narratives themselves use: public recognition performed by a person with authority. In African congregations, that person is the pastor.

4. HEALTH-SEEKING BEHAVIOUR: THERAPEUTIC ITINERARIES AND THEIR PUBLIC-HEALTH CONSEQUENCES

4.1 What People Actually Do

Therapeutic itineraries in African settings are sequential, plural and largely undisclosed to clinicians. Each of those three properties has public-health consequences, and the third is the one that receives least attention.

The plurality is well documented. Among patients with sickle cell disease at a tertiary hospital in Lagos, Busari and Mufutau (2017) found a high prevalence of complementary and alternative medicine use running alongside conventional treatment rather than replacing it; a pattern that chronic, painful, incurable conditions reliably produce. Afolaranmi and Hassan (2020) found comparable preferences among patients on long-term treatment at Jos University Teaching Hospital. Enrolment in biomedical care does not terminate other therapeutic commitments; it adds to them.

The sequence matters more than the plurality. Asante, Tuck and Atobrah (2023), interviewing thirty Akan cancer patients at a Ghanaian teaching hospital, found that patients attributed cancer to both physical and spiritual causation and pursued both accordingly -- but that traditional and spiritual practitioners were typically consulted *first*, with the hospital reached later. For a disease whose prognosis is staged, order of consultation is the whole game.

The non-disclosure is the quietest problem. Moshabela et al. (2017), synthesising evidence from eastern and southern Africa, describe patients moving among clinics, traditional healers and faith healers along the HIV care cascade, with the movement producing support in some cases and interrupted adherence or unmanaged interaction risks in others. A clinician who does not know that a patient is also taking a herbal preparation cannot assess the interaction. A patient who expects to be reprimanded will not volunteer the information. This is a communication failure with a clinical cost, and it is generated by the clinic's posture rather than by the patient's beliefs.

4.2 Where the Delay Is

The strongest evidence for harm comes from HIV, and it is genuinely strong. Audet et al.'s (2014) cross-sectional study in rural Mozambique quantified what had previously been asserted. Sixty-two per cent of symptomatic HIV-positive patients had sought care from a traditional healer before presenting at a health facility. Median time to testing was two months for those who saw no healer, three months for those who saw one, and nine months for those who saw several. Fifty-six per cent had received a diagnosis of spiritual affliction; sixty-six per cent had undergone subcutaneous herbal treatment administered with razor blades, which introduces a transmission risk of its own. Most damning for the collaboration literature: two hundred healers in the district had already been trained, and only 9% of participants reported having been referred by a healer to a health facility.

That last number deserves to be sat with. It is the clearest available demonstration that training healers, absent any structural relationship that makes referral consequential for them, does not produce referral. Sensitisation is not a referral system.

Cancer shows the same shape. Late-stage presentation among Ghanaian patients tracks the sequence in which spiritual and herbal care precede hospital attendance (Asante, Tuck & Atobrah, 2023). Epilepsy shows it in a different register: where large minorities believe traditional or prayer-based treatment efficacious, and where that belief is strongest among those who have the condition, anticonvulsant adherence is predictably poor (Winkler et al., 2010). Psychosis shows it most acutely, because the pathway into faith healing for psychosis often involves restraint.

Preventive care shows a quieter version of the same effect. Analysing Zimbabwe's 2010-2011 Demographic and Health Survey, Kriss et al. (2016) compared 462 children of Apostolic families with 597 others aged twelve to twenty-three months. Sixty-one per cent of Apostolic children had received all four basic EPI vaccines against sixty-eight per cent of the rest; sixteen per cent had received none against nine per cent. After adjustment for socioeconomic position, Apostolic children were almost twice as likely to have received no vaccination at all (aOR 1.83) and a third less likely to have a card available for inspection (aOR 0.68). The gap is substantial but it is not a boycott. Most Apostolic children were vaccinated, which means the doctrinal prohibition on medicine that the movement is known for was being widely circumvented in practice by the mothers concerned. The measurable harm sits in a minority, and it is the minority that population-level rhetoric about "the Apostolics" consistently obscures.

And yet the delay is not evenly distributed across conditions, and this is where the subtraction framing breaks down. For chronic pain in sickle cell disease, parallel use of complementary therapies imposes no measurable delay because there is no time-critical decision to delay (Busari & Mufutau, 2017). For a woman in labour, the delay is measured in hours and can be fatal. For HIV, it is measured in months and shortens life. Public health should care about the variance, not the aggregate.

4.3 Why People Move

The explanations patients give for their itineraries are consistent across settings, and none of them is about ignorance.

Izugbara and Wekesah (2018) asked Nigerian women what quality maternity care means in a plural environment. Their answers turned on affordability, convenience, respectful treatment and perceived effectiveness. Formal accreditation did not appear as a criterion. Informal providers who were courteous, available and affordable acquired authority that credentialled providers had failed to earn. This finding is frequently cited and rarely absorbed: the women were evaluating providers rationally, using criteria that predict whether care will actually be received rather than criteria that predict whether it meets professional standards.

Peprah et al. (2018), studying faith-healing users in urban Ghana, found the same structure. Users judged these services effective while maintaining relationships with formal healthcare; their decisions reflected trust, cultural intelligibility and prior treatment experience. Obiwulu, Akah and Ajah (2020) show in southeast Nigeria that traditional religious worldviews continue to direct health-seeking even among populations with extensive exposure to both Christianity

and biomedicine, because those worldviews answer the question biomedicine declines to answer: why this person, why now.

Sundararajan et al.'s (2020) Ugandan model names the three levels at which this operates. At provider level, traditional healers demonstrate care through time and respect while biomedical providers are reported as dismissive. At system level, biomedical facilities offer diagnostic technology that patients value but also procedures they fear. At peer level, community testimony circulates, endorsing healers and amplifying negative accounts of clinics. None of these is a belief about supernatural causation. All three are assessments of institutions.

This is the review's central claim in its empirical form. Where clinics are rude, distant, expensive or opaque, patients go elsewhere first, and religious and traditional healing are the elsewhere that is available. The religious content of the alternative explains what people say about their illness. The institutional failure explains where they go.

4.4 What the Trials Show

Three randomised trials from the region test whether the relationship between religious healing and biomedicine can be redesigned, and their results are more encouraging than the observational literature would predict.

The COSIMPO trial is the landmark. Gureje et al. (2020) randomised primary healthcare clinics across Nigeria and Ghana to a collaborative shared-care intervention in which traditional and faith healers worked with primary health-care workers, or to enhanced care as usual, and measured psychosis outcomes at six months. The collaborative arm produced significantly greater symptom reduction. No system disappeared; healers continued to practise, and clinicians continued to prescribe. What changed was the interface.

The prayer-camp trial is the more uncomfortable finding. Ofori-Atta et al. (2018) randomised 139 residents of a Ghanaian prayer camp to an intervention delivering psychiatric care within the camp, or to camp care as usual, over six weeks. Total Brief Psychiatric Rating Scale symptoms were significantly lower in the intervention arm ($p = 0.003$, effect size -0.48), with improvement concentrated in thought disturbance and hostility. But there was no significant difference in days spent in chains. Medication reduced symptoms and did not reduce restraint.

That result should be allowed to bite. It shows that clinical integration into a coercive setting can improve clinical outcomes while leaving the coercion intact, and it undermines any argument that better medicine will render abusive practice obsolete. Chaining is a practice with its own logic -- containment, and the family's need for respite -- and it is not a symptom of untreated psychosis that resolves when treatment arrives. It requires separate regulatory attention. Arias et al. (2016) found Ghanaian prayer-camp healers willing to accept medication while retaining spiritual accounts of illness, which is precisely the coexistence the trial exploited; the trial then demonstrated the limits of what such coexistence buys.

The third trial addresses the upstream question of whether religious authority can be enlisted rather than accommodated. Mwakisole et al. (2023) randomised twenty-four rural Tanzanian

communities, twelve to an intervention in which religious leaders attended a one-day seminar covering scriptural perspectives on contraception alongside information about available methods, twelve to delayed intervention. Contraceptive uptake rose by nineteen per cent in intervention communities. The mechanism is worth naming precisely: the seminar changed what leaders taught about what the text permits, and behaviour followed.

Put these three together and a pattern emerges that neither the enthusiasts nor the critics of faith healing will entirely like. Collaboration improves outcomes (Gureje et al., 2020). Teaching religious leaders changes population behaviour (Mwakisole et al., 2023). And integration does not by itself end abuse (Ofori-Atta et al., 2018). The tractable target is the referral relationship and the content of religious teaching; the intractable target, requiring law rather than partnership, is coercive restraint.

5. AUTHORITY, REGULATION AND COLLABORATION IN COMPARATIVE PERSPECTIVE

5.1 Legitimacy From Below and From the State

Authority in plural medical environments is not produced by efficacy. It is produced by recognition, and recognition has at least two independent sources.

State recognition is the one policy discourse notices. Guma and Mokgoatsana (2020) trace how colonial and postcolonial structures in South Africa elevated Western biomedicine while marginalising African indigenous healing, which nonetheless retained cultural legitimacy and eventually secured statutory acknowledgement. Kpobi and Swartz (2019) describe the parallel formalisation of indigenous and faith healing in Ghana. Ashworth and Cloatre (2022) show what such recognition costs: global efforts to incorporate traditional medicine translate diverse practices into categories legible to law and biomedical science, recognising standardisable techniques while marginalising spiritual, oral and lineage-based knowledge that will not standardise. Recognition is a filter, not a welcome.

Legitimacy from below operates on entirely different criteria, and Izugbara and Wekesah's (2018) Nigerian maternity data remain the best demonstration. Practitioners without credentials acquire authority through interpersonal conduct and practical accessibility where regulation is weak. For Christian healing this matters directly: pastors and prayer ministries accumulate credibility through testimony, reputation and culturally intelligible explanation, and no accreditation body mediates the process.

Healers have also constructed legitimacy deliberately. Osseo-Asare (2016) documents Ghanaian literate healers in the mid-twentieth century using associations, printed texts, correspondence and engagement with government to reposition indigenous expertise as respectable and professionally organised, contesting colonial hierarchies of medical knowledge on their own terms. This is not a story of tradition passively awaiting state validation.

Collaboration nonetheless remains asymmetric. Adekannbi (2018) found referral between orthodox and traditional practitioners in Nigeria occurring informally and flowing predominantly toward biomedical institutions, reflecting unequal control over what counts as legitimate knowledge. Nemutandani, Hendricks and Mulaudzi (2016) found South African allopathic practitioners raising concerns about diagnosis, evidence, confidentiality and referral, while traditional practitioners sought recognition within a system historically built to exclude them. Both accounts describe a relationship in which one party sets the terms.

5.2 The Diaspora Mirror: The United States as a Case of Biomedical Dominance

The United States is useful here for two reasons, neither of which is that it is comparable. It is the setting where biomedical dominance is most complete, which makes it a control case for what happens to religious healing under those conditions; and it hosts African Christian communities whose healing practices continue in altered form, which makes it a mirror.

Under strong biomedical dominance, religious healing does not disappear. It gets reclassified. Robles, Upchurch and Kuo (2017) show that American estimates of complementary medicine use shift substantially depending on whether prayer is counted as a modality, which means the boundary is definitional rather than behavioural. Stussman et al. (2020) find American physicians recommending complementary approaches including massage, chiropractic, yoga and acupuncture, practices that entered the clinic by being retranslated into the languages of safety, efficacy and regulation. Nothing comparable has happened to prayer, which cannot be standardised into a dose.

Clinician religiosity persists inside the system. Curlin et al. (2005) found in a national survey that many American physicians regarded religion or spirituality as personally significant and reported that it influenced their practice, which unsettles any assumption that biomedical professionalism is religiously neutral at the level of practitioners. Lawrence and Curlin (2009) found that physicians do not uniformly rank patient autonomy above professional judgement or religiously informed moral considerations. Institutional religiosity has sharper edges: Sawicki (2016) shows American Catholic hospitals operating within mainstream care while observing directives that restrict certain services, with patients often unaware of the restriction until they encounter it. McDowell and South (2017) found Bible Belt patients identifying prayer as significant to their care while reporting professional uncertainty about when to offer spiritual support. Abdulla, Hossain and Barla (2019) report comparable inconsistency in British hospital practice, and Schreiber, Verrall and Whitehead (2022) find Australian general-practice nurses endorsing spiritual care in principle while citing inadequate training as the barrier in practice. Steinhorn, Din and Johnson (2017) show integrative and palliative medicine incorporating spirituality as supportive meaning-making rather than as therapy.

The mirror function is the more interesting one. Wabyanga, Nyamnjoh and Ugba (2021) trace African Pentecostal divine-healing practice across the continent and its diaspora, showing continual reinvention under conditions of religious competition and secular medical culture. The diaspora case establishes something the African data alone cannot: that these practices do not depend on weak health systems. Transplanted into a setting of abundant, accessible biomedicine,

they persist -- differently, more privately, competing with therapy and wellness industries rather than with herbalists, but they persist.

That observation constrains the argument of this review, and the constraint should be admitted. If religious healing were purely a response to institutional failure, it would attenuate where institutions function. It does not attenuate; it changes shape. Institutional failure explains the *urgency* of the itinerary in African settings and much of its sequencing. It does not explain the existence of religious healing, which has independent theological and social grounds. The rational-response thesis is a claim about why people go first to one place rather than another. It is not a claim that faith is a symptom of poverty.

5.3 Regulatory Repertoires: Latin America, India, East Asia

Other regions supply a catalogue of options that African health systems are effectively choosing among, often without acknowledging the choice.

Shim's (2018) comparison of China, Korea and Japan identifies three distinct settlements: interpenetrative pluralism, in which traditional and biomedical systems are institutionally equivalent; exclusionary pluralism, in which they are separate; and subjugatory pluralism, in which one is subordinated. Hesketh and Zhu (1997) describe the Chinese arrangement as a deliberate two-system policy rather than mere toleration. The taxonomy is useful because South African, Ghanaian and Nigerian arrangements all fall toward the subjugatory end while using the vocabulary of the equivalent end.

Latin America shows recognition as a political variable. Papalini and Avelin Cesco (2022) find that states across six countries differ sharply in the legal status they accord indigenous, natural and complementary medicines. Franco de Sá, Nogueira and Guerra (2019) document Brazilian traditional and complementary practices entering public policy while continuing to encounter biomedical hegemony and demands for scientific validation. Fernandez, Silva and Sacardo (2018) show Brazilian professionals' discomfort with religion affecting access when patients' commitments are treated as interference. Lucchetti et al. (2016) describe São Paulo Spiritist centres providing religious therapies while distinguishing spiritual experience from conditions they regard as requiring psychiatric care, a self-limiting practice that African prayer camps rarely match. Gamero-Vega et al. (2018) survey Latin American faith-based and faith-placed health interventions, the closest regional analogue to the Tanzanian religious-leader trial. Hendrickson (2014) documents *curanderismo* in the Mexico-United States borderlands as a transcultural formation combining herbal preparation, intercessory prayer and holistic anthropology.

India and its neighbours supply the household-level picture. Mohanty and Sharma (2021) show engagement with traditional therapies reflecting affordability and health-system conditions as much as cultural continuity. Khalikova (2020) describes practitioners and families moving across Ayurveda, Unani, homeopathy, yoga and biomedicine in ways that make authority relational rather than jurisdictional. Albert et al. (2015) found indigenous communities in northeast India continuing to rate local tribal medicine highly effective despite state promotion of AYUSH systems, which is the clearest available demonstration that official and lived legitimacy can

diverge. Ramakrishnan et al. (2014) found Indian traditional and allopathic practitioners open to spirituality as a dimension of care; Ramakrishnan et al. (2015) found Indian and Indonesian physicians differing in comfort with patients' spiritual needs according to local medical culture. Woodward's (1985) older Javanese material remains instructive on how religious, magical and biomedical knowledge can be ordered as complementary within a single coherent worldview. Del Castillo (2021) argues from the Philippine pandemic experience for collaboration rather than opposition between religious communities and health professionals.

Elsewhere, the lesson is about the difficulty of implementation. Torri and Hollenberg (2013) describe Bolivian intercultural health initiatives foundering on differences in epistemic authority and professional recognition rather than on ideology. Ijaz and Boon (2018) show that regulatory language requirements for traditional acupuncturists in Canada, the United States and Australia reshape whose expertise is officially recognisable through rules that appear purely technical. Hoyler et al. (2018) find biomedical and traditional practitioners in rural Guatemala borrowing from and adapting to one another in ways no traditional-versus-modern binary captures. Foley et al. (2020) report Australian adults with chronic conditions consulting complementary practitioners for wellbeing support that conventional services had not supplied.

The comparative payoff is a warning. African health systems currently practise subjugatory pluralism while aspiring rhetorically to partnership, and the gap between the two is where collaboration initiatives die. Bolivia shows that goodwill without a settlement of epistemic authority produces nothing. Ghana shows that formalisation without referral incentives produces 9% referral rates (Audet et al., 2014; Kpobi & Swartz, 2019). The choice of regulatory model is not a technicality downstream of clinical questions. It determines whether clinical collaboration is possible at all.

6. ETHICAL INTEGRATION, IMPLICATIONS AND RESEARCH PRIORITIES

6.1 What Integration Must Refuse

An argument for collaboration is worthless unless it specifies what it will not collaborate with. Three practices fall outside.

The first is coercive restraint. The prayer-camp trial established that improving clinical care inside a camp did not reduce days in chains (Ofori-Atta et al., 2018). Restraint is therefore not a gap that medicine fills but a practice requiring prohibition and enforcement. Any collaboration framework that treats it as a cultural difference to be respected is complicit.

The second is instructed treatment discontinuation. Pastors who teach that antiretroviral therapy signals insufficient faith are not offering an alternative therapeutic philosophy; they are intervening in a treatment decision without competence or accountability, and the Cape Town data show how often basic knowledge of transmission and pharmacology is absent (Azia et al., 2025). Sarkar and Seshadri (2015) advise clinicians facing requests for faith healing to engage the patient's belief system without either dismissing it or endorsing it, and to preserve informed

choice throughout. The advice is sound and insufficient, because it addresses the clinician rather than the pastor. The Tanzanian trial suggests the missing half: reach the religious leader with content, before the patient reaches the clinic (Mwakisole et al., 2023).

The third is the concealment of institutional limits. Whether a patient learns at the point of need that an institution will not provide a service is an autonomy question wherever it arises, in Catholic hospitals in the United States (Sawicki, 2016) and in faith-based facilities across Africa that constitute a large share of provision (Olivier et al., 2015).

Beyond these refusals, the ethical terrain is genuinely plural and should be treated as such. Ogu (2022) shows Igbo folk medicine to possess internal moral norms governing the healer-patient relationship which differ from biomedical bioethics without being absent. Odia (2014) describes Nigerian medical decision-making occurring in a moral environment shaped simultaneously by religion, culture and law. Igboin (2015) argues from a Nigerian Christian standpoint that severing spirituality from medical practice impoverishes care for patients who understand illness in moral and transcendent terms. Kassim and Alias (2016) note that end-of-life decisions engage convictions about sanctity and divine sovereignty that cannot be bracketed away. Liefbroer, Ganzevoort and Olsman (2019) insist on distinguishing respectful spiritual assessment from confessional persuasion and on clarifying whether clinicians or specialist providers carry responsibility. Puchalski et al. (2014) place spiritual care within an interdisciplinary model in which clinicians identify concerns and refer complex needs onward. Family preference varies within a single unit, as the KwaZulu-Natal intensive-care data show (Zambezi, Emmamally & Mooi, 2022).

6.2 Designing Referral Rather Than Displacement

If the diagnosis in section 4 is right, the intervention follows from it. The problem is not that patients consult healers. It is that consultation does not terminate in referral, that referral does not terminate in arrival, and that arrival is not disclosed back to the healer.

The Mozambican 9% figure is the benchmark of failure (Audet et al., 2014). Two hundred trained healers produced almost no referrals, because training conferred knowledge without conferring any reason to act on it. Referral costs a healer a client and returns nothing. Krah, de Kruijf and Ragno (2018) identified the corresponding obstacles in northern Ghana: mistrust, professional hierarchy and biomedical personnel's limited knowledge of traditional practice. Their recommendations, which run to negotiated protocols, reciprocal education, defined scopes of practice and functioning communication channels, amount to building a relationship rather than delivering a workshop. Musyimi et al. (2016) demonstrated in rural Kenya that structured dialogue among faith healers, traditional healers and formal health workers surfaces both genuine epistemological difference and workable collaboration, particularly in mental health where movement between providers is the norm.

What distinguishes COSIMPO from a sensitisation programme is precisely this structural quality: healers and primary care workers shared responsibility for the same patients over time, and outcomes improved (Gureje et al., 2020). Chung et al. (2021), reviewing international

delivery models for traditional and complementary medicine, reach the same conclusion from a different direction, emphasising practitioner competence, quality assurance, interprofessional communication and condition-specific referral arrangements over unstructured coexistence. Schiff et al. (2018) show from Israeli hospital experience that complementary services can be embedded safely when practitioner selection, incident reporting and continuous review are designed in from the start.

Four design features emerge from this literature. Referral must be condition-specific rather than general, since the conditions where delay kills are identifiable in advance. It must be bidirectional, so that the healer learns what happened to the person referred. It must carry a reason for the healer to comply, whether recognition, remuneration or continued involvement in care. And it must be built on an explicit settlement of who decides what, because Bolivia demonstrates what happens when that question is deferred (Torri & Hollenberg, 2013).

6.3 Research Priorities and an Honest Account of the Evidence

The evidence base for this field is thinner than the confidence of its literature suggests, and four gaps are serious.

The first is the absence of behavioural measurement attached to hermeneutical variation. Section 2 argued that reading traditions predict behaviour better than religiosity does, and the Cape Town pastor study is the best evidence available for it (Azia et al., 2025). That is one qualitative study with twenty participants. Nobody has yet measured health-seeking outcomes across congregations classified by reading tradition, which is a straightforward study design that would either substantiate this review's central hermeneutical claim or refute it.

The second is the shortage of itinerary data with timestamps. Audet et al. (2014) produced the delay figures that anchor section 4 because they asked about sequence and duration. Most studies of medical pluralism ask what people use, not when and in what order, and the resulting literature can describe plurality without identifying where the harm sits.

The third concerns interaction safety. Herbal preparations and pharmaceuticals are routinely co-administered across the region, and the pharmacovigilance data on specific combinations barely exist (Moshabela et al., 2017). This is not an ethical dilemma but an empirical vacuum, and it is fillable.

The fourth is the near-total absence of evaluation of religious-leader interventions outside reproductive health. The Tanzanian trial established that a one-day seminar changed contraceptive uptake by nineteen per cent (Mwakisole et al., 2023). Whether an equivalent seminar on Exodus 15:26 and secondary causation would change antiretroviral adherence or the timing of cancer presentation is unknown and testable.

Gallego-Pérez et al. (2020) argue from the Americas for equitable access to validated information about traditional and integrative medicines, and for research attending to cultural appropriateness and health inequity alongside efficacy. Their framing applies with full force

here, with one addition. The African material demands research on hermeneutics as a modifiable exposure, which is not a category the funding architecture currently recognises.

A final judgement is warranted. Much of the religion-and-health literature on Africa is written either to defend religious healing against biomedical condescension or to indict it for harm, and both postures produce weak evidence. The defenders rarely count delays; the critics rarely ask why the clinic was the second choice. This review has argued that the delays are real, the reasons are institutional, and the remedy is structural. None of those three claims flatters either camp.

CONCLUSION

Sacred texts operate in African health systems as working documents, and they do so through three connected mechanisms this review has tried to keep distinct.

Interpretive traditions determine what a healing narrative is taken to be. Mission-church, African Instituted, Pentecostal-charismatic and African biblical-hermeneutic readings construe the same texts as record, script, promise and cultural resource respectively, and those construals carry different implications for whether a person on treatment should remain on it. The clearest evidence for the consequence comes from Cape Town, where pastors of a single denomination held opposite positions on antiretroviral therapy grounded in opposite accounts of how divine agency relates to secondary causation (Azia et al., 2025). Piety did not distinguish them. Hermeneutics did.

Bodily ethics determines who can speak about illness. Leviticus 13-14 transmits a classification practice in which visible conditions trigger examination and examination determines belonging (Feder, 2021; Rooke, 2020). The Psalms and Job transmit a countervailing right to protest and a refusal of the retributive equation (Southwood, 2018a, 2018b; Van der Zwan, 2022; Daliman et al., 2022). The Gospels transmit a method for reversing exclusion through public recognition, most sharply in the account of the haemorrhaging woman whose healing is completed by being made to identify herself (Oke, 2017). African congregations inherit all three, and which one predominates shapes whether HIV, epilepsy or impairment can be named aloud (Campbell, Skovdal & Gibbs, 2011; Chisale, 2020; Winkler et al., 2010).

Health-seeking behaviour is where these become measurable. Sixty-two per cent of symptomatic HIV-positive Mozambicans consulted a healer first, and those who consulted several waited nine months to test rather than two (Audet et al., 2014). Ghanaian cancer patients reached hospital after spiritual and herbal care (Asante, Tuck & Atobrah, 2023). These delays are real and some of them are lethal. But the Ugandan evidence on why people move points at institutions rather than at beliefs: healers gave time and respect, clinics gave neglect and fear (Sundararajan et al., 2020), and Nigerian women evaluating maternity providers weighed courtesy and affordability rather than credentials (Izugbara & Wekesah, 2018).

The argument this review has defended is that therapeutic pluralism in African contexts is a rational response to institutions that are inaccessible, unintelligible or impersonal, and that public

health should therefore stop trying to displace religious healing and start identifying which delays it causes and which of those referral design can shorten. The randomised evidence supports the reorientation without romanticising it. Collaborative care with traditional and faith healers improved psychosis outcomes across Nigeria and Ghana (Gureje et al., 2020). Teaching Tanzanian religious leaders what scripture permits raised contraceptive uptake by nineteen per cent (Mwakisole et al., 2023). And psychiatric care delivered inside a Ghanaian prayer camp reduced symptoms while leaving days in chains unchanged (Ofori-Atta et al., 2018), which marks the boundary at which partnership must give way to prohibition.

Two things are therefore true at once, and holding both is the whole discipline of this subject. Religious healing in Africa causes measurable harm in specific, identifiable conditions, and religious institutions are the most underused referral infrastructure on the continent. The health systems that will do best are those that stop asking congregations to believe less and start asking pastors to read more carefully.

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