



Decolonising Mental Health in African Public Health: A Critical Review of Epistemic Frameworks

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Received Date: August 12, 2026; **Accepted Date:** September 08, 2026; **Published Date:** September 15, 2026

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Abstract

Background: Contemporary mental health frameworks in African public health systems remain deeply rooted in Western biomedical and psychological paradigms that emerged from colonial encounters. Despite growing recognition of the social determinants of health and calls for culturally appropriate interventions, mental health policy, research, and practice across the African continent continue to privilege Eurocentric epistemologies while marginalising indigenous knowledge systems, philosophies, and healing practices. This conceptual dominance raises fundamental questions about the epistemic violence inherent in mental health governance and the sustainability of interventions that fail to resonate with African cosmologies and communal understandings of wellbeing.

Objective: This critical review interrogates the epistemic foundations of mental health conceptualisation in African public health frameworks, focusing on South Africa, Ghana, and Kenya as three countries selected through a principled operationalisation of mental health policy focus and documented colonial genealogy. It examines how Western psychiatric nosology, diagnostic categories, and intervention models maintain colonial patterns of knowledge production across these contexts. Drawing on decolonial theories articulated by Frantz Fanon, Ngũgĩ wa Thiong'o, and Sabelo Ndlovu-Gatsheni, this study analyses the mechanisms through which African philosophies of personhood are systematically

excluded, tokenised, or reduced to "cultural factors" within dominant mental health discourse. Central to this review's contribution is an argument against confining decolonial critique to Ubuntu alone: drawing on Menkiti's and Gyekye's communitarian debate, Wiredu's Akan conceptual analysis of personhood, and Mbiti's, Kagame's, and Jahn's cosmological and metaphysical frameworks, the review demonstrates that African philosophy offers a plural, contested, and far deeper epistemological resource than a single-concept reading of Ubuntu allows.

Methods: This theoretical review synthesises literature from public health, decolonial studies, indigenous psychology, and African philosophy. Analysis focuses on: (1) WHO mental health frameworks (WHO-AIMS) and their application in South Africa, Ghana, and Kenya; (2) the colonial genealogies of mental health legislation in each country; (3) decolonial theoretical contributions to understanding epistemic violence; (4) African philosophical traditions of holistic personhood extending beyond Ubuntu; and (5) community and indigenous approaches to psychological wellbeing. The review employs a decolonial lens to examine how power relations shape what counts as legitimate knowledge in mental health discourse across these three national contexts.

Results: Analysis reveals that mental health policy in South Africa, Ghana, and Kenya predominantly adopts DSM and ICD diagnostic frameworks with minimal adaptation to local ontological or cultural contexts. The concept of mental illness

itself reflects individualistic Western ontologies that conflict with African relational understandings of personhood and communal wellbeing. Indigenous healers, who address spiritual, ancestral, and communal dimensions of distress, remain positioned outside evidence-based practice, revealing hierarchies of knowledge that mirror colonial structures. Critically, the documented treatment gaps across all three countries — 92% in South Africa, an estimated 98% in Ghana, and coverage rendered mathematically improbable in Kenya — cannot be explained by resource deficits alone; they reflect a fundamental mismatch between the epistemological assumptions of formal mental health systems and the ontological commitments of the populations they serve.

Conclusion: Decolonising African mental health requires epistemic disobedience — a fundamental reimagining of mental health grounded not in a single philosophical touchstone but in the full plurality of African philosophies, cosmologies, and healing traditions. This review proposes an African-centred theoretical model that moves beyond Ubuntu to integrate the wider landscape of African personhood philosophy, recognises the spiritual and relational dimensions of wellbeing, honours indigenous healing knowledge, and addresses the coloniality of mental health systems in South Africa, Ghana, and Kenya. Such a framework positions African epistemologies not as supplementary cultural considerations but as foundational knowledge systems capable of generating more contextually grounded, sustainable, and effective public mental health approaches, with implications for policy development, research methodologies, professional training, and service delivery across the continent. The review also identifies practical requirements for co-produced policy, networked community and specialist services, rights-based safeguards and participatory implementation research.

Keywords: Decolonisation, mental health, African public health, South Africa, Ghana, Kenya, holistic personhood, epistemic violence, indigenous knowledge systems

Introduction

The study of mental health in Africa cannot be disentangled from the colonial architectures that produced it. What counts as mental illness, who has the authority to diagnose it, what constitutes effective treatment, and whose knowledge of the mind is regarded as legitimate — these are not neutral scientific questions. They are deeply political ones, shaped by centuries of epistemic violence in which African ways of knowing, healing, and understanding the person were systematically displaced, pathologised, and erased (Ndlovu-Gatsheni, 2018; Fanon, 1967). This literature review locates the argument of the present study within that critical terrain.

The core contention is that contemporary mental health frameworks operating in African public health systems are not simply technical instruments adapted from Western contexts; they are the living residue of colonial knowledge projects that positioned European epistemologies as universal and relegated African ontologies — including philosophically rich

understandings of personhood, spirituality, communalism, and intergenerational being — to the margins of legitimate health discourse. Drawing on decolonial scholarship, African philosophy, indigenous psychology, and comparative public health policy, this review maps the epistemic architecture that continues to govern mental health systems in three African countries: South Africa, Ghana, and Kenya.

This review is structured in five thematic strands. First, it operationalises what constitutes a meaningful focus on mental health in African public health policy, enabling principled country selection. Second, it traces the colonial genealogies of mental health legislation in the three selected countries. Third, it critically examines how current policy frameworks retain biomedical, DSM- and ICD-aligned diagnostic epistemologies that conflict with African relational ontologies. Fourth, it introduces the philosophical resources of African thought — reaching beyond Ubuntu into a broader landscape of African conceptions of holistic personhood — as legitimate foundations for an alternative epistemic framework. Fifth, it reads the structural underperformance of existing mental health systems against this decolonial diagnostic, arguing that the treatment gap is not only a resource problem but an epistemic one.

Country Selection: Operationalising a Mental Health Focus

The selection of South Africa, Ghana, and Kenya as focal countries was not arbitrary. It required a principled operationalisation of what it means for an African country to have centralised mental health as an area of public health focus. Drawing on the WHO's Assessment Instrument for Mental Health Systems (WHO-AIMS) framework and a review of comparative African public health literature (Kleintjes et al., 2010; Doku et al., 2012; Gureje & Herrman, 2019), this study operationalises a mental health policy focus as meeting at least four of the following criteria: (1) the existence of a national mental health policy or strategic plan that is legally enacted or formally adopted; (2) dedicated mental health legislation beyond general health law; (3) the allocation of a quantifiable proportion of the national health budget to mental health; (4) the existence of specialised mental health institutions and/or community mental health infrastructure; (5) ratification of international human rights instruments with mental health implications, particularly the UN Convention on the Rights of Persons with Disabilities (UNCRPD); and (6) a documented body of national mental health research and data.

A further criterion, essential to this study's decolonial argument, was added: each selected country must have a documented colonial history and must demonstrate, within its contemporary mental health policy, evidence that Western epistemic frameworks — specifically biomedical psychiatry and diagnostic nosologies such as the DSM and ICD — have been adopted in ways that are substantially unreflective of local ontological, philosophical, and cultural contexts. This final criterion distinguishes the present review from

comparative policy studies that assess coverage, resourcing, and rights compliance without interrogating the epistemological conditions under which those systems operate (Gureje & Herrman, 2019).

Applying these criteria to the landscape of sub-Saharan African countries, a review of available policy documentation, peer-reviewed literature, and institutional health system surveys identified a group of nations that have made significant, documented investments in formalising mental health care: South Africa, Ghana, Kenya, Nigeria, Ethiopia, Uganda, Rwanda, and Tanzania (Kleintjes et al., 2010; Wainberg et al., 2017). From this group, South Africa was selected as the primary site of analysis, given the author's location as a South African-based scholar, the density and accessibility of its mental health data, and the particularly acute tension between its progressive legislative framework and the persistent coloniality of its clinical epistemology (Pillay, 2017; Ratele, 2024). Ghana and Kenya were selected as the two additional sites on the basis of: their well-documented colonial histories under British administration; the existence of formal, enacted mental health legislation; robust national mental health policy frameworks that have been the subject of peer-reviewed scholarship; and a documented pattern in which Western biomedical frameworks have been absorbed into formal health systems in ways that marginalise indigenous healing and African understandings of mental wellbeing (Roberts et al., 2014; Atwoli, 2024). With the country sample established, the review now turns to each national context in turn, beginning with South Africa.

Country Context I — South Africa: Colonial Legacies and the Persistence of Biomedical Governance

Colonial History and the Psychiatry of Control

South Africa's mental health system was built within the racial architecture of colonialism and apartheid. The first mental health legislation — the Lunacy Act of 1916 — was explicitly organised around racialised categories, reflecting colonial psychiatry's concern not with African wellbeing but with the management, control, and confinement of those whose behaviour threatened the social order of the settler state (Swartz, 1998; Bhugra & Bhui, 2018). For the better part of the twentieth century, mental health in South Africa operated as an instrument of racial segregation: separate, unequal facilities; psychiatric diagnosis deployed in service of political suppression; and an entire infrastructure oriented towards custodial confinement rather than therapeutic care. The South African National Mental Health Policy Framework (2013–2020) acknowledged this explicitly, noting that 'mental health services continue to labour under the legacy of colonial and apartheid era mental health systems' (Department of Health, Republic of South Africa, 2013, p. 4).

The 1992 White Paper on National Health and the 2002 Mental Health Care Act (Act 17 of 2002) represented significant post-apartheid reforms, establishing a rights-based legislative framework and mandating the integration of mental

health into primary health care. However, critics have argued that legislative reform without epistemic reform reproduces the structural conditions of colonial psychiatry in new institutional clothing (Pillay, 2017; Ratele, 2024). The diagnostic categories mandated by the Act remain those of the International Classification of Diseases (ICD), a nosological system developed predominantly from European and North American clinical research traditions that takes the individual as the primary unit of pathology (Mkhize, 2004; Nwoye, 2017a).

Data Profile: The Scope and Treatment Gap of Mental Illness

South Africa carries a substantial and documented burden of mental ill-health. Findings from Global Burden of Disease estimates indicate that 15.9% of South Africans have experienced a mental or substance use disorder within a 12-month period (Department of Health, 2023). Among adolescents in sub-Saharan Africa, systematic review data indicate a median point prevalence of 26.9% for depression and 29.8% for anxiety (Department of Health, 2023). A 13-year actuarial analysis of medical scheme data revealed a 46% increase in the prevalence of registered or claimed mental health conditions between 2012 and 2024, with one in seven Discovery Health Medical Scheme members actively receiving treatment for a mental health condition by 2024 — a figure that reflects only the private healthcare sector.

Yet access to care remains profoundly unequal. South Africa spends approximately 5% of its national public health budget on mental healthcare, a figure that, while nominally meeting the WHO's minimum threshold, is concentrated overwhelmingly at the level of specialised inpatient facilities: 86% of mental health expenditure is directed to inpatient care, with nearly half occurring at the psychiatric hospital level (Lund et al., 2019). The effective treatment gap — defined as the proportion of those requiring mental health care who do not receive it — is estimated at approximately 92% for the uninsured population (Lund et al., 2019).

These figures reveal a system in structural crisis. This study argues that the crisis is not only logistical — a product of inadequate funding or insufficient clinicians — but epistemic. The persistent model of care is biomedical, hospital-centred, and pharmacological: it addresses the symptom as an individual biological event, detached from its social, historical, spiritual, and communal determinants. The National Mental Health Policy Framework 2023–2030 continues to deploy the ICD framework as its primary diagnostic architecture (Department of Health, 2023), and makes only limited, instrumentalised reference to indigenous or community-based knowledge systems.

The Epistemological Residue: DSM, ICD, and the Marginalisation of African Healing

The Mental Health Care Act of 2002 mandated evidence-based practice as the standard of care, a formulation that, in

practice, has consistently privileged randomised controlled trial (RCT) methodologies and pharmacological interventions developed in and for Western populations (Patel et al., 2018). Traditional health practitioners — whose practices encompass ancestral, spiritual, and communal dimensions of healing that are deeply consonant with African relational understandings of personhood — are recognised by the Traditional Health Practitioners Act (Act 22 of 2007) but remain excluded from formal mental health care pathways and from the evidentiary standards that govern integrated primary health care (Mabunda et al., 2022). This exclusion enacts what Santos (2014) terms epistemicide: the active erasure of knowledge systems through the assertion of a monopoly on what constitutes valid knowledge.

The consequence of this epistemological dominance is systemic: in contemporary South Africa, a person experiencing psychological distress in a township or rural area encounters a mental health system that can only recognise and treat their condition through the lens of DSM or ICD categories, pharmacological intervention, or referral to specialised psychiatric facilities. The rich repertoire of spiritual, communal, and healing resources that might address their distress — the sangoma who understands the ancestral dimensions of their suffering, the community elder who can mediate social rupture, the healer who recognises the spiritual ecology of their affliction — remains relegated to the category of the superstitious, the unproven, or the irrelevant. This is not simply a problem of service integration or workforce diversity; it is a problem of epistemic colonisation that renders whole dimensions of African thought and practice invisible within the very systems that claim to serve African populations. The South African case therefore shows why legislative recognition alone is insufficient: epistemic reform must also alter who participates in care and what counts as valid evidence. A structurally similar pattern, differently inflected by its own colonial genealogy, is evident in Ghana.

Country Context II — Ghana: From the Lunatic Asylum to the Mental Health Act

Colonial Genealogy: The Gold Coast and the Institution of Confinement

Ghana (formerly the Gold Coast) was colonised by Britain, and its mental health infrastructure bears the institutional imprint of that encounter with particular clarity. The first piece of mental health legislation was the Lunatic Asylum Ordinance of 1888, which empowered colonial authorities to arrest and detain as special prisoners any vagrant persons considered to exhibit signs of mental disturbance (Ghana Ministry of Health, 2019). In 1906, the colonial administration established the Accra Asylum — subsequently renamed Accra Psychiatric Hospital — as a dedicated custodial facility, reflecting the colonial understanding of mental illness as deviance to be confined rather than distress to be healed (Asiamah & Napor, 2023).

Pre-colonial Asante society, by contrast, held a holistic understanding of mental health that integrated physical, social,

spiritual, and relational dimensions. Asiamah and Napor (2023) document that traditional Asante communities understood mental disturbance as arising from disrupted social environments, supernatural forces, and violations of communal norms — a framework that centred the person as embedded within family, ancestors, and the living cosmos. Colonialism systematically displaced this understanding. Under British rule, the Native Customs Regulation Ordinance of 1878 banned indigenous healing practices outright, constituting what Ofori-Atta et al. (2010) describe as an institutional suppression of indigenous cosmological beliefs about health and the person (Ofori-Atta et al., 2018).

Contemporary Policy: The Mental Health Act of 2012 and Its Epistemological Limits

Ghana enacted a landmark Mental Health Act (Act 846) in 2012 — the first comprehensive mental health legislation since independence in 1957 — establishing a Mental Health Authority, providing for the rights of persons with mental illness, mandating integration of mental health into primary health care, and making provisions for collaboration with traditional healers through the Ghana Federation of Traditional Medicine Practitioners (GHAFTRAM) (Roberts et al., 2014; Patel et al., 2018). Ghana subsequently adopted a Twelve-Year Mental Health Policy (2019–2030), which explicitly acknowledged the historic failures of the asylum system and the 'over-reliance on the medical model to the detriment of psychosocial care' (Ghana Ministry of Health, 2019, p. 5).

Despite these reforms, the diagnostic and classificatory architecture of Ghanaian mental health care also encompasses the ICD framework of the Ghana Health Service, administered through psychiatric hospitals and community psychiatric nursing services (Doku et al., 2012). Peer-reviewed analysis has consistently documented the gap between policy intent and clinical practice: there is approximately one psychiatrist for every 1.5 million people in Ghana, with only three major psychiatric hospitals serving the entire country, concentrated in the urban south (Roberts et al., 2014). Only an estimated 2% of Ghanaians requiring mental health care have access to formal services (Ofori-Atta et al., 2018). The plural health-seeking reality — in which a significant proportion of Ghanaians consult indigenous and faith healers for conditions that biomedical systems would classify as mental disorders — is acknowledged in policy but not integrated into the formal care pathway in any epistemologically meaningful way (Ofori-Atta et al., 2018; Kpobi et al., 2019). Implementation remains constrained by limited resources, service-delivery capacity and the incomplete integration of cultural knowledge into formal care pathways (Ghana Ministry of Health, 2019; Roberts et al., 2014).

Comparative policy analysis of Ghana's 2012 Act indicates that, while it moved the country towards rights-based principles, implementation challenges related to resource constraints, service delivery capacity, and cultural integration remain significant barriers (Roberts et al., 2014; Doku et al., 2012). The Committee on the Rights of Persons with

Disabilities identified persistent concerns including laws permitting involuntary commitment and substitute decision-making regimes — practices that reflect not only resource constraints but an individualistic, biomedical ontology that understands the person as a discrete subject of legal and clinical intervention, rather than as constituted through relationships, obligations, and spiritual belonging.

Ghana's mental health trajectory illuminates a central theme of this review: the persistence of colonial epistemological frameworks even when formal legal architecture has been reformed. The formal recognition of traditional healers and mental health practitioners through legislation has not translated into a fundamental reorientation of mental health systems towards African epistemologies. Instead, traditional healing remains marginal — acknowledged in policy documents, studied anthropologically, and occasionally incorporated into "culturally sensitive" training modules — but never positioned as foundational to mental health theory and practice. This is the institutional enactment of epistemic violence: the formal recognition of African knowledge alongside its continuing structural subordination. Kenya's trajectory, considered next, sharpens this picture further, revealing how progressive constitutional and policy architecture can coexist with a biomedical model that is structurally unable to scale. The gap between formal recognition and practical authority also provides a useful comparison for Kenya, where progressive policy language confronts similarly centralised service structures.

Country Context III — Kenya: Colonial Psychiatry, the Mau Mau, and the Unscalable Biomedical Model British Colonial Psychiatry as Racial Technology

Kenya's encounter with formal mental health systems was forged in the crucible of British colonial rule and was, from the outset, inseparable from racial ideology and political control. Colonial administrators applied mental health legislation imported directly from Britain and British India — the first Kenyan Mental Health Act (1989) being the culmination of a legislative tradition that had, throughout the colonial period, treated mental disturbance primarily as a matter of social order rather than therapeutic care (Atwoli, 2024). The infamous case of Mathari Mental Hospital — established under colonial rule and later used as a site of political detention during the Mau Mau uprising — exemplifies the deployment of Western psychiatry not as care but as a technology of colonial control. At the height of the uprising, the colonial government sought the counsel of Dr. J.C. Carothers, the head of Mathari Hospital, whose psychiatric theories pathologised African political resistance as evidence of psychological deficiency (Keller, 2007).

Pre-colonial Kenyan communities, in contrast, possessed rich, contextually embedded understandings of mental disturbance that integrated spiritual causation, ancestral relationships, communal disruption, and the ecology of social life (Atwoli, 2024). These understandings — epistemologically consistent with the broader African

philosophical tradition of relational personhood — were systematically displaced by biomedical psychiatry, which positioned itself as the scientific correction of 'primitive' explanatory systems.

The integration of Kenyan mental health into the British colonial administrative structure meant that psychiatric practice was organised explicitly around racial hierarchy and social control. Mental health legislation was deployed not to serve the wellbeing of colonised populations but to manage those deemed threatening to colonial order. Deviance, resistance, and the psychological distress produced by dispossession and exploitation were pathologised and medicalised, rendering invisible the structural violence inherent in colonialism itself. Post-independence Kenya retained the Mental Health Act inherited from the colonial period (subsequently revised in 1989), maintaining the institutional apparatus of custodial psychiatry while nominal sovereignty shifted to African hands. This represents what Ndlovu-Gatsheni (2018) describes as "flag independence" — formal political autonomy accompanied by the continuation of colonial structures of knowledge and power. The Mathari Mental Hospital, built under colonialism as an instrument of control, continues to dominate Kenya's mental health landscape, symbolising the persistence of colonial architectures in ostensibly independent African states.

Contemporary Policy: Progressive Architecture, Unscalable Implementation

Kenya's Mental Health Policy 2015–2030, launched following the promulgation of the 2010 Constitution — which explicitly included the right to the highest attainable standard of mental health — and its accompanying Mental Health Action Plan 2021–2025, represent the most comprehensive policy articulations of Kenya's mental health priorities (Kenya Ministry of Health, 2015; Kenya Ministry of Health, 2021). Critically assessed, these documents articulate a progressive, rights-based shift towards universal mental health coverage and the integration of mental health into primary care settings (Atwoli, 2024).

However, peer-reviewed analysis of these frameworks reveals a structural disjuncture. Di Pierdomenico et al. (2024), applying an Intersectionality-Based Policy Analysis Framework to Kenya's 2015 Mental Health Policy, find that despite its human rights and social determinants rhetoric, a default to Western biomedical solutions for addressing mental distress continues to dominate institutionally and in practice, producing a persistent disjuncture between policy commitment and implementation (Di Pierdomenico et al., 2024). The DSM and ICD remain the operative diagnostic frameworks; Kenya's mental health workforce is critically insufficient with approximately one psychiatrist per 500,000 people; and mental health receives roughly 0.01% of the national health budget, rendering clinical coverage of the country's population 'mathematically impossible' under the existing model (Lichty, 2026).

Kenya's Human Rights Commission audit of mental health care, referenced extensively in the literature, confirmed that psychiatric care remains highly institutionalised and centralised, with 70% of all psychiatric beds located in a single facility — the legacy architecture of colonial confinement (Kenya Human Rights Commission, 2011). Much like in Ghana, comparative policy analysis indicates that Kenya's 2022 amendments to its mental health legislation showed markedly limited responsiveness to human rights obligations relative to regional peers, and that persistent laws permitting involuntary commitment and forced treatment reflect an institutional model still shaped by colonial custodialism (Di Pierdomenico et al., 2024). Having traced these three national trajectories, the review now turns to the theoretical resources needed to explain why formally independent, reform-minded systems nonetheless reproduce colonial epistemological patterns.

Epistemic Violence and the Coloniality of Mental Health Knowledge

Decolonality as Framework: Fanon, Ndlovu-Gatsheni, and Ngũgĩ wa Thiong'o

The theoretical scaffolding of this study is drawn from the tradition of decolonial thought, which distinguishes between colonialism as a formal political-territorial relationship and coloniality as the persistence of colonial logics of power, knowledge, and being long after formal independence (Quijano, 2000; Mignolo, 2011; Ndlovu-Gatsheni, 2013). For the present argument, the most consequential dimension of coloniality is what Ndlovu-Gatsheni (2018) names the 'coloniality of knowledge' — the entrapment of African knowledge production within power relations dominated by European and North American epistemologies. Ndlovu-Gatsheni's (2018) project of 'epistemic freedom' begins with the recognition that Africa's mental universe was invaded and colonised alongside its territories and bodies: to seek decolonisation only in political or economic terms while leaving epistemological structures intact is to achieve what he calls a 'flag independence' rather than a genuine liberation.

Frantz Fanon's intervention remains foundational. In *The Wretched of the Earth* (1963) and *Black Skin, White Masks* (1967), Fanon articulated the psychopolitical dimensions of colonial domination with a precision that no subsequent theoretical framework has fully superseded. For Fanon, colonialism was not merely a political arrangement but a psychic structure: it operated by internalising in the colonised a sense of ontological inferiority, a conviction that their own ways of knowing, being, and healing were primitive, irrational, or simply absent. Western psychiatry was not innocent of this project; it was, in the colonial African context, one of its most active instruments. Ratele's (2024) recent engagement with this legacy in the South African context articulates the persistence of what he names colonial mentality or epistemic self-colonisation within African psychology — an internalised conviction of the assumed superiority of Western frameworks that operates even among African psychologists who enjoy formal political freedom.

Ngũgĩ wa Thiong'o's (1986) concept of 'decolonising the mind' — the recovery of cognitive and cultural autonomy from the linguistic and conceptual apparatus of colonial education — provides the third pillar of this study's theoretical framework. Applied to mental health, Ngũgĩ's argument suggests that the dominance of English-language, Western-university-trained mental health professionals, operating through diagnostic manuals produced in the Global North, constitutes a form of cognitive imperialism that shapes what is speakable, diagnosable, and treatable in African public health systems.

The specific mechanics of this cognitive imperialism operate at multiple levels. At the level of professional training, psychiatrists, psychologists, and mental health practitioners across South Africa, Ghana, and Kenya are educated predominantly through curricula organised around DSM and ICD frameworks, with African philosophy, indigenous psychology, and decolonial theory remaining marginal or absent from formal professional education. At the level of institutions, mental health policy remains hierarchically structured: international organisations such as the WHO set the epistemological frame; national governments adopt and adapt that frame through policy; and practitioners implement systems grounded in assumptions about the nature of the person, the causes of mental distress, and the pathways to healing that originate in Western academic traditions. This is the institutional channel through which coloniality of knowledge is perpetuated — not primarily through overt cultural imperialism but through the mundane, bureaucratic entrenchment of a single epistemological framework as the standard against which all other frameworks are measured.

Furthermore, the power relations embedded in this epistemological dominance are sustained by economic structures. Research funding, publication opportunities, professional advancement, and access to international platforms of knowledge exchange all flow through channels controlled by institutions in the Global North. An African researcher who seeks to conduct research on mental health through African philosophical frameworks faces significant barriers: funding agencies prioritise empirical studies grounded in established (Western) theoretical models; high-impact journals privilege methodologies consistent with biomedical paradigms; and international conferences operate predominantly in English through frameworks defined in the Global North. These structural constraints mean that even African scholars who are intellectually committed to decolonial approaches face powerful institutional incentives to work within, rather than against, the existing epistemological architecture. This represents what Ratele (2024) identifies as epistemic self-colonisation at the structural level — the internalisation not merely in individual consciousness but in institutional systems of the assumption that Western epistemologies are the legitimate standard.

Epistemic Violence in Mental Health Nosology

The DSM and ICD diagnostic frameworks that govern mental health practice in South Africa, Ghana, and Kenya were developed through research conducted overwhelmingly on Western, Educated, Industrialised, Rich, Democratic (WEIRD) populations (Henrich et al., 2010). Their deployment as universal diagnostic standards in African contexts enacts what Spivak (1988) named 'epistemic violence' — the imposition of a knowledge system that renders other ways of knowing invisible, inadequate, or pathological. Kpanake's (2018) cross-cultural psychiatric research demonstrates that many African cultures operate with a fundamentally tripartite understanding of the person — encompassing spiritual agency (ancestors, God, spirits), social agency (family, clan, community), and self-agency — that shapes illness attribution, help-seeking behaviour, and the very phenomenology of mental distress in ways that are poorly captured by ICD diagnostic categories.

When an Akan person in Ghana describes psychological distress in terms of a disrupted relationship with the Okra (soul) or when a Kenyan elder invokes ancestral displeasure as a causal account of a community member's altered mental state, these are not deficient explanatory frameworks awaiting correction by biomedicine. They are epistemologically coherent accounts of mental disturbance arising from sophisticated — if differently formalised — philosophical traditions. The reduction of such accounts to 'cultural factors' within Western psychiatric formulation, rather than their recognition as legitimate ontological frameworks, constitutes the specific form of epistemic violence that this study seeks to interrogate. The broader decolonial literature reinforces this diagnosis. Drawing on Santos's (2014) concept of 'the ecology of knowledges,' this study argues that what is required in African public health is not the supplementation of biomedical frameworks with cultural sensitivity training, but a fundamental epistemological reorientation that positions African knowledge systems — including indigenous healing, relational ontologies, and holistic personhood frameworks — as foundational rather than supplementary. Having established why African ways of knowing have been marginalised, the review now turns to the substantive content of that marginalised knowledge, beginning with African philosophies of personhood.

African Philosophical Traditions and the Concept of Holistic Personhood

Beyond Ubuntu: The Depth of African Personhood Philosophy

It would be an impoverishment of African philosophical thought to reduce the alternative epistemological resources available to mental health theory to the concept of Ubuntu. While Ubuntu — the Nguni-derived principle encapsulated in the maxim 'umuntu ngumuntu ngabantu' ('a person is a person through other persons'/ 'I am because you are') is philosophically significant and has been productively elaborated in psychological and health scholarship (Metz,

2022; Mkhize, 2008; Malherbe & Ratele, 2022), it represents a particular formulation of a much broader African philosophical discourse on personhood, selfhood, and the constitution of the human being. Confining the decolonial critique of Western mental health to Ubuntu risks replicating within African thought the same reductive essentialism that the decolonial project sets out to challenge.

African philosophy has generated a rich, contested, and genuinely pluralistic body of thought on the nature of the person. The debate between Menkiti's (1984) radical communitarian thesis — in which personhood is not biologically given but normatively achieved through moral participation in communal life — and Gyekye's (1992) moderate communitarian position, which insists that a degree of intrinsic individuality grounds personhood independently of communal achievement, constitutes one of the most sophisticated engagements with the metaphysics of selfhood in modern philosophy (Imafidon, 2022). Additionally, Wiredu's (1996) Akan conceptual analysis further elaborates the constitution of the human being into multiple ontological components; Okra (soul), Sunsum (character/spirit), Honhom (breath/life-force), and Nipadua (body) — revealing a tradition of personhood philosophy that is intersectional, holistic and multidimensional in ways that Western Cartesian frameworks simply do not anticipate.

Similarly, Mbiti's (1969) influential formulation of African ontology through the lens of the Bantu metaphysical hierarchy — God, spirits, living persons, animals, and inanimate matter, held together by the vital force that Kagame (1956) identified through the concept of Ntu — offers a cosmological frame within which mental health cannot be understood apart from spiritual and ancestral relations. Jahn's (1961) analysis of the concept of Muntu (person) within Bantu-Kongo philosophy reveals a conception in which human identity is constituted through the intersection of Ntu (being), Kuntu (manner), Hantu (place and time), and Kintu (material existence) — a metaphysical grammar that places the person not as an isolated subject but as a node within a relational and cosmological network.

Yoruba Omoluabi and Akan Sunsum: Culture-Specific Frameworks for Psychological Wellbeing

The philosophical resources for a decolonial mental health framework extend well beyond Southern African traditions. For instance, the Yoruba concept of Omoluabi — a normative framework of personhood describing an individual who embodies honour, hard work, communal generosity, and moral rectitude — constitutes an indigenous psychological framework with direct relevance to understanding wellbeing, distress, and healing (Adetula et al., 2022). Unlike DSM constructs of personality functioning, which assess the individual against statistically normative population parameters, Omoluabi grounds psychological evaluation in the relational and moral fabric of communal life.

The Akan concept of Sunsum (spirit or character) — distinct from Okra (soul) and from the physical body — provides a framework for understanding psychological wellbeing in terms of spiritual vitality that neither biomedical psychiatry nor cognitive psychology can accommodate within their current paradigms (Gyekye, 1995; Wiredu, 1992). In Akan thought, depression, anxiety, or what Western psychiatry might classify as a mood or personality disorder may be understood as a disturbance of the Sunsum — a disruption of the spiritual-relational fabric of the person that requires communal, spiritual, and ceremonial intervention alongside or instead of pharmacological management.

Kpanake's (2018) synthesis of cultural concepts of the person across African societies identifies a tripartite model of African relational personhood — encompassing spiritual agency, social agency, and self-agency — as a near-universal structural feature of African psychological frameworks, despite their considerable cultural diversity. This model, he argues, underlies African illness attributions, help-seeking behaviour, and healing rituals in ways that render Western individually-oriented psychotherapy, as typically practised, a poor fit for the ontological commitments of African clients. Nwoye's (2017a) Africentric theory of human personhood, developed explicitly as a contribution to African psychology, synthesises these traditions into a framework that centres the spiritual, communal, ancestral, and ecological dimensions of selfhood — providing a theoretical spine for psychotherapeutic practice that does not begin with, or presuppose, European individualism.

The Spiritual Dimension: Ancestors, Divination, and Ecological Selfhood

A distinctive and philosophically significant feature of African conceptions of personhood is the integration of the spiritual and ancestral into the constitution of the self. In many African philosophical traditions, the person is not bounded by the skin; the self extends into a network of relations that includes the ancestors (those who have passed but remain present), the spirit world, and the natural environment (Mbiti, 1969; Nwoye, 2017a; Mkhize, 2004). Mental distress, in this framework, may signal not a chemical imbalance in an isolated brain but a rupture in these wider relational networks — a disruption in one's obligations to the ancestors, a breakdown in communal harmony, or an encounter with malevolent spiritual forces.

Indigenous healers — sangomas, diviners, herbalists, prayer healers — who operate within these frameworks are not offering alternative or complementary medicine in the sense that this terminology implies subordination to a biomedical primary. They are offering care grounded in a different but internally coherent ontological system. The fact that these systems have been designated traditional, alternative, or simply non-evidence-based within formal health policy is not a scientific conclusion but a political one — a reflection of the colonial hierarchy of knowledge that this study seeks to critique (Mabunda et al., 2022; Ofori-Atta et al., 2018).

Synthesis: The Epistemological Argument

Across South Africa, Ghana, and Kenya, the evidence reviewed here reveals a consistent pattern: formal mental health systems that have been constructed, legislated, and reformed through Western biomedical frameworks — DSM and ICD diagnostic categories, hospital-centred care models, pharmacological treatment protocols, and evidentiary standards grounded in WEIRD-population research — and that marginalise, subordinate, or simply do not engage with the rich African philosophical traditions of holistic personhood, relational ontology, spiritual healing, and communal wellbeing.

This pattern is not accidental. It is the product of a colonial epistemological inheritance that positioned Western knowledge as universal and African knowledge as local, partial, or pre-scientific. The result is what Ndlovu-Gatsheni (2018) names the invasion of the mental universe of the colonised — a penetration of Western conceptual categories so deep that they have been internalised as simply the way things are in mental health governance, even by African professionals, policymakers, and researchers. Ratele (2024) identifies this internalisation as epistemic self-colonisation: the condition in which political freedom has been achieved but cognitive freedom remains foreclosed.

The treatment gaps documented across all three countries — 92% in South Africa (Lund et al., 2019), an estimated 98% in Ghana (Ofori-Atta et al., 2018), and clinical coverage that is mathematically impossible in Kenya (Lichty, 2026) — cannot be explained by resource deficits alone. They reflect a fundamental mismatch between the epistemological assumptions of formal mental health systems and the ontological commitments, health-seeking behaviours, and cultural frameworks of the populations those systems are meant to serve. A system grounded in African relational personhood, spiritual ecology, and communal healing would not merely supplement the biomedical model with cultural competency; it would begin from a different understanding of what the person is, what mental distress means, and what healing requires from and within an African context.

From Epistemic Critique to Practice: Policy and Service Implications

Translating this epistemological critique into practical policy and service reform requires movement along several concrete pathways. At the level of policy architecture, national mental health frameworks in South Africa, Ghana, and Kenya could formally recognise indigenous and faith healers as co-equal partners within stepped-care and referral pathways, rather than as adjuncts consulted only after biomedical options are exhausted, extending existing but under-resourced provisions such as South Africa's Traditional Health Practitioners Act and Ghana's collaboration with GHAFTRAM into funded, monitored components of primary mental health care (Rall & Swartz, 2025). At the level of service delivery, community health worker and lay counsellor

training curricula could be redesigned around African relational and tripartite models of personhood (Kpanake, 2018) rather than imported symptom checklists, enabling frontline workers to engage ancestral, spiritual, and communal explanatory frameworks as clinically relevant rather than as barriers to be managed. At the level of professional regulation, statutory bodies such as the HPCSA could accredit collaborative training placements with recognised traditional and faith healers, giving epistemic pluralism institutional teeth rather than leaving it as aspirational policy language.

Recent scholarship illustrates what such translation can look like in practice. Swartz's (2022) reflection on the limits of professionalism within South African mental health care, and Alemu, Osborn, and Wasanga's (2023) proposal for a network-based approach to psychopathology as a decolonising tool, both demonstrate that epistemic reorientation need not remain at the level of critique; it can generate concrete clinical and methodological alternatives. Similarly, Cartmill et al.'s (2023) call to reimagine global mental health in Africa reinforces the argument that policy transformation and epistemic transformation must proceed together rather than sequentially.

Implementation Challenges

Nonetheless, the implementation of a decolonised mental health framework faces substantial structural obstacles that this review does not wish to understate. First, funding architectures in all three countries remain tied to donor and multilateral priorities that are themselves organised around biomedical metrics of cost-effectiveness, creating a structural disincentive to invest in indigenous healing infrastructure that does not produce comparably quantifiable outcomes (Lund, 2010). Second, the quality assurance and safety regulation of traditional and faith healing practices remains underdeveloped relative to biomedical governance, raising legitimate concerns about accountability, consent, and the potential for harm that any integrated model must address rather than romanticise (Mkhize, 2008). Third, the professional training pipeline itself is a bottleneck: curricula reform at the pace this review calls for requires buy-in from accreditation bodies, university faculties, and professional councils that are themselves products of the epistemological architecture under critique, generating considerable institutional inertia. Fourth, workforce shortages documented across all three countries mean that already over-stretched health systems have limited capacity to absorb the additional coordination burden that genuine collaboration between biomedical and indigenous practitioners would require (Rall & Swartz, 2025). None of these challenges is a reason to abandon the decolonial project; rather, they constitute the practical terrain on which epistemic disobedience must be operationalised, and they point directly to the future research priorities identified in the conclusion below.

Having outlined both the practical promise and the structural obstacles of this argument, the review now makes explicit the methodological approach through which it was constructed.

Methodology

Theoretical Framework: Decolonial Critical Review

This study employs a decolonial critical literature review as its primary methodological approach. A critical literature review — distinct from a systematic review — is not primarily concerned with the extraction and synthesis of empirical findings from a pre-specified set of studies. It is instead concerned with the interrogation of a field of scholarship: the identification of its conceptual premises, the examination of its epistemic foundations, and the critical analysis of what is assumed, included, excluded, and silenced within dominant frameworks (Snyder, 2019). The decolonial orientation of this review adds a further methodological layer: it is attentive to power relations as constitutive of knowledge, and it foregrounds African epistemologies not as data to be incorporated into Western frameworks but as legitimate knowledge systems in their own right (Ndlovu-Gatsheni, 2018; Santos, 2014).

This approach is consistent with an emerging tradition in African public health and psychological scholarship that engages both empirical and theoretical literatures through a critical epistemological lens (Mabunda et al., 2022; Ratele et al., 2018; Kong et al., 2023). It does not seek to exclude biomedical knowledge but to locate it as one knowledge system among others — to provincialise, in Chakrabarty's (2000) terms, what has been presented as universal.

Inclusion Criteria and Database Strategy

Literature for this review was drawn from multiple disciplinary traditions: public health and global mental health; decolonial studies and postcolonial theory; African philosophy; indigenous and community psychology; mental health policy analysis; and medical anthropology. The following electronic databases and repositories were searched: PubMed/MEDLINE; PsycINFO; African Journals Online (AJOL); Google Scholar; the WHO Global Mental Health Atlas; and government health policy portals for South Africa (Department of Health), Ghana (Ghana Health Service and Ministry of Health), and Kenya (Ministry of Health). Search terms were developed iteratively and included, individually and in combination: 'decolonial mental health Africa,' 'African philosophy personhood psychology,' 'mental health policy South Africa/Ghana/Kenya,' 'colonial psychiatry Africa,' 'epistemic violence health,' 'indigenous healing African mental health,' 'DSM' 'ICD' 'colonialism' 'Africa,' 'Ubuntu holistic personhood,' 'Akan Yoruba Bantu personhood,' and 'African decolonial public health.'

Inclusion criteria encompassed: peer-reviewed scholarly publications in English; government policy documents and national health strategies; national and international mental health data reports; book chapters and monographs from established academic publishers where peer-reviewed article coverage was limited. The date range was not systematically restricted, given the historical nature of part of the argument,

but emphasis was placed on literature published between 2012 and 2026, with foundational historical and philosophical texts included where they constituted primary theoretical sources (e.g., Fanon, 1963; Mbiti, 1969; Wiredu, 1996). Exclusion criteria included grey literature of indeterminate provenance and literature addressing mental health in African contexts without any engagement with cultural, philosophical, or epistemic dimensions.

Analytical Framework: Epistemic Mapping

Analysis proceeded through a process of epistemic mapping: the systematic identification of the epistemological assumptions embedded in mental health policy documents, clinical frameworks, and research paradigms across the three case study countries. This involved: (1) reading national mental health policy documents not merely for their content commitments but for their underlying ontological premises — who counts as a legitimate healer, what counts as evidence, what model of the person is presupposed; (2) tracing the genealogy of those premises to colonial encounters, identifying specific legislative and institutional mechanisms through which Western epistemologies were institutionalised; (3) identifying the African philosophical traditions that those epistemological frameworks have displaced or marginalised; and (4) articulating the structural and epistemic consequences of that displacement in the form of documented treatment gaps, care mismatches, and the exclusion of indigenous healing from formal health systems.

This analytical process is consistent with Quijano's (2000) concept of the coloniality of power, which identifies the classification of populations according to race, knowledge, and being as the foundational gesture of colonial governance, and with Mignolo's (2011) concept of the colonial wound — the condition of those whose knowledge systems have been systematically devalued and who must, therefore, engage in epistemic disobedience to reclaim intellectual autonomy. Epistemic disobedience — a concept central to this study's constructive argument — involves not the rejection of all Western knowledge but the refusal to position that knowledge as the only legitimate epistemological starting point, and the deliberate re-centring of African philosophical and healing traditions as foundational resources for theory and practice.

Positionality

As a South African-born scholar of Ghanaian heritage and a registered Clinical Psychologist with the Health Professions Council of South Africa (HPCSA), and an academic engaged in teaching, research, and clinical work across decolonial psychology, African philosophy, and psychobiography, this positionality is not incidental to the research. It constitutes an epistemological resource. As Ratele (2024) argues, the capacity to theorise from an African location — not merely to incorporate African examples into Western frameworks — is itself an act of epistemic freedom. The researcher's experience of navigating both the clinical demands of an HPCSA-regulated practice grounded primarily in Western diagnostic

and therapeutic frameworks, and the intellectual commitments of African-centred scholarship, provides an embodied understanding of the epistemic tensions this review seeks to make visible. Consistent with decolonial methodological principles, this positionality is disclosed not as a confession of bias to be managed, but as a legitimate epistemic location from which this inquiry proceeds.

Limitations

Several limitations of this review are acknowledged. First, the literature reviewed is primarily in English, which necessarily reflects a colonial linguistic inheritance and may under-represent scholarship produced in African languages — a limitation that is itself illustrative of the epistemic dynamics this study critiques. Second, the selection of three case study countries, while principled and defensible, cannot represent the full diversity of Africa's 54 nations or the considerable variation in colonial history, linguistic tradition, post-independence governance, and epistemological landscape across the continent. Third, as a theoretical and critical review rather than an empirical study, the argument is necessarily interpretive and discursive, and does not produce the kind of quantitative evidence that would satisfy positivist evidentiary standards — a limitation that is, however, itself part of the decolonial argument, insofar as the elevation of quantitative evidence over theoretical and philosophical knowledge is one of the epistemological hierarchies this study seeks to interrogate. Having set out the theoretical argument, the country evidence, and the methodological approach underpinning it, the review now draws these strands together.

Conclusion: Towards Epistemic Disobedience in African Mental Health

This critical review has traced the genealogies of mental health systems in South Africa, Ghana, and Kenya, revealing a consistent pattern: the institutional dominance of Western biomedical frameworks — DSM and ICD diagnostic categories, hospital-centred care models, pharmacological interventions, and evidentiary standards grounded in WEIRD-population research — coupled with the systematic marginalisation of African philosophical traditions, indigenous healing systems, and relational ontologies of personhood. This is not a problem of inadequate cultural competency or insufficient integration of traditional healers into existing biomedical structures. It is a problem of epistemic colonisation — the persistence of colonial hierarchies of knowledge long after formal political independence.

The treatment gaps documented in all three countries — reaching 92% in South Africa, an estimated 98% in Ghana, and clinical coverage that is mathematically impossible in Kenya — are symptoms of this epistemic mismatch. They reflect the fundamental incommensurability between systems grounded in individualistic, biomedical ontologies and the relational, communal, and spiritual frameworks through which most African populations understand and experience mental distress. No amount of additional funding, increased clinician

numbers, or expanded psychiatric facilities will resolve this mismatch if the underlying epistemological architecture remains unchanged. A system cannot serve a population whose fundamental understanding of the person, mental distress, and healing it does not recognise or validate.

Decolonising African mental health requires epistemic disobedience: a deliberate refusal to accept the monopoly of Western epistemologies and a strategic re-centring of African philosophical and healing traditions as foundational resources for theory and practice. This does not mean rejecting biomedical knowledge, but rather positioning it as one knowledge system among others — provincialising what has been presented as universal. Drawing on the vast landscape of African philosophy — from Menkiti and Gyekye's sophisticated analyses of communitarian personhood, to Wiredu's multidimensional ontology of the Akan person, to Mbiti and Kagame's cosmological frameworks centred on vital force and relational being, to Nwoye's contemporary Africentric theory of personhood — mental health in African contexts can be grounded in epistemologies that are genuinely African, not merely decorated with African examples.

Operationally, this requires transformations across multiple domains. In policy, mental health frameworks must be explicitly reoriented to position African epistemologies as foundational and to recognise indigenous healing systems as legitimate components of mental health infrastructure, not as supplementary cultural considerations. In research, funding agencies and academic institutions must create space for scholarship grounded in African philosophical frameworks and methodologies that are not reducible to biomedical paradigms. In professional training, curricula in psychology, psychiatry, nursing, and social work across the continent must integrate African philosophy, indigenous psychology, and decolonial theory as central rather than peripheral content. In clinical practice, mental health professionals must be enabled — indeed, required — to engage with the spiritual, ancestral, communal, and relational dimensions of distress that their predominantly biomedical training has rendered invisible.

Most fundamentally, decolonising mental health requires recognising that African philosophy is not merely culturally interesting but epistemologically necessary — those relational conceptions of personhood, spiritual and ancestral dimensions of being, and communal understandings of wellbeing are not local variations on universal truths but offer genuinely alternative frameworks for understanding what it means to be human and how human flourishing is constituted and sustained. The alternative is the continuation of what Ndlovu-Gatsheni (2018) calls "flag independence" in mental health — formal African sovereignty over systems that remain conceptually colonised, perpetuating hierarchies of knowledge that reflect and reinforce broader patterns of global epistemic inequality.

The stakes of this argument extend beyond mental health policy and practice, though the evidence presented in South Africa, Ghana, and Kenya demonstrates that the stakes are

material and consequential there. At a broader level, this review contributes to a growing decolonial scholarship in African public health that insists that liberation — genuine freedom — requires not only political and economic transformation but epistemic liberation: the restoration of African thought as a legitimate, generative, and necessary resource for addressing the fundamental problems of human health, wellbeing, and flourishing. Decolonising African mental health is thus an act of intellectual freedom and a precondition for the development of mental health systems that genuinely serve African populations and reflect African understandings of what it means to care for the mind, the spirit, and the person embedded in community.

Future research should move from theoretical mapping towards empirical testing of these arguments: comparative implementation studies of collaborative biomedical-indigenous care models, practitioner- and patient-reported outcome research grounded in African relational rather than DSM/ICD constructs, and policy evaluation of the limited jurisdictions that have begun to formalise traditional healer integration. In practical terms, the immediate priorities identified by this review are threefold: revising professional curricula in psychology, psychiatry, nursing, and social work to include African philosophy and indigenous psychology as core rather than elective content; piloting funded, monitored collaborative care pathways between biomedical and traditional practitioners in at least one district or county within each of the three countries reviewed; and developing culturally grounded outcome measures that can make the effectiveness of indigenous and spiritual healing legible to policymakers without reducing it to biomedical terms of evaluation. Taken together, these steps would begin to translate the epistemic argument advanced in this review into the institutional architecture of African public health, moving decolonisation from a diagnostic vocabulary into a programme of implementable reform.

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Citation: Plaatjie QA (2026); *Decolonising Mental Health in African Public Health: A Critical Review of Epistemic Frameworks*. *Adv Pub Health Com Trop Med: APCTM*-276.