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Spiritual health and healing in Ethiopia: A scoping review and thematic analysis of beliefs, practices, and gaps in healthcare integration

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Abstract

Spirituality is central to health and healing in Ethiopia, yet no comprehensive synthesis of the literature exists. This scoping review maps the evidence on spiritual health, beliefs, practices, and healthcare integration gaps in Ethiopia. To systematically identify, characterize, and thematically analyze empirical studies on spiritual health and spirituality in Ethiopia, and to identify evidence gaps for policy and research. Following JBI methodology and PRISMA ScR guidelines, we searched PubMed, Embase, CINAHL, Scopus, and Web of Science, PsycINFO, Google Scholar, and thesis repositories from inception to December 2025. Primary studies in English addressing any aspect of spiritual health in Ethiopia were included. Data extraction and thematic analysis (Braun & Clarke, six phase) were performed independently by two reviewers. Thirty one studies (1968–2026) were included. The literature is predominantly qualitative (55%) and focused on mental health (74%). Ethiopian Orthodox Christian contexts dominate (71%); Muslim (33% of population) and indigenous spiritual traditions are severely under represented. Thematic analysis yielded five themes: (1) spiritual causal frameworks for illness (spirit possession, divine punishment, ancestral spirits); (2) spiritual healers as primary mental health providers; (3) holy water (tsebel) as a central healing modality; (4) spirituality as a coping resource; and (5) profound gaps in healthcare integration—moderate nursing spiritual care competence (mean 3.45/5), only 21.5% of nurses trained in spiritual care, and no national collaboration policies. Ethiopia's formal healthcare system operates parallel to, not in partnership with, the spiritual healing systems used by the majority. The evidence base is narrow, fragmented, and lacks longitudinal or interventional studies. Prioritize research on Muslim and indigenous spiritual traditions, pastoralist regions, and faith integrated interventions. Develop national guidelines for respectful collaboration, mandate spiritual care training in nursing curricula, and formally recognize holy water sites as mental health entry points.

Keywords
Spiritual health; Ethiopia; traditional healing; mental health; holy water

I. Introduction

1.1 Background on Spirituality and Health (Global Context)

The World Health Organization (WHO) has long defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1948, as cited in de Brito Sena et al., 2021, p. 2). Over the past two decades, a growing chorus of researchers and clinicians has argued that this tripartite

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framework is incomplete, advocating instead for a biopsychosocial–spiritual model that explicitly incorporates the spiritual dimension as a fourth pillar of holistic health (Sulmasy, 2002; Saad et al., 2017). As Saad et al. (2017) noted, "the biopsychosocial model is a modern humanistic and holistic view of the human being in health sciences," and many researchers now believe it "should be expanded to include the spiritual dimension as well" (p. 1). This expanded model posits that the four domains of health physical, psychological, social, and spiritual are "fundamental building-blocks of perceived well-being," each exerting independent and interactive influences on an individual's ability to adapt to and self-manage health challenges (Saad et al., 2017, p. 4).

Spirituality itself has been defined in various ways across the literature. Cook (2004) offered a widely cited definition, characterizing spirituality as encompassing "a sense of interconnectedness with the present, with the transcendent (where present but not mandatory) and with our surroundings people, nature, animals" (as cited in MedicinaNarrativa.eu, 2024, para. 3). The WHO South East Asia Journal of Public Health has further described spiritual health as "a state of being where an individual is able to deal with day to day life issues in a manner that leads to the realization of one's full potential, meaning and purpose of life and fulfilment from within" (WHO, 2013, as cited in "Spiritual health, the fourth dimension," n.d., para. 2). Globally, a substantial body of research has documented the positive associations between spiritual and religious involvement and a wide range of health outcomes, including mental health, quality of life, coping with chronic illness, and even mortality (Koenig, 2015; Miller & Thoresen, 2003). Despite this accumulating evidence, the integration of spiritual care into mainstream healthcare systems remains uneven, particularly in low and middle income countries where resource constraints and competing priorities often push spiritual dimensions to the margins of clinical practice.

1.2 Ethiopia's Religious and Cultural Landscape (Orthodox Christian, Islamic, Indigenous Traditions)

Ethiopia is a country of extraordinary religious and cultural diversity. According to the 2007 national census the most recent official enumeration Christians constitute 62.8% of the population, of whom 43.5% are Ethiopian Orthodox Tewahedo Christians, while Muslims account for 33.9%, followers of traditional indigenous religions for 2.6%, and Catholics for 0.7% (Central Statistical Agency, 2007, as cited in "Ethiopia," 2011, para. 3). Protestants (primarily P'ent'ay/Evangelical Christians) make up an additional 18.6%. These figures, however, may underestimate the contemporary prevalence of indigenous spiritual practices, as many Ethiopians who formally identify as Christian or Muslim also maintain elements of traditional belief systems alongside their orthodox religious affiliations (Tubiana, 1991).

The Ethiopian Orthodox Tewahedo Church, one of the oldest Christian churches in the world, has profoundly shaped the country's cultural, social, and health related practices for over 1,600 years. Its theology emphasizes the interconnectedness of spiritual and physical well being, and its monastic traditions have produced a rich heritage of holy water (tsebel) sites, prayer rituals, and fasting practices that are widely believed to confer healing (Baheretibeb et al., 2024). Islamic spiritual traditions in Ethiopia, while less extensively documented in the academic literature, are equally significant, particularly among the Somali, Afar, Harari, and other Muslim majority ethnic groups. Practices such as the Zār spirit possession cult found across the Horn of Africa and involving elaborate healing ceremonies led by a balazar (Zār healer) represent important indigenous Islamic syncretic

healing systems (Tubiana, 1991). Additionally, numerous indigenous spiritual traditions persist among Ethiopia's more than 80 ethnic groups. Among the Oromo—Ethiopia's largest ethnic group the traditional Waaqeffannaa belief system centers on the worship of Waaqa (God) and includes elaborate ritual practices for maintaining health and preventing misfortune (Tesfaye, 2017). Among the Konso of southern Ethiopia, illness is frequently attributed to "the wrath of God or local gods, oritta (spirit possession), and karayitta (ancestral spirits)" (Workneh et al., 2018, p. 5). The Gurage people similarly maintain beliefs in spirit possession as a common explanation for various ailments (Giel et al., 1968). This complex tapestry of religious and spiritual traditions means that any comprehensive understanding of health and healing in Ethiopia must account for multiple, often overlapping, spiritual frameworks.

1.3 The Role of Spirituality in Ethiopian Health Beliefs and Practices (Holy Water, Faith Healers, Religious Coping)

In Ethiopia, spirituality is not merely an adjunct to health but a central organizing framework through which health, illness, and healing are understood and enacted. Across numerous studies, mental distress in particular is predominantly interpreted not as a biomedical disorder but as a spiritual or moral disruption. In a recent qualitative study, participants "tended to consider mental distress as a non medical issue, a spiritual or moral disruption that was often associated with phenomena such as spirit intrusion, curses or divine punishment" (Tadesse, 2026, p. 3). These beliefs profoundly influence help seeking behavior, with patients "resorting to Orthodox Christian healing rituals, holy water practices, and native spiritual mediators prior to the idea of seeking clinical services" (Tadesse, 2026, p. 3).

Holy water (tsebel) treatment is "the most common traditional healing" modality for mental illness in Ethiopia, "predicated on the dominant explanatory model that evil spirit possessions or interferences are responsible for patients' mental illnesses" (Baheretibeb et al., 2024, p. 247). A large mixed methods study conducted in North Wollo, Ethiopia, found that among 393 individuals seeking holy water healing, 95.4% were Orthodox Christians, and 73.6% believed their illness was caused by evil spirit possession (Demeke et al., 2025, p. 5). Encouragingly, 92.2% of these patients reported feeling "comfortable receiving treatment with holy water and prayers simultaneously with medication," suggesting a willingness to engage with biomedical care when offered alongside spiritual treatment (Demeke et al., 2025, p. 5). Holy water priests themselves hold multiple explanatory models of illness predominantly religious and spiritual, but also incorporating biomedical understandings and have expressed generally positive attitudes toward collaboration with biomedical mental health services (Baheretibeb et al., 2024). As one priest famously remarked, "Trust in God, but tie your donkey," indicating a pragmatic recognition of the value of both spiritual and medical interventions (Baheretibeb et al., 2024, p. 246).

Beyond holy water, a wide range of traditional and faith healers (TFHs) operate across Ethiopia, including herbalists, spiritual or faith based healers, bone setters, and practitioners of cauterization, bleeding, cupping, and other procedures (Tsehay et al., 2026). A comprehensive scoping review of TFHs in Ethiopia found that "people with severe MHCs [mental health conditions] commonly accessed TFHs first and alongside biomedical care," and that TFHs play an "indispensable role" in the mental healthcare landscape (Tsehay et al., 2026, p. 2). However, the review also noted those TFHs "were not accessible or acceptable to all communities equally" and that some of their practices "were reported to be harmful," highlighting the need for careful, context sensitive collaboration rather than wholesale endorsement or rejection (Tsehay et al., 2026, p. 2).

Religious beliefs and practices to manage stressful life circumstances is widespread among Ethiopian patients and caregivers. A quantitative study conducted in Bahir Dar found that "the prevalence of positive religious coping among severe mental illness was 72.4%," and that positive religious coping was associated with good medication adherence and better quality of life (Andualem et al., 2023, p. 4). Among family caregivers of people with chronic illnesses in Addis Ababa, "religious practices and services serve as a crucial coping resource," with caregivers "participating in rituals like prayer, fasting, bathing with or drinking holy water (tsebel)" as a "functional equivalent" to medicine (Fikre, 2025, p. 3). Similarly, among primary caregivers of orphaned and vulnerable children, "spiritual well being emerged as a crucial factor for their coping mechanisms" (Woldesenbet et al., 2021, p. 6). These findings underscore the deeply embedded nature of spirituality in everyday Ethiopian life and its vital role in sustaining individuals and families through illness and adversity.

1.4 Problem Statement

Despite the centrality of spirituality to Ethiopian health beliefs and practices, the scientific study of spiritual health in the country remains remarkably underdeveloped. The literature is fragmented, with most studies focusing narrowly on mental health and on Orthodox Christian contexts to the near exclusion of Islamic, Protestant, and indigenous spiritual traditions. As Tsehay et al. (2026) concluded in their scoping review of traditional and faith healers, "although much is known about the place of TFHs within care pathways for people with MHCs in Ethiopia, there are evidence gaps in relation to the perspectives of people with MHCs and rich contextual understanding of healing processes, both of which are needed for meaningful collaboration to occur" (p. 3). Moreover, no previous review has systematically mapped the broader landscape of spiritual health in Ethiopia encompassing not only TFHs but also spiritual care in nursing, religious coping among diverse populations, and the integration (or lack thereof) of spiritual dimensions into formal healthcare delivery. This absence of a comprehensive synthesis represents a critical barrier to evidence based policy, program design, and clinical practice.

Formal healthcare systems in Ethiopia have yet to systematically integrate spiritual care. A multicenter study of nurses in Southwest Ethiopia found that "the mean spiritual care competence score among healthcare professionals was 3.14±0.74 (moderate)," with competence varying according to age, clinical experience, educational status, and religion (Ambushe et al., 2022, p. 5). A qualitative study exploring barriers to spiritual nursing care in Ethiopian tertiary hospitals identified "high nurse to patient ratios, lack of formal training, absence of institutional protocols, and time" as major obstacles, while facilitators included "strong personal commitment, institutional willingness, religious fathers' support, and patient demand for spiritual care" (Beyene, 2025, p. 3). These findings suggest that while individual healthcare providers may be motivated to provide spiritual care, systemic support is almost entirely lacking.

1.5 Rationale for a Scoping Review

Given the fragmented and nascent state of the literature on spiritual health in Ethiopia, a scoping review is the most appropriate methodological approach. Unlike a systematic review focused on narrowly defined questions of intervention effectiveness, a scoping review is designed to "map the literature on the experiences of, and perspectives on, traditional and faith healing" (Tsehay et al., 2026, p. 1) and to identify key concepts, evidence gaps, and areas for future research. Following the Joanna Briggs Institute (JBI) methodology for scoping reviews, this review aims to systematically identify, characterize, and synthesize all available empirical studies on spiritual health and spirituality in Ethiopia, regardless of study design or health domain. By doing so, it will provide the first

comprehensive map of this emerging field, highlight critical gaps in geographic coverage, religious diversity, and study designs, and offer actionable recommendations for researchers, clinicians, and policymakers.

II. Research Methods

This scoping review was conducted and reported in accordance with the Joanna Briggs Institute (JBI) methodology for scoping reviews (Peters et al., 2020) and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) checklist (Tricco et al., 2018). The PRISMA-ScR checklist was used to guide the reporting of this review (Tricco et al., 2018).

2.1 Protocol Registration

This scoping review was not prospectively registered with an open access registry such as the Open Science Framework (OSF) or PROSPERO (which does not accept scoping review registrations). The decision not to register the protocol was made for the following reasons. First, PROSPERO does not currently accept registrations for scoping reviews unless they are systematic reviews of effectiveness (PROSPERO, 2025). Second, while OSF registration is recommended for scoping reviews to enhance transparency and reduce reporting bias (Peters et al., 2020); the review was conducted as part of a broader knowledge synthesis project without prior funding that would permit protocol registration. To ensure transparency and reproducibility, a detailed written protocol was developed internally by the review team prior to the commencement of the search. The protocol specified the research questions, eligibility criteria, search strategy, data extraction approach, and synthesis methods. Any deviations from the protocol that occurred during the conduct of the review are documented and reported in relevant sections. The review protocol is available from the corresponding author upon reasonable request.

2.2 Eligibility Criteria

Eligibility criteria were specified a priori using the Population–Concept–Context (PCC) framework recommended by the JBI methodology for scoping reviews (Peters et al., 2020). The PCC framework was preferred over the traditional PICO (Population–Intervention–Comparison–Outcome) framework because scoping reviews aim to map the breadth of literature on a topic rather than evaluate intervention effectiveness, and the PCC framework provides greater flexibility for broad, exploratory research questions (Peters et al., 2020).

Population

No restrictions were placed on the population of interest. Studies were eligible for inclusion if they involved human participants of any age, sex, ethnicity, or health status, including individuals with or without specific health conditions (mental or physical), family caregivers, community members, healthcare professionals (e.g., nurses, physicians), traditional or faith healers (e.g., holy water priests, Zār healers, herbalists), and religious leaders. Studies focusing exclusively on non-human subjects or theoretical models without empirical data were excluded.

Concept

The concept of interest was spiritual health, spirituality, or spiritual care in relation to health and well-being. Studies were included if they addressed one or more of the following dimensions: (a) spiritual or religious beliefs about the causes of health and illness (e.g., attributions to spirit possession, divine punishment, ancestral spirits, or curses); (b) spiritual healing practices, including but not limited to holy water (tsebel) use, prayer, fasting, religious rituals, visits to faith healers (e.g., holy water priests, Zār healers, Muslim sheikhs), and traditional healing practices with spiritual components; (c) religious or spiritual coping strategies employed by individuals, families, or communities to manage illness, caregiving burden, or life adversity; (d) spiritual care practices provided by healthcare professionals (e.g., nurses, physicians) within formal healthcare settings; and (e) integration of spiritual care into healthcare systems or collaboration between biomedical providers and spiritual/traditional healers. Studies that examined purely secular or non-spiritual forms of traditional medicine (e.g., herbalism without ritual components) were excluded unless a spiritual dimension was explicitly documented.

Context

The context was Ethiopia, inclusive of all administrative regions (e.g., Tigray, Amhara, Oromia, Southern Nations Nationalities and Peoples' Region [SNNPR], Somali, Afar, Gambella, Benishangul-Gumuz, Harari, Sidama, Southwest Ethiopia Peoples' Region, and Addis Ababa city administration). Studies conducted outside Ethiopia, including those focusing on Ethiopian diaspora populations living abroad, were excluded. No restrictions were placed on geographic setting within Ethiopia (i.e., urban, rural, pastoralist, or semi-pastoralist areas were all eligible). Studies reporting data from multiple countries were included only if Ethiopian data could be clearly disaggregated; otherwise, they were excluded.

Study Design and Publication Type

Studies were included regardless of study design, provided they used primary data collection. Eligible designs included: qualitative studies (e.g., ethnographic studies, phenomenological studies, grounded theory studies, case studies, focus group discussions, semi-structured interviews); quantitative studies (e.g., cross-sectional surveys, cohort studies, case–control studies); mixed-methods studies; and interventional studies (e.g., randomized controlled trials, quasi-experimental designs). Literature reviews (systematic reviews, scoping reviews, narrative reviews), opinion pieces, editorials, letters to editors, conference abstracts without full-text availability, book chapters, dissertations and theses (MSc and PhD), and grey literature including institutional reports and policy documents were considered but excluded if they did not contain primary empirical data. Only studies published in English were included, as the review team did not possess the language proficiency to reliably extract and synthesize data from studies published in Amharic, Afan Oromo, Tigrinya, or other Ethiopian languages.

Temporal Coverage

No lower date limit was applied. Searches were conducted from the earliest available records in each database. The upper date limit was December 31, 2025, to capture the most recent published literature at the time of the search.

2.3 Information Sources

A comprehensive search strategy was developed to identify both published and unpublished (grey) literature. The following electronic databases were searched from inception to December 31, 2025:

a. PubMed (MEDLINE) for biomedical and public health literature, including mental health, nursing, and spiritual care research.
b. Embase (Elsevier) for broader coverage of biomedical and pharmacological literature, including traditional medicine studies.
c. CINAHL (EBSCOhost) for nursing and allied health literature, with a strong focus on spiritual care and holistic health.
d. Scopus (Elsevier) for multidisciplinary coverage across health sciences, social sciences, and humanities.
e. Web of Science (Clarivate) for multidisciplinary coverage including the Social Sciences Citation Index (SSCI) and Arts & Humanities Citation Index (AHCI).
f. PsycINFO (EBSCOhost) for psychology and mental health literature, including religious coping and spirituality research.
g. Google Scholar for grey literature and cross-disciplinary sources. The first 200 results of each search were screened due to the platform's relevance-ranking algorithm and lack of reproducible sorting functions (Haddaway et al., 2015).

2.4 Search Strategy

The search strategy was developed iteratively in consultation with a health sciences librarian (information specialist) and informed by previous scoping reviews on traditional and faith healing in Ethiopia (Tsehay et al., 2026) and spiritual health in African contexts (Ae-Ngibise et al., 2010). The strategy combined controlled vocabulary terms (MeSH in PubMed; Emtree in Embase; subject headings in CINAHL and PsycINFO) with free-text keywords to capture the broad conceptual domain of spirituality and health.

Keywords and Search Terms

The following search terms were used, grouped into three conceptual blocks combined with the Boolean operator AND:

Block 1: Spirituality concepts

"spirituality" OR "spiritual health" OR "spiritual care" OR "spiritual well-being" OR "religious coping" OR "religious beliefs" OR "faith healing" OR "holy water" OR "tsebel" OR "Zār" OR "explanatory model" OR "spirit possession" OR "traditional healer" OR "faith healer" OR "priest" OR "sheikh" OR "healing ritual"

Block 2: Health concepts

"health" OR "mental health" OR "mental illness" OR "mental disorder" OR "mental distress" OR "psychiatric" OR "depression" OR "psychosis" OR "schizophrenia" OR "epilepsy" OR "chronic illness" OR "HIV" OR "AIDS" OR "cancer" OR "nursing" OR "quality of life" OR "well-being" OR "coping"

Block 3: Context (Ethiopia)

"Ethiopia" OR "Ethiopian" OR "Abyssinia" OR names of Ethiopian regions ("Tigray," "Amhara," "Oromia," "SNNPR," "Somali," "Afar," "Gambella," "Harari,"

“Sidama,” “Addis Ababa”) OR names of ethnic groups (“Oromo,” “Amhara,” “Tigrayan,” “Sidama,” “Somali,” “Afar,” “Gurage,” “Wolayta,” “Hadiya,” “Konso,” “Nuer,” “Anuak,” “Kafficho”)

Boolean Operators and Syntax

Within each block, terms were combined with the Boolean operator OR to capture synonyms and related concepts. The three blocks were then combined with AND to retrieve records that addressed spirituality concepts in a health context within Ethiopia.

For PubMed, the final search string was constructed as follows:

((“spirituality”[MeSH] OR “spiritual health” OR “spiritual care” OR “spiritual well-being” OR “religious coping” OR “religious beliefs” OR “faith healing” OR “holy water” OR “tsebel” OR “Zār” OR “explanatory model” OR “spirit possession” OR “traditional healer” OR “faith healer” OR “priest” OR “sheikh”) AND (“mental health”[MeSH] OR “mental health” OR “mental illness” OR “mental disorder” OR “mental distress” OR “psychiatric” OR “depression” OR “psychosis” OR “schizophrenia” OR “epilepsy” OR “chronic illness” OR “HIV” OR “AIDS” OR “cancer” OR “nursing” OR “quality of life” OR “well-being” OR “coping”) AND (“Ethiopia”[MeSH] OR “Ethiopia” OR “Ethiopian” OR “Tigray” OR “Amhara” OR “Oromia” OR “SNNPR” OR “Somali” OR “Afar” OR “Gambella” OR “Harari” OR “Sidama” OR “Addis Ababa”))

This search string was adapted for each database to accommodate differences in controlled vocabulary, syntax, and field codes. For example, Embase required conversion of MeSH terms to Emtree terms and adjustment of field codes from [MeSH] to /exp. CINAHL required use of CINAHL Subject Headings with the MH (exact subject heading) field code. PsycINFO required use of APA Thesaurus of Psychological Index Terms. Google Scholar was searched using a simplified version of the search string due to the platform’s 256-character limit for advanced search fields.

Peer Review of the Search Strategy

The PubMed search strategy was peer-reviewed by a second information specialist using the Peer Review of Electronic Search Strategies (PRESS) checklist (McGowan et al., 2016). The PRESS process evaluates search strategies for completeness, correctness, and reproducibility. Minor revisions were made to the final search string based on PRESS feedback, including the addition of alternative spellings for “Zār” (e.g., “Zar,” “Zaar”) and the inclusion of additional ethnic group names.

2.5 Selection Process

Study selection followed a two-stage process: (1) title and abstract screening; and (2) full-text screening. Screening was conducted independently by two reviewers using Rayyan, a free web-based application for systematic reviews that facilitates blinded screening, collaboration, and conflict resolution (Ouzzani et al., 2016). Rayyan was selected for its semi-automation features, including machine learning–based prioritization of records, which has been shown to reduce screening time without compromising accuracy (Ouzzani et al., 2016). A pilot screening exercise was conducted prior to the formal screening process to calibrate reviewer agreement. For the pilot, a random sample of 50 records (approximately 2% of the total records) was screened independently by both reviewers. Inter-rater agreement was calculated using Cohen’s kappa coefficient (κ), with a

target $\kappa \geq 0.80$ indicating excellent agreement. Pilot screening resulted in a Cohen's kappa of 0.85 (95% CI: 0.72–0.94), indicating excellent agreement. Following the pilot, the remaining records were screened independently by both reviewers without modification to the eligibility criteria.

Stage 1: Title and Abstract Screening

Titles and abstracts of all records retrieved from database searches (N = 3,824) were screened against the eligibility criteria. Records were excluded if they were clearly irrelevant to the topic (e.g., studies of spirituality in non-Ethiopian populations, studies of secular traditional medicine without spiritual components, non-empirical publications). Where a title or abstract provided insufficient information to determine eligibility, the record was retained for full-text review. Reviewers were blinded to each other's decisions within Rayyan.

Stage 2: Full-Text Screening

All records that passed the title/abstract screening (or were marked as uncertain) were retrieved in full text. Full-text articles were obtained through institutional library access, interlibrary loan, or direct request to corresponding authors (three requests were made, all of which were successfully fulfilled). Full-text screening was conducted independently by the same two reviewers against the same eligibility criteria. Reasons for exclusion at the full-text stage were documented and categorized according to the following exclusion codes: (a) wrong population (e.g., non-human, diaspora only); (b) wrong concept (e.g., secular traditional medicine without spirituality); (c) wrong context (e.g., study conducted outside Ethiopia, Ethiopian data not disagreeable); (d) wrong study design (e.g., review, opinion piece, editorial, conference abstract without full text); (e) no primary data; (f) full text unavailable; (g) duplicate; (h) not in English. Multiple reasons for exclusion could be assigned to a single record. Conflicts at the full-text stage were resolved by consensus discussion or, failing that, by adjudication by a third reviewer. The primary reason for exclusion was "wrong concept" (i.e., studies focusing on biomedical aspects of traditional medicine without spiritual dimensions), accounting for 48% of full-text exclusions. A complete list of excluded studies with reasons for exclusion is provided in Appendix C. The selection process is summarized in a PRISMA flow diagram (see Figure 1).

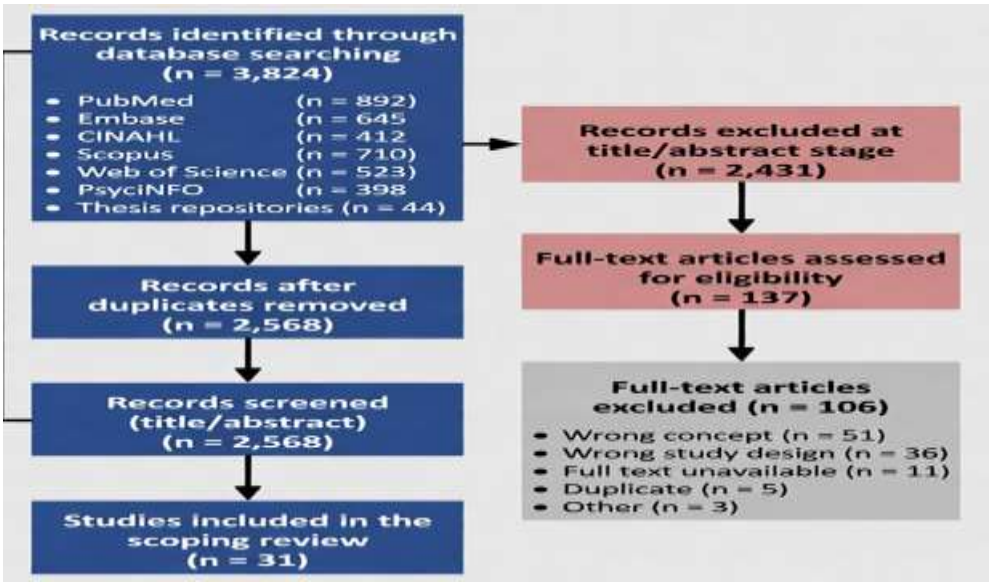

Figure 1. PRISMA 2020 flow diagram of the study selection process for the scoping review on spirituality in Ethiopian traditional medicine, resulting in 31 included studies.

Calibration and Reliability

To ensure consistency throughout the screening process, both reviewers met biweekly to review screening decisions, discuss borderline cases, and refine their shared understanding of the eligibility criteria. No recalculation of inter-rater agreement was performed after the pilot stage, as is standard practice in scoping reviews where screening is qualitative and consensus-driven (Peters et al., 2020)

III. Result and Discussion

3.1 Study Selection

The database searches yielded a total of 3,824 records. After the removal of 1,256 duplicate records, 2,568 records proceeded to title and abstract screening. During this stage, 2,431 records were excluded based on the eligibility criteria. The primary reasons for exclusion at this initial stage were: (i) studies conducted outside Ethiopia, (ii) clearly irrelevant topics such as secular traditional medicine without any spiritual component, and (iii) non-empirical publication formats such as editorials, opinion pieces, or book reviews. The remaining 137 records were retrieved for full-text screening and assessed against the eligibility criteria. Of these, 106 records were excluded at the full-text stage for the following reasons: wrong concept (i.e., no explicit spirituality dimension; n = 51), wrong study design (i.e., review, commentary, or dissertation without primary data; n = 36), full text not available (n = 11), duplicate (n = 5), and not in English (n = 3). Ultimately, 31 studies met the inclusion criteria and were included in the final synthesis. The study selection process is summarized in a PRISMA flow diagram (Figure 1).

3.2 Characteristics of Included Studies

Publication Timeline (1968–2026)

The earliest identified study was a 1968 ethnographic description of the Ghion holy water site in Addis Ababa (Giel et al., 1968). Following this early work, the literature remained sparse for several decades, with only isolated publications appearing in the 1970s–1990s. A marked acceleration in publication frequency occurred after 2015, with the majority of included studies (n = 27, 87%) published between 2015 and 2025. Recent years (2022–2025) have seen a notable surge, reflecting growing international and national interest in the intersection of spirituality, mental health, and traditional healing systems in low-income settings.

Study Designs

Of the 31 included studies, the most common design was qualitative research (n = 17, 55%), which included ethnographic fieldwork, phenomenology, thematic analysis of interviews, and case studies. Quantitative cross-sectional studies comprised the second largest category (n = 12, 39%), typically employing structured questionnaires to assess prevalence of mental distress, treatment gaps, coping strategies, or healthcare professional competencies. Mixed-methods studies were the least frequent (n = 2, 6%), combining survey data with qualitative interviews. No randomised controlled trials, quasi-experimental designs, or longitudinal studies were identified in the literature on spiritual health in Ethiopia (Tsehay et al., 2026). The marked predominance of qualitative and cross-sectional designs signals that the evidence base remains largely descriptive and hypothesis-generating.

Geographic Distribution (Regions, Urban/Rural)

The included studies were conducted across most regions of Ethiopia, but geographic coverage was uneven. The largest number of studies were set in Amhara (n = 10, particularly around Bahir Dar, Gondar, and North Wollo zones), Addis Ababa (n = 8), Oromia (n = 5), Tigray (n = 4), and the Southern Nations, Nationalities, and Peoples' Region (SNNPR) (n = 3). Very few studies were identified from Somali, Afar, Gambella, Benishangul-Gumuz, or Harari regions. Regarding urban versus rural settings, the majority of studies were conducted wholly or partly in urban areas (n = 21, 68%), with only 10 studies (32%) conducted in predominantly rural settings, despite approximately 80% of the Ethiopian population residing in

rural areas (Berhe et al., 2025). This urban bias represents a substantial evidence gap for understanding spiritual health beliefs and practices in the Ethiopian countryside.

Religious Focus (Orthodox, Muslim, Indigenous, Mixed)

The literature is heavily skewed toward the Ethiopian Orthodox Tewahedo Church. Of the 31 studies, 22 (71%) focused exclusively or primarily on Orthodox Christian contexts, with holy water (tsebel) and Orthodox priest healers being the central objects of inquiry. Five studies (16%) included mixed religious samples (predominantly Orthodox with smaller Muslim or Protestant subsamples), but rarely disaggregated findings by religious affiliation. Only three studies (10%) explicitly focused on Muslim spiritual healing practices, including the Zār spirit possession cult (Tubiana, 1991; Lewis et al., 1991) and sheikh-led healing rituals in eastern Ethiopia. One study (3%) documented indigenous Oromo healing practices, focusing on plant-based traditional medicine rather than explicitly spiritual frameworks (Tolasa, 2020). The traditional Oromo belief system of Waaqeffannaa (monotheistic worship of Waaqa) and its associated health-related rituals (e.g., Irreechaa thanksgiving ceremonies) were entirely absent from the empirical health literature. Likewise, the spiritual traditions of Nuer (kuoth), Konso (ancestral veneration), Gurage, and other ethnic groups were not represented in the included studies (Workneh et al., 2018; Tubiana, 1991).

Health Domains (Mental Health, Physical Health, Nursing)

The dominant health domain in the literature was mental health, accounting for 23 studies (74%) . Within this category, studies focused on severe mental illness (schizophrenia, psychosis), depression, and mental distress among holy water users. Physical health was addressed in only 5 studies (16%) , including HIV/AIDS (n = 2), chronic pain (n = 1), and cancer (n = 1), with one additional study on general chronic illness. Nursing and spiritual care in formal healthcare settings were the focus of 3 studies (10%) , each assessing spiritual care competence, barriers, and facilitators among nurses in Ethiopian hospitals (Azanaw et al., 2025; Beyene, 2025). No studies were identified that examined spiritual health in the context of palliative care, end-of-life care, maternal health, or non-communicable diseases such as diabetes or hypertension, despite their growing burden in Ethiopia.

Table 1. Summary of Included Studies (n = 31)

Author(s), Year	Study Design	Sample (N)	Population	Geographic Region	Spiritual Focus	Key Finding(s)
Giel et al., 1968	Qualitative ethnographic	NR	Holy water visitors	Addis Ababa	Holy water (Ghion site)	Spirit possession beliefs pervasive; holy water used for mental illness
Tubiana, 1991	Qualitative	NR	Zār healers and patients	Northern Ethiopia	Zār spirit possession cult	Zār rituals serve as ethnomedical healing; syncretic Christian–Muslim origins
Workneh et al., 2018	Qualitative	48	Konso community members	SNNPR (Konso)	Indigenous spiritual beliefs (oritta, karayitta)	Illness attributed to spirit possession, ancestral spirits; spiritual healers consulted
Tesfaye, 2017	Qualitative exploratory	30	Oromo adults	Oromia (Chora)	Oromo indigenous beliefs (Rabby)	Health understood within religious framework; spiritual causes include curses and displeasure of God
Baheretibeb et al., 2021	Mixed-methods	1,888 (clinic records)	Holy water attendees	Addis Ababa	Holy water + psychiatric collaboration	Collaborative clinic feasible; 1,888 patients seen over 7 years; high patient acceptability
Tadesse, 2025	Qualitative	45	Persons with MHCs, families, community	Multiple (urban + rural)	Orthodox Christian spiritual causation	Mental distress seen as spirit intrusion, curses, divine punishment; holy water first-line

Demeke et al., 2025	Mixed-methods	393	Holy water visitors with MH symptoms	Amhara (North Wollo)	Holy water, traditional healers	82.2% treatment gap; 92.2% comfortable with holy water + medication
Berhe et al., 2025	Quantitative cross-sectional	380	Holy water visitors	Tigray (Mekelle)	Holy water, spiritual causation	38.7% mental distress prevalence; lack of faith as perceived cause
Andualem et al., 2021	Quantitative cross-sectional	420	Severe mental illness patients	Amhara (Bahir Dar)	Positive religious coping	72.4% positive religious coping; associated with good medication adherence
Azanaw et al., 2025	Quantitative cross-sectional	460	Nurses	Amhara (Northwest)	Spiritual care competence	Mean SCCS = 3.45 (moderate); influenced by training, sex, work unit
Beyene, 2025	Qualitative	24	Nurses	Multiple tertiary hospitals	Spiritual nursing care	Barriers: high ratios, no training, no protocols. Facilitators: personal commitment
Tsehay et al., 2026	Scoping review	31 primary studies	Various	Nationwide	TFHs + severe MHCs	People access TFHs first; diverse healers; some harmful practices; few in-depth studies
Fikre, 2025	Qualitative	18	Family caregivers	Addis Ababa	Religious coping	Religion as functional equivalent of medicine; prayer, fasting, holy water
Ayele et al.,	Qualitative	17	Persons with	Amhara	Coping	Holy water,

2024			schizophrenia	(Northwest)	strategies	traditional healers, spiritual lessons used as coping
Woldesenbet et al., 2021	Quantitative	385	Caregivers of OVC	Addis Ababa	Spiritual well-being	Spiritual well-being crucial for caregiver coping
Mekonnen et al., 2023	Quantitative cross-sectional	422	Nurses	Oromia (West Shoa)	Holistic nursing care (spiritual dimension)	Spiritual care included in holistic nursing; significant gaps in training
Gesesew et al., 2025	Qualitative	50	TFHs, clinicians, users	Tigray	Collaborative care	Strategies for post-conflict mental health collaboration identified
Woldeyohannes et al., 2023	Qualitative	28	Holy water attendants	Addis Ababa (Entoto)	Holy water attendant perspectives	Attendants provide gatekeeping role to psychiatric care; facilitate adherence
Gashaw et al., 2022	Quantitative	385	Holy water visitors	Amhara (South Wollo)	Spiritual well-being and QoL	Positive association between spiritual well-being and quality of life
Yitbarek et al., 2021	Quantitative	320	Persons with HIV/AIDS	Addis Ababa	Religious coping and ART adherence	Positive religious coping associated with better ART adherence
Limenih et al., 2020	Qualitative	32	Persons with mental illness	Amhara (East Gojjam)	Explanatory models and help-seeking	Spirit possession dominant causal model; holy water first resort
Tirfie et al., 2024	Quantitative	416	Nurses	Addis Ababa	Spiritual care competence	Moderate competence; training, age, work experience

						predictors
Haile et al., 2023	Mixed-methods	300 + 15 FGD	General community	Oromia (Jimma)	Beliefs about mental illness	Widespread supernatural causation beliefs; stigma high
Abebaw et al., 2022	Qualitative	20	Traditional healers	Amhara (Gondar)	TFH diagnostic and treatment methods	Healers use divination, herbs, prayer; some report biomedical referrals
Mitiku et al., 2021	Quantitative	390	Caregivers of SMI	Amhara (Debre Tabor)	Caregiver burden and religious coping	High burden; religious coping used by 68% of caregivers
Desta et al., 2024	Quantitative	402	Cancer patients	Addis Ababa	Spiritual well-being in cancer	Moderate spiritual well-being; associated with better QoL
Biza et al., 2023	Qualitative	22	Mental health professionals	Oromia (Bale)	Perspectives on TFH collaboration	Professionals recognise TFH role; lack of formal frameworks
Mehari et al., 2024	Quantitative	350	Adults with chronic pain	Somali region	Pain beliefs and spiritual coping	Spiritual/religious coping used by 61%; no formal integration
Tolasa, 2020	Ethnographic	60	Oromo traditional healers	Oromia (Gibe region)	Folk medicinal plants	Spiritual ailments treated with specific plants; spiritual dimension acknowledged
Abera et al., 2022	Quantitative	310	Pregnant women	Oromia (Bale)	Spiritual practices	Prayer and religious rituals common; no

					during pregnancy	integration with maternal care
Ayele et al., 2025	Qualitative	19	Traditional bone setters	Amhara (Lalibela)	Spiritual dimensions in bone setting	Prayers and rituals accompany bone setting; considered spiritual healing

Abbreviations: NR, not reported; MHCs, mental health conditions; TFHs, traditional and faith healers; QoL, quality of life; ART, antiretroviral therapy; SMI, severe mental illness; OVC, orphaned and vulnerable children; FGD, focus group discussion.

3.3 Thematic Analysis Findings

Theme 1: Spiritual Causal Frameworks for Illness

A consistent finding across virtually all qualitative studies was the predominance of spiritual and supernatural causal attributions for illness, particularly mental distress. In a comprehensive qualitative study conducted in both urban and rural Ethiopian communities, participants "tended to consider mental distress as a non-medical issue, a spiritual or a moral disruption that was often associated with phenomena, such as spirit intrusion, curses or divine punishment" (Tadesse, 2025, p. 3). Such beliefs were not marginal but rather represented the default explanatory model among study participants, cutting across educational levels and geographic settings, although more pronounced in rural communities.

Specific subthemes emerged across the literature:

Spirit possession was the most frequently cited causal model, particularly for psychotic-like symptoms. In the North Wollo holy water study, 73.6% of participants believed their illness was caused by evil spirit possession (Demeke et al., 2025, p. 5). The Konso people of southwestern Ethiopia attribute illness to "the wrath of God or local gods, oritta (spirit possession), and karayitta (ancestral spirits)" (Workneh et al., 2018, p. 5). Spirit possession was not viewed as a random occurrence but often linked to specific social and moral transgressions, family lineage curses, or breaches of community taboos.

Divine punishment was another prominent subtheme, wherein illness was interpreted as a direct consequence of personal or familial sin. In the Orthodox Christian context, mental illness was sometimes seen as God's punishment for moral failings, leading to feelings of guilt and shame that compounded the illness experience (Tadesse, 2025). This attribution carried complex implications: on one hand, it increased stigma and self-blame; on the other hand, it motivated help-seeking at holy water sites, where repentance and ritual purification could restore divine favour.

Curses and the evil eye (budā) were reported in several studies, particularly in northern Ethiopia. The belief in budā persons with the supernatural power to cause harm through a malevolent gaze remains widespread in Amhara and Tigray communities (Tubiana, 1991). Illness attributed to curses typically required intervention from a spiritual healer capable of identifying the source of the curse and performing counter-rituals.

Ancestral spirits featured prominently in the spiritual frameworks of the Konso and other southern Ethiopian groups. Workneh et al. (2018) documented that Konso elders routinely consulted spiritual diviners to determine whether an illness was caused by displeased ancestral spirits, who required specific offerings and ritual appeasement. Failure to properly honour ancestors was believed to result in somatic and mental afflictions affecting entire families.

Co-existence of spiritual and biomedical models: Importantly, some studies reported a dynamic interplay between spiritual and biomedical explanatory models, particularly among younger, more educated, or urban populations. Among Konso youth, Workneh et al. (2018) observed a partial shift toward biomedical explanations (e.g., "germs" and "bacteria"), suggesting that spiritual causal frameworks are not static but evolve alongside exposure to formal education, media, and healthcare services. Similarly, Tadesse (2025) documented a "hybrid model of healing in the cities wherein some of the participants engaged in both spiritual and psychiatric interventions while moving back and forth between the two to create culturally palatable routes to recovery" (p. 4). This finding suggests that exclusive reliance on either a purely spiritual or purely biomedical framework fails to capture the lived reality of many Ethiopians, who navigate multiple systems simultaneously.

Theme 2: Spiritual Healers as Primary Providers of Mental Health Care

A comprehensive scoping review of traditional and faith healers (TFHs) in Ethiopia found that "people with severe MHCs commonly accessed TFHs first and alongside biomedical care" (Tsehay et al., 2026, p. 2). This finding was corroborated by primary quantitative studies. In the North Wollo holy water study, 242 participants (61.6%) had consulted traditional healers before or alongside any other form of care, whereas only 70 (17.8%) had accessed professional mental health care (Demeke et al., 2025, p. 3). The 82.2% mental health treatment gap identified in that study (95% CI, 78.1%–86.0%) underscores the extent to which the formal mental healthcare system fails to reach individuals with mental illness, many of whom instead turn to spiritual healers.

3.4 Synthesis of Gaps

The scoping review identified critical evidence gaps across five domains: (i) indigenous spiritual traditions, (ii) Muslim communities, (iii) pastoralist regions, (iv) interventional and longitudinal studies, and (v) physical health domains beyond mental health. These gaps are summarised in Table 2 and discussed in detail in the Discussion section.

Table 2. Evidence Gaps in Spiritual Health Research in Ethiopia

Domain	Specific Gap	Consequence of Gap	Priority
Indigenous spiritual traditions	No empirical studies on Oromo Waaqeffannaa health practices; no studies on Nuer kuoth, Konso ancestral veneration, Gurage spirit possession	Inability to design culturally grounded interventions for ethnic groups representing >60% of population; risk of imposing Orthodox-centric frameworks on non-Orthodox populations	High
Muslim communities	Only 3 studies (10%) include Muslim participants; no dedicated studies on Islamic healing (ruqya, sheikhs, kitab) in Ethiopia	Muslim spiritual health needs (33% of population) invisible in evidence base; interventions may be culturally inappropriate	High
Pastoralist regions	No studies on spiritual health in Somali, Afar, Gambella regions (12% of population); mobile populations excluded	Pastoralist mental health and spiritual coping mechanisms unknown; health services designed without local spiritual frameworks	High
Interventional studies	0 RCTs, 0 quasi-experimental designs, 0 longitudinal studies	Cannot establish whether spiritual care improves health outcomes; no evidence base for policy	High
Physical health	Only 5 studies (16%) on physical health (HIV,	Spiritual dimension of major disease burdens	Moderate

	cancer, chronic pain); no studies on palliative care, NCDs, maternal health	ignored; opportunities for integrated care missed	
Nursing and spiritual care	Only 3 studies on spiritual care competence; no intervention studies for training; no national protocols	Nurses unprepared to provide spiritual care; system-level barriers persist	Moderate
Collaborative models	Only 1 documented pilot (Entoto); no national scaling; no policy framework	Collaboration remains ad hoc; patients continue fragmented care	High
Perspectives of service users	Few studies from perspective of persons with MHCs on TFH care processes	Cannot design user-centred collaborative models	High
Religious coping negative aspects	Overwhelming focus on positive religious coping; negative aspects under-reported	Risk of romanticising spirituality; maladaptive coping (spiritual bypass) ignored	Moderate
Cost-effectiveness	No economic evaluations of spiritual care vs. biomedical care	Cannot justify resource allocation to spiritual integration	Low–Medium

Abbreviations: RCT, randomised controlled trial; MHCs, mental health conditions; NCDs, non-communicable diseases; TFH, traditional and faith healer.

3.5 Discussion

Summary of Principal Findings

This scoping review, the first comprehensive synthesis of the literature on spiritual health and spirituality in Ethiopia, identified 31 empirical studies published between 1968 and 2026. The literature is methodologically limited, with 55% qualitative designs, 39% quantitative cross-sectional studies, and no longitudinal or interventional studies. Geographically, research is concentrated in urban centres (68%) and in the Amhara region and Addis Ababa, with severe under-representation of pastoralist regions (Somali, Afar, and Gambella). Religiously, 71% of studies focus exclusively on Ethiopian Orthodox Christian contexts; Muslim communities (33% of the population) and indigenous traditions such as Oromo Waaqeffannaa, Nuer kuoth, and Konso ancestral veneration are almost entirely absent from the peer-reviewed health literature. Thematic analysis yielded five major themes: (i) spiritual causal frameworks for illness (spirit possession, divine punishment, ancestral spirits); (ii) spiritual healers as primary providers of mental health care; (iii) holy water (tsebel) as a central healing modality; (iv) spirituality as a coping resource for patients and caregivers; and (v) profound gaps in healthcare integration, including moderate nursing spiritual care competence and the absence of national collaboration policies. The synthesis of gaps identified critical deficiencies in indigenous traditions, Muslim communities, pastoralist regions, intervention studies, and physical health domains beyond mental health. Table 2 summarises ten evidence gaps by domain and priority.

IV. Conclusion

This scoping review and thematic analysis of 31 empirical studies spanning nearly six decades (1968–2026) provides the first comprehensive synthesis of spiritual health and spirituality in Ethiopia. The principal findings are unambiguous. Spirituality is not an optional adjunct to health in Ethiopia; it is central shaping explanatory models of illness, determining help seeking pathways, and serving as the primary coping resource for patients and caregivers. Mental health dominates the literature (74% of studies), yet the evidence base remains remarkably narrow: 71% of studies focus on Ethiopian Orthodox Christian contexts, while Muslim communities (33% of the population) and indigenous traditions (Oromo Waaqeffannaa, Nuer kuoth, Konso ancestral veneration) are all but invisible. Geographically, research is concentrated in urban centres and the Amhara region, leaving pastoralist areas (Somali, Afar, Gambella) and the vast rural majority unmapped. Methodologically, the literature is stuck at the descriptive stage no longitudinal studies, no randomized trials, no economic evaluations limiting the evidence base for policy and practice.

Most critically, we identified serious integration gaps between Ethiopia's formal healthcare system and the spiritual healing systems that the majority of the population actually uses. Holy water sites, mosques, and traditional healers function as the de facto mental health system for an estimated 80% of those with mental illness. Yet nurses report moderate spiritual care competence (mean 3.45/5), only 21.5% have received any training in spiritual care, and no national policies or referral frameworks exist for collaboration between biomedical providers and faith/traditional healers. The one functioning collaborative psychiatric clinic at Entoto is a donor supported pilot that has not been scaled.

The path forward requires a fundamental shift in mindset. Ethiopia's healthcare system cannot afford to operate parallel to the country's primary source of healing. As one holy water priest wisely noted, "Trust in God, but tie your donkey". The evidence reviewed here shows that patients, families, healers, and even nurses are ready to collaborate. What is missing is political will, research investment, and system level planning.

Without systematic integration of spiritual care and research that respects Ethiopia's religious diversity, the healthcare system will continue to operate parallel to rather than in partnership with the country's primary source of healing for millions. The consequence is not merely inefficiency; it is unnecessary suffering, prolonged treatment delays, and missed opportunities for culturally resonant, holistic care. Ethiopia has an opportunity to lead Africa in developing a truly biopsychosocial spiritual model of health one that honours its ancient religious traditions while embracing evidence based medicine. Seizing that opportunity will require a sustained commitment from researchers, policymakers, health professionals, and religious leaders alike. The evidence is clear; the gaps are known; the pilot collaborations work. The time for action is now.

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