Chapter 3

Decolonising Health Communication Strategies: The Inclusion of Traditional Healers from Sub-Saharan Africa into Multi-Sectoral Health Crisis Communication Interventions

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Abstract

Traditional healers form one of the most influential voices amongst rural and increasingly urban populations in several sub-Saharan African countries. They offer great potential for effective multi-sectoral, health crisis communication interventions in sub-Saharan African countries. Yet they are often excluded by policymakers when health problems that affect their stakeholders are formulated. When crises escalate, however, it appears that they are invited to partner with policymakers in multi-sectoral interventions meant to find effective solutions. This belated inclusion of traditional healers by policymakers is unfortunate because effective multi-sectoral health interventions should involve all relevant stakeholders from the conceptualisation stage. Globally, most countries follow a biomedical paradigm of health practices also referred to as Western, mainstream or conventional medicine. It is inevitable then, that biomedical health practices have a dominant influence on the conceptualisation of health crisis communication strategies, while alternative approaches are marginalised, thus leading to the exclusion of divergent approaches. Theoretically, decolonisation of health crisis

communication strategies in sub-Saharan Africa would advocate for the involvement of traditional healers, given that traditional healers exert a strong influence on the well-being of their clients who often prioritise them in their health-seeking behaviour. Most African populations in sub-Saharan Africa make parallel use of traditional / alternative and Western medicine. Such health-seeking behaviour should inform reciprocal actions by policymakers to ensure equity of participation especially during health crises when reaching the largest possible percentage of the population is critical, through promotion of divergent approaches.

Introduction

Multi-sectoral health interventions have proved to be effective as health crisis communication strategies in Africa. Multi-sectoral approaches are integrated collaborative processes that involve various stakeholders to address complex challenges and interrelated goals that relate to public healthcare (Fox, 2014; WHO, 2016; Brinkerhoff et al., 2017; Lubinga & Sitto-Kaunda, 2024). Even then, these multi-sectoral health interventions have not always considered traditional healers (THs) as important or viable co-formulators of health communication strategies. Studies show that the use of traditional medicines are the main source of healthcare for mental illnesses in Uganda and that patients with AIDS (acquired immunodeficiency syndrome) symptoms in Malawi, South Africa, Uganda and Zimbabwe have used traditional medicine (Kasilo et al., 2019). In the past, during epidemics and pandemics, well-designed communication strategies have faced implementation obstacles, including failure, because policymakers were unable to secure the collaboration of the masses of people that health interventions are meant to benefit. But there is clear evidence that epidemics and other health problems in Africa, including human immunodeficiency virus (HIV) and AIDS, tuberculosis (TB), malaria, cholera, psychiatric conditions and other diseases, have greatly affected populations, especially in the poorer communities (Mokgobi, 2013).

Typically, what happens during crises is that health communication strategists turn to THs in order to engage the mostly rural masses as part of alternative health communication

only when strategies with other communicators have not been successful. The routine exclusion of THs in health communication in sub-Saharan Africa is a consequence of health authorities following a hegemonic biomedical paradigm. Given that the majority of people in sub-Saharan Africa frequently turn to THs – especially during crises – this approach should be rethought. Decolonisation can be achieved only if an African approach to doing things is strategically combined with existing biomedical practices. This paradigm should be considered by policymakers as part of a multi-sectoral crisis health communication strategy.

The lack of optimal buy-in into health communication strategies when crises arise, especially by rural populations in sub-Saharan Africa, may be caused by the failure of policymakers and implementers to include socio-cultural stakeholders as co-creators of these strategies. Socio-cultural stakeholders, specifically THs, have the potential to reach hitherto inaccessible audiences in Africa's mostly rural communities. As already pointed out, during times of epidemics and pandemics, many Africans use a combination of Western and traditional medicine, with the latter sought first.

Having established that policymakers should include THs to partner with during the formulation of health crisis communication strategies, the question that then arises is how they can be involved and how existing perceptions amongst policymakers can be changed. These problems may also be exacerbated by poor legislation in some sub-Saharan countries affecting when and how THs participate in health interventions.

Contextualising Traditional Healing and the Health-Seeking Behaviour of Sub-Saharan Africans

Many Africans in general, and sub-Saharan Africans in particular, habitually engage in health-seeking behaviour that involves the use of traditional medicine, with some routinely consulting with THs. For instance, in Ghana, it appears that up to 70% of patients use traditional or herbal medicines with some health facilities reportedly initiating the use of herbs as part of healthcare delivery (James et al., 2018). THs, who abound in both rural

and urban areas of sub-Saharan Africa, have provided health services over centuries, a clear indication of how effective their practice is to users. Even though traditional healing has for many years been most popular in rural areas, the migration of African populations from rural to (peri-) urban areas has ensured that the health-seeking behaviour is carried over to and sustained in new migration settings (Mokgobi, 2013). Furthermore, the recent proliferation of e-traditional healing propelled by popularisation through digital as well as social media has ensured a wider reach and sustainability amongst both urban and rural Africans. Africa remains a largely rural continent.

A 2020 report by the Organization for Economic Co-operation and Development (OECD), *Africa's Urbanization Dynamics 2020: Africapolis, Mapping a New Urban Geography* (OECD, 2020) indicates that Egypt and Libya in North Africa are the most urbanised countries in Africa, at 93% and 81%, respectively. On the other hand, there are over 20 sub-Saharan African countries with less than 40% urbanisation levels. In 2020, urbanisation in East Africa (Rwanda and Burundi), Southern Africa (Malawi) and West Africa (Niger) was below 20%, with Niger at 17%, Burundi at 21%, and Eritrea at 24%, representing some of the lowest levels of urbanisation in sub-Saharan Africa. Within the context of a mostly rural continent, to most sub-Saharan African citizens, socio-cultural relationships are crucial for informing and guiding behaviour, including health-seeking behaviour. In sub-Saharan African countries, 80% of the population purportedly rely on traditional medicine for their health needs (Renckens & Dorlo, 2013). Mushebenge et al. (2021) posit that THs, also termed as traditional health practitioners (THPs) are more accessible to the populace, with a significantly higher proportion of THPs (1:500 persons) than conventional medical practitioners (1:40,000 persons). Furthermore, the use of traditional medicine may involve in-person consultations, or more recently, the increasing phenomenon of virtual consultations with THs.

Therefore, THs are important stakeholders forming the socio-cultural fabric of African communities. And given that communication is an integral part of influencing health-

seeking behaviour, the people who communicate such messages matter, as they affect prevailing perceptions and cultural beliefs. Cultural-oriented health theories such as Pen 3 Cultural Theory by Airhihenbuwa (1989) have proved the importance of culture in influencing the behaviour of individuals.

Given that Africans routinely seek the help of THs, in some contexts they have proved to be successful communicators in multi-sectoral health interventions. For example, in Uganda, a study on the use of THs to influence HIV testing found that the delivery of point-of-care HIV tests by THs to adults of unknown serostatus significantly increased rates of HIV testing, with 100% of patients being tested in an intervention group (Sundararajan et al., 2021). The parallel health-seeking behaviour of sub-Saharan Africans involving both traditional and biomedical medicine proves that the former is trusted and considered to be as effective as the latter. In countries such as Cameroon, prevailing tropical diseases such as human African trypanosomiasis (sleeping sickness), Buruli ulcer, and snake bites have been investigated and managed by THs, with reports that in Central Africa, in general, more than 80% of the patients seen in hospitals first consulted a TH (Nolna et al., 2020). Similarly, Abbo (2011) reported that over 80% of patients with psychosis used both biomedical and traditional healing systems and that those who combined the two systems seemed to have a better outcome. This practice, which indicates high levels of trust in traditional medicine by African populations, is driven by word-of-mouth exchanges by users in interpersonal communication contexts between THs and their clients.

Health is a subjective construct

Perceptions, especially in health, remain subjective constructs which cut through segments of society illustrating differences in backgrounds and frames of reference. Health is also defined differently depending on whether it is defined by health professionals or patients. Therefore, by definition, the health concept rests on an individual perspective on health and illness (Souto et al., 2018). From a patient's point of view, health refers to the ability to live expressed in a state of health (Krabbe, 2016).

Perception is a process in which the individual organises the sensory stimuli into meaningful information (Hamlyn, 2019; Ross, 2010). According to Crown (2012), health perceptions encompass both physical and mental well-being and, for some, even spiritual attainment. Souto et al. (2018:2186) state that health perceptions are personal beliefs and assessments of the general state of health that show how people consider themselves to be well or not, and an individual's perceptions can reflect feelings and beliefs that extend beyond their current physical state. Such subjectivity extends to the decisions that people make, regarding whether to use services of THs or not.

In Africa, traditional healing exists in parallel with biomedicine and continues to play an important role in primary healthcare for many Africans. While traditional healing exists as an accepted form of healthcare in Africa and other parts of the world, it varies greatly across different countries and regions because they are influenced by factors such as culture, personal attitudes and patient health information (Zhandire et al., 2021). Gyasi et al. (2011) argue that although traditional healing appears to be embedded in the personal preferences, values, religion and philosophies of people, its development should not end up in political polemics; rather, real, concrete and interactive action should follow the recognition of the contribution of traditional healing to the healthcare of people. Given the sheer variety of personal values and religion as well as the philosophies of people, perceptions on traditional healing as a practice and THs as practitioners will most likely differ.

Mixed Perceptions Towards Health in Diverse Sub-Saharan Contexts

Trust and authenticity in Sierra Leone

The health-seeking behaviour of sub-Saharan Africans involving consultation with THs is greatly informed by their beliefs as well as their experiences. These populations have relied on centuries of interpersonal interactions with THs and often compare

communication between biomedical health personnel with experiences with those of THs.

For instance, during the 2014 to 2016 Ebola epidemic in Sierra Leone, people chose to consult with local THs whom they knew and trusted when the health crisis peaked, due to negative rumours about medical personnel (Dziewanski, 2015). Several Sierra Leoneans reported negative experiences about "rude or unhelpful medical staff in clinical settings that they found to be intimidating and unfamiliar" (Dziewanski, 2015).

Perceived commercialisation of health in the Democratic Republic of Congo (DRC)

In the Democratic Republic of Congo (DRC) the local people believed that the spread of Ebola was driven by commercial benefit, specifically that it was a result of business actions during the DRC's tenth Ebola outbreak in Kivu (MSF, 2020). This led to attacks on health centres, threats and murder of healthcare workers (Muzembo et al., 2020). Their study revealed several negative perceptions by local people about the spread of the disease, including the fact that Ebola was interpreted as a plot by multinational corporations. Local people believed and feared that it was created as a tool for genocide; it was perceived to be a biological weapon. People expressed concerns over organ trafficking during the Ebola epidemic. In addition, Ebola was rumoured by people to be subject to politicisation. Political leaders were perceived by populations to be ambivalent, especially through the exclusion of some community leaders from response efforts. These actions by political leaders led to distrust of political authorities by the public as well as distrust in the healthcare system (Muzembo et al., 2020).

Mistrust and othering in South Africa and Ghana

It can be argued that general perceptions of health and what is considered a legitimate health provider are represented by an integration of various definitions of health by different stakeholders in society and these health definitions and perceptions have a bearing on health behaviours. Studies by

Goodwin and Engstrom (2002) and Zahrt and Crum (2017) in the United States (US) found that health perceptions are an important indicator of health outcomes. In this case the perception of traditional medicine and THs will also depend on how it is defined by the stakeholders in society, including patients who sometimes consult THs. In South Africa, De Andrade (2011) reported that there appears to be a perception that THs are more attuned to people's needs and that "they fit the psychology of our people". For their part, Van Niekerk et al. (2014) found mutual mistrust between allopathic and THs. On the other hand, in Ghana, Gyasi et al. (2011) perceived traditional medicine as readily available to the people and less expensive, hence easily accessible. Hlobano (2013) revealed that in South Africa, THs experienced mistrust and disrespect by biomedical health professionals, who demonstrated ignorance towards traditional medicine. Gyasi et al. (2011) propose policy options that seek to address some of the difficulties and challenges encountered by the practice of traditional medicine and improve the quality, safety, and standard of service.

Furthermore, Nkosi and Sibiya (2018) found that in South Africa, THs referred patients to the hospital, but radiation oncologists did not reciprocate (there was no referral from the radiation oncologists). They reported that both parties value cooperative practice but were still wrestling with THs' own locally developed practices of traditional medicine use. In addition, in Ghana, Nyame et al. (2021) reported that underlying the widespread approval of forging partnerships, there were mutual undertones of suspicion. While primary healthcare providers were mainly concerned that THs cause harm to service users, service users and their caregivers highlighted the failure of conventional medical care to meet their healthcare needs.

Theory

A number of theories could underpin the argument for the inclusion of THs in the conceptualisation of health crisis communication strategies. This chapter proposes decoloniality, Africanisation and culture-centred approaches (Dutta-Bergman, 2004; Dutta 2007).

Decoloniality as a theory is described as a family of diverse positions that share a view of coloniality as the fundamental problem in the modern age and not as a singular theoretical school of thought (Maldonado Torres, 2011). A number of Global South scholars argue that the core argument of decoloniality is premised on the agenda of shifting the geography and biography of knowledge – who generates knowledge and from where (Mignolo, 2007; Escobar, 2004; Maldonado Torres, 2011; Moyo, 2024). These authors from the Global South argue for the promotion of knowledge and views from their perspectives as opposed to those of the Global North / Western societies.

Decoloniality thus aims to disrupt Westernisation to open multiple other forms of being in the world (Letsekha, 2022). According to Letsekha (2022), constructing a new path of "thinking, sensing, believing, doing, and living", involves the fact that this new path "... cannot be built with the master's tools for the master's tools will never dismantle the master's house. They may allow us temporarily to beat him at his own game, but they will never enable us to bring about genuine change".

From an African point of view, Ndlovu-Gatsheni (2015) revealed that decoloniality is borne out of a realisation that the modern world is an asymmetrical world order that is sustained not only by colonial matrices of power but also by pedagogies and epistemologies of equilibrium that continue to produce alienated Africans who are socialised into hating the Africa that produced them and liking the Europe and America that reject them.

As it applies to African traditional medicine, Ndlovu-Gatsheni's argument (2015) can be seen to criticise the notion of undermining and separating African traditional medicine from Western medicine. This practice indirectly continues to promote 'white supremacy' in the design of health communication strategies. Issues of 'whiteness', 'racism' and 'white privilege' are components of 'white supremacy' and are associated with the political power during the colonial and apartheid regimes (Mashau, 2018). Mashau (2018) refers to societal marginalisation as well as the exclusion of African solutions to African health problems by policymakers who suppress indigenous health

knowledge. Furthermore, indigenous health knowledge is often measured against biomedical knowledge, with the latter being favoured in the design of health communication strategies.

The continual use of biomedical specialists or experts as predominant sources of health solutions and as providers for health knowledge and concrete information for the design of health communication strategies in Africa speaks to the marginalisation of indigenous health knowledge. Westernised systems such as biomedical paradigms are viewed as being colonial by decoloniality theorists with their prevailing societal hegemony perceived as continuing to erode the indigenous African cultures and wisdom systems. Decolonisation is primarily a knowledge project grounded in African philosophy, which is generally tied to indigeneity, which in principle is the idea that knowledge construction and pursuit must be relevant to the context of the people (Manthalu & Waghid, 2019). On the other hand, Africanisation comprises a focus on indigenous African knowledge and concerns simultaneously 'legitimation' and 'protection from exploitation' of this knowledge (Horsthemke, 2004). Africanisation has become important to African people in their quest for unity and a sense of belonging, having pride in who they are and what they stand for. According to Louw (2010), Africanisation is the process of defining or interpreting African identity and culture; it is not a process of exclusion, but rather of inclusion. It is a learning process and a way of life for Africans. It involves incorporating, adapting, and integrating other cultures into and through African visions to provide the dynamism, evolution, and flexibility so essential in the global village.

It can be argued that Africanisation refers to conscious and deliberate decisions by policymakers to include traditional / indigenous knowledge in health communication strategies, to ensure the inclusion of indigenous health knowledge in key decision-making bodies. Africanisation in the context of decoloniality may mean embracing African knowledge and develop a sense of loyalty towards indigenous health knowledge through its adoption and promotion for health communication strategies, ensuring equity with Western solutions. In relation to this argument, during the Coronavirus disease 2019 (COVID-19)

pandemic, South African National Co-ordinator of the Traditional Healers Organisation, Gogo Maseko (IOL, 2020) argued that society shuns traditional medicine, with "the worst culprits being medical schools, media houses and religious institutions, that have been colonised for far too long, and look down on every traditional or indigenous cultural practice that might empower Africa's people."

For users of both biomedical and traditional medicine, the interaction between these two worldviews is complex and results in cognitive conflict. Yet, Africanisation as a legacy should enable a connection with broader African indigenous knowledge and the establishment of indigenous health solutions that bind Africans together (Louw, 2010). This should be done to confront the sense of 'Africanness', transcend the individual identity by seeking commonality, recognising and embracing African otherness. The inclusion of indigenous health knowledge for health solutions during the designing of health communication strategies is one way of understanding Africanisation as a move towards an understanding of African contexts and the socio-economic realities of the African people.

Considering the diversity of the African context, Africanisation implies concentrating efforts on obtaining new insights and developing new praxis on the contextual realities of the beneficiaries of services within a specific context (Van der Westhuizen & Greuel, 2017). Africanisation would require the development of health communication strategies that are African-related, reflecting indigenous health solutions. This does not mean that policymakers should focus solely on the development of new decolonised health communication strategies, but that they should effectively include African indigenous knowledge in the designing of health solutions. This move would involve multicultural and multi-sectoral health communication strategies that provide insight into and exhibit understanding of African contexts.

A culture-centred approach

Dutta's culture-centred approach examines the voices of marginalised groups and explores the interaction between culture and structure that create conditions of marginality (Dutta-Bergman, 2004a, 2004b; Dutta, 2007). This theory argues for the inclusion of subaltern classes that have traditionally been marginalised and are absent in dominant theories and models (Dutta, 2011). Most of the behavioural change theories that have predominantly informed health communication, such as the health belief model, theories of planned behaviour, and the theory of reasoned action, have neglected the importance and influence of culture as well as representatives of indigenous health knowledge such as THs. Dutta posits that the culture-centred approach necessitates working from within, where cultural members actively participate in defining problems and developing solutions (Dutta, 2007, 2011). Culture is a communicative process by which shared meanings, beliefs, and practices are produced (Geertz, 1973) as well as a shared experience that is central to living and communicating for social groups.

THs also play an advocacy role. They not only communicate with their clients, but also communicate for and are advocates for their clients. For instance, during the COVID-19 pandemic in several sub-Saharan African countries, societal members who consult with THs were disadvantaged when they could not gain access to their practitioners. Specifically in South Africa, during hard lockdown, which resulted in the restriction of movement, groups of workers including biomedical doctors were designated as essential service providers and were allowed to work. THs were excluded from being provided with special travel permits even though the Traditional Health Practitioners Act number 22 of 2014, hereafter referred to as the Traditional Health Practitioners Act (South Africa, 2007), allows THs registered with the Traditional Health Practitioners Council of South Africa to issue valid medical certificates as recognised professionals to patients seeking treatment based on traditional beliefs (Nzimande et al., 2021; Tshehla, 2015). During the COVID-19 pandemic, traditional healers pleaded with the government to be allowed to support the fight against COVID-19 (Beyers, 2020) because they

were not consulted by the Department of Health, even THs are officially considered as part of the government system to provide healthcare. The president of the Traditional Healer Association in the Southern Africa Development Community (SADC) region, Dr Sylvester Hlati, complained that THs and patients were left out of South African national pandemic preparations. THs were unable to collect traditional medicines and herbs from various parts of the country but also to consult with their patients (Mukwevho, 2020). THs had to protest against their exclusion from the COVID-19 consultation process before they were brought on board (Bhengu, 2020).

Discussion

Factors changing the Practice of Traditional Healing for interpersonal communication in sub-Saharan Africa contexts

The growth of e-traditional healing: Ease of Access and Sustainability of practice

The proliferation of digital and social media technologies as well as ease of access to related communication platforms have transformed the public sphere. Such technological growth has created new ways of doing things, enabling people to be within "click" reach of others. Interpersonal communication contexts involving traditional healing have not escaped the effects of digital technologies. Whereas in the past, traditional healing was limited to in-person interpersonal communication, digital technologies have facilitated virtual interactions. Traditional healing involving the use of digital technologies, virtual or e-traditional healing emerged before the COVID-19 pandemic, but this period, characterised by hard lockdowns that limited in-person consultations, accelerated the practice. As GogoOnline (2022) posits, participation in an online session with a TH is how the digital world is changing the way they communicate, because many THs are connecting with patients online, arguing that spiritual connections have no boundaries. E-traditional healing may have opened up opportunities for traditional healing that

transcend the boundaries of access to potential patients previously imposed by physical or in-person interpersonal communication.

Multiple digital and social media technologies have provided a plethora of platforms for e-traditional healers as well as interested publics. Digital media such as websites reaching broad audiences and used as a means of creating awareness about various options for traditional healer locations as well as more interpersonal social media enabling one-on-one interactions are available for public use. A case in point is 'GogoOnline', a South African website created during the COVID-19 pandemic in 2020, where interested people are able to find traditional healers located near them. Some of the THs listed on the 'GogoOnline' Facebook page have Twitter as well as Instagram accounts where interaction with clients takes place. Schütz (2021) observes that 'GogoOnline' is a database for THs to advertise their services, launched during lockdown. 'GogoOnline' co-founder and healer-in-training, Xhanti Madolo, states that while the platform may have assisted healers with accessing permits, he believes that THs' success may have been curtailed not just by the lockdown regulations but by a historical lack of recognition. The 'GogoOnline' Facebook page features numerous THs available to the public for consultation and lists their fields of specialisation. Phaliso (2021) states that with the launch of the 'GogoOnline' directory, THs and their clients can now connect digitally wherever they are in South Africa. The directory lists THs' names, location, contact details and the services that they provide. However, rapid changes in digital and social media as well as the growth of artificial intelligence (AI) mean that e-traditional healing long superseded the mere provision of TH location, contact details and services. International consultations have been in existence for a long time.

Public perceptions of THs have often been misinformed, judgemental and backward (GogoOnline, 2022). Societal and individual cultural beliefs are intrinsically interwoven with traditional healing. Traditional healing is a topic that has been sensationalised and its practice is still perceived by some people, depending on their beliefs, as not being a reputable healing form in its own right. Chigona et al. (2008) reported that the use of technology to store and share patient and treatment information

with other THs, healer associations and Western-oriented health providers, would require a major change in relationships between traditional healers and biomedical healthcare providers.

"Scientification" of Traditional Healing in sub-Saharan Africa: Marketing Communication for herbal remedies

Synergising traditional healing with biomedical healthcare could be fast-tracked by recent developments in relationships between the two groups. The recent COVID-19 pandemic illustrated that traditional medicines that have over the years been considered ineffective due to a lack of scientific evidence, could prove to be effective in treatment of diseases with the commencement of clinical studies. In diverse sub-Saharan African countries, scientific trials of traditional herbal medicines commenced during the pandemic (Mutombo et al., 2023). For instance, clinical trials of herbal medicines as supplementary in the treatment of COVID-19 were either completed or were ongoing in Burkina Faso, the Democratic Republic of Congo (DRC), Ghana, Guinea, Madagascar, Nigeria (which has the only privately funded study), South Africa, United Republic of Tanzania, Uganda while Nigeria had the only privately funded study. Furthermore, clinical observational studies were conducted in Benin, Burkina Faso, Congo and DRC. In countries such as DRC, Guinea, Madagascar and Uganda, some of the traditional medicine products received marketing authorisation. Popular herbal products were sanctioned by some African governments, including high-ranking officials such as the President of Madagascar, Andry Rajoelina, for COVID-organics with *artemisia* from Madagascar (Shaban, 2020) and Uganda's National Drug Authority endorsed a herbal medicine, *Covidex* (Athumani, 2021).

Figure 1: Covidex. Source: UBC (2021)

In other sub-Saharan African countries, acknowledgement of herbal remedies as supplementary alternatives to biomedical treatments took place at lower levels. For instance, in the DRC biochemists advised people to take *maniguette* or *mondongo* and vegetables including ginger, garlic and onions in addition to respecting protective measures, even while many people bought *Kongo-bololo* as herbal treatment (Nsono, 2020). The move towards scientific recognition of traditional medicines will inevitably be partially driven through communication, as

was the case with government support and marketing of herbal products during the recent COVID-19 pandemic.

The future of Traditional Healing in Sub-Saharan Africa

Possible benefits of integrating traditional healing in multi-sectoral health interventions

Opportunities exist to integrate THs into the pyramid of care by, for example, providing them with suitable technology to contribute to adequate patient management and transfer to other healthcare services when appropriate. It is possible to go further. With the advance of telemedicine, especially during the COVID-19 pandemic, THs could be trained and equipped with smartphones and other technology that will help them to contribute to the surveillance of epidemics and pandemics. Their integration into the formal healthcare system will both facilitate overall care provision as well as increase quality control of TH activities, as should be done with any health professional. Such regulation will limit the malpractice that is seen in many African countries, where traditionally prescribed drugs are not controlled.

Without the integration of traditional and Western medicine, patients might languish in either of the medical systems, leading to delays in care and, in some cases, death. Devising efficient schemes to collaborate with THs will make them assets in providing healthcare in our communities, instead of the liabilities they might, in some cases, be. For example, the OECD (2021) stated that a multi-sectoral, integrated approach to mental health means making mental health a priority in sectors beyond the mental health system. Good performance in mental health is not only the responsibility of mental health specialists, but rather must include a wide range of actors and sectors, including teachers and schools, line managers and workplaces, as well as other community actors. Similarly, Green and Colucci (2020) found that despite differing conceptualisations of mental illness causation, both THs and biomedical practitioners recognise that patients can benefit from a combination of both practices

and demonstrate a clear willingness to work together. It can be argued that the multisectoral approach insists on ensuring that an integrated perspective is included within the mental health system. In relation to this study, it can be argued that more could still be done to strengthen the multisectoral health interventions designed for African communities. Hence, the focus in this area of development is critical in Africa, where health problems weigh more heavily on communities with lower economic status, unemployment and so on, where an integrated health system is needed.

Mokgobi (2013) reported that the delay in integrating the two healthcare systems means that people continue to enlist the services of both modern healers and THs without realising how potentially dangerous it could be. This is especially if the two sides do not communicate about the remedies that they inadvertently and simultaneously administer for the same illness. With this in mind, the study argues that the integration of these two practices in mostly sub-Saharan countries is no longer a luxury but a necessity. De Leeuw (2017) clarified that the conceptual foundations for integral health governance, policy, and action delineates the different sectors and their possible engagement and provides an overview of a continuum of methods of engagement with other sectors to secure integration. Although there is an understanding of the necessity of both types of healing, providers may need to be pushed to reach this understanding by the institutionalisation of traditional healing by the government (Hardy, 2008).

On the other hand, the WHO (2018) revealed that many of the determinants of health and well-being – commercial, cultural, economic, environmental, political, and social – are influenced by policies beyond the health sector. Therefore, the WHO (2018) further argues that multisectoral and intersectoral action is required for effective health promotion at the local, national, regional, and global levels. This chapter argues that a multisectoral approach to health interventions may see the involvement of all health sector stakeholders, including THs. This multisectoral approach has the potential to reduce health inequalities and improve the health well-being of disadvantaged

communities. Moreover, this may tackle the inequitable distribution of power in terms of whose insights and voices carry more weight when health interventions are developed. This study further understands that achieving a balance of power by incorporating a wide range of insights and voices in health interventions development is a shared responsibility and requires the involvement of all health sector stakeholders, including THs.

Conclusion

The health-seeking behaviour of most sub-Saharan Africans points towards the potential of THs to form one of the crucial communication pillars in health crisis communication. The recent COVID-19 pandemic forced sub-Saharan African countries to begin scientific testing of traditional medicines increasing the potential of use and acceptability by the government and public. Furthermore, tools such as e-traditional healing have enhanced and increased the means of contact between THs and their clients, escalating the potential for effective communication. We argue that THs play an important role in interpersonal health communication and migrated health practices in sub-Saharan Africa. Their current 'missing voices' in the formulation of future health crisis communication strategies should be remedied through inclusion by policymakers in multisectoral interventions. Therefore, THs could become an important part of multisectoral health interventions during future health crises.

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