

COMMENTARY

Integrating traditional healers into the emergency care continuum in Uganda: a missed opportunity?

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ABSTRACT

Traditional healing systems remain central to healthcare delivery in many low- and middle-income countries, including Uganda, where they are deeply embedded within community health-seeking practices. At the same time, Uganda continues to face significant challenges in developing an effective and coordinated emergency care system, with delays in accessing timely care contributing to preventable morbidity and mortality. Traditional healers are frequently the first point of contact for patients, including those with acute and potentially life-threatening conditions. Despite their accessibility and influence, they remain largely excluded from formal emergency care planning. This paper explores the potential for integrating traditional healers into Uganda's emergency care continuum by repositioning them as Tier-1 emergency care actors within community-based response systems. We propose a structured, systems oriented model that emphasizes basic emergency training in danger-sign recognition, clearly defined referral pathways, bidirectional collaboration with biomedical providers, and integration within existing health system frameworks. The model highlights the importance of governance, certification, monitoring, and pilot implementation to ensure feasibility and accountability. However, integration carries important risks, including misdiagnosis, delayed referral, harmful practices, and regulatory challenges. To address these concerns, the proposed approach emphasizes a limited scope of practice focused on early recognition and referral, supported by safeguards such as standardized training, supervision, and policy oversight. This conceptual framework aims to inform future research, pilot programs, and policy discussions on strengthening emergency care systems in Uganda and similar settings. With careful implementation, integrating traditional healers into Tier-1 emergency care structures may reduce delays, improve referral systems, and enhance patient outcomes.

African relevance

- Emergency care systems in many African countries remain fragmented, with significant prehospital delays and limited formal EMS coverage.
- Traditional healers are often the first point of contact for acutely ill or injured patients in rural and peri-urban African communities.
- This paper proposes a structured Tier-1 emergency care integration model that formally links traditional healers to emergency medical services through training and referral pathways.
- The model is designed for low-resource African settings and aligns with ongoing efforts to strengthen emergency care systems across the continent.

- The framework may be adaptable to other African countries with similar pluralistic health systems.

Introduction

Cultural diversity shapes healthcare practices worldwide. In many low- and middle-income countries (LMICs), traditional healing systems coexist alongside biomedical services and remain deeply embedded within community life. In sub-Saharan Africa, traditional medicine continues to play a significant role in primary healthcare delivery [1]. Uganda faces persistent challenges in building a robust emergency care system. Delays in accessing timely emergency services contribute to preventable morbidity and mortality, particularly in rural and

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peri-urban settings. Community members often rely on informal providers and uncoordinated lay first responders who use locally available transportation to access care [2]. Despite recent policy efforts to strengthen emergency medical services (EMS), access remains uneven and fragmented [3]. Traditional healers are frequently the first point of contact for patients, and in Uganda, traditional healers play a significant role in health-seeking behavior across a range of conditions. Studies have shown that patients frequently utilize traditional healers for initial care, particularly for chronic illnesses, mental health conditions, and culturally perceived diseases [4–6]. This widespread utilization highlights their influence within community-level healthcare and underscores their potential role in early stages of emergency care pathways. This paper examines the potential to integrate traditional healers into Uganda's developing emergency care continuum, reframing them not as competitors to biomedical systems but as potential Tier-1 emergency actors within community-based response structures.

Who are traditional healers?

Traditional healers are community-recognized practitioners who provide care based on indigenous knowledge systems, spiritual beliefs, and the use of plant, animal, and mineral-based remedies [7,8]. In Uganda, spiritual healers, herbalists, and bone-setters often undergo lengthy apprenticeship processes and are socially legitimized within their communities [8]. Contrary to common misconceptions, traditional healing in many Ugandan communities follows structured systems of training, spiritual initiation, and community certification. These practitioners often manage a wide range of conditions, including fractures, burns, epilepsy, and other acute presentations that overlap with emergency medicine. In Uganda, traditional healers have been shown to play a role in diagnosis, patient monitoring, and referral practices within community settings [8,9]. Their accessibility, affordability, and cultural alignment make them trusted providers, particularly in settings where formal services are geographically distant or perceived as culturally insensitive.

The role of traditional healers in Uganda's health landscape

In Uganda, many conditions commonly managed by traditional healers, such as trauma, infections, and obstetric emergencies, fall within the scope of emergency medicine. National assessments indicate that trauma and infectious conditions represent a significant burden of emergency presentations [3]. Despite lacking formal biomedical training, evidence from Uganda also demonstrates that traditional healers contribute to care pathways in mental health and other chronic conditions, often serving as initial points of consultation before referral to biomedical services [10,11]. These patterns suggest that traditional healers are already embedded within informal referral networks, although these remain unstructured and unregulated.

Challenges in emergency care access in Uganda

Uganda's emergency care infrastructure remains in development. A national cross-sectional survey found significant gaps in ambulance coverage, coordination systems, and trained personnel [3]. Police vehicles and informal transportation frequently serve as the primary means of casualty transfer. The WHO Emergency Care Systems Framework emphasizes the importance of community engagement and early recognition of danger signs in improving survival outcomes [12]. However, fragmentation between community-based actors and formal health systems contributes to delayed presentation and poor outcomes. The disconnect between biomedical services and culturally rooted healthcare practices may further delay care-seeking, particularly when communities perceive formal services as inaccessible or mistrustful of indigenous practices.

Risks of exclusion

Excluding traditional healers from emergency system planning creates a critical blind spot for formal healthcare systems and policymakers, as it overlooks a key point of initial care-seeking within communities. Patients often present late to hospitals after initial consultation with traditional practitioners, sometimes with advanced disease or complications. Without structured referral mechanisms, healers may attempt to manage conditions beyond their capacity.

WHO guidance on prehospital trauma systems emphasizes the role of trained lay first responders in resource-limited settings [13]. Tier-1 emergency care refers to community-based, low-resource emergency response systems involving trained lay responders who provide early recognition, basic stabilization, and referral using locally available resources. These systems have demonstrated effectiveness in LMIC contexts [14]. Traditional healers, if appropriately trained in danger-sign recognition and referral protocols, could function within such Tier-1 frameworks.

Models of inclusion: A systems approach

Integration efforts should focus on pragmatic, culturally sensitive collaboration rather than replacement or medicalization of traditional practice.

1) Basic Emergency Training

Short, context-adapted training programs focusing on recognition of life-threatening conditions (e.g., severe bleeding, seizures, respiratory distress) and early referral could be developed. WHO's Basic Emergency Care course provides a scalable model for structured emergency training [12].

2) Referral Networks

Formalized referral pathways, such as mobile phone communication or coordination with community health workers, could bridge the gap between healers and facilities.

3) Trust-Building Forums

Structured dialogue between biomedical providers and traditional healers may reduce mistrust and align shared goals for patient survival.

4) Pilot Programs and Evaluation

Community-based pilot projects should assess feasibility, referral rates, timeliness of care, and patient outcomes, building local evidence before national scale-up.

5) Bidirectional Training and Cultural Competency

For integration efforts to be effective and sustainable, training should not be unidirectional. In addition to equipping traditional healers with basic emergency care skills, formal emergency care providers should also be oriented to traditional healing practices, cultural beliefs, and community health-seeking behaviors. This bidirectional approach can foster mutual respect, reduce mistrust, and improve communication between providers. By promoting cultural competency among biomedical practitioners, integrated systems may become more acceptable to communities and better aligned with existing care pathways.

6) Implementation and Governance Considerations

- o Effective integration of traditional healers into the emergency care continuum will require clear governance structures and institutional oversight. The Ministry of Health should play a central role in developing policy frameworks, setting training standards, and ensuring alignment with national emergency care strategies. Certification processes may be necessary to formally recognize trained traditional healers who participate in referral networks, while maintaining clear boundaries of practice.

- o Monitoring and evaluation systems should be established to assess key indicators, including referral rates, timeliness of care, and patient outcomes. These systems would provide critical data to

inform scale-up and ensure accountability. Additionally, pilot programs implemented at the community level can serve as platforms to evaluate feasibility, acceptability, and safety before broader national adoption.

o Collaboration between traditional healer associations, health-care providers, and policymakers will be essential to ensure co-ownership, sustainability, and trust in the integration process. Such governance mechanisms can help translate conceptual models into safe, effective, and scalable health system interventions.

Similar community-based emergency response models have been implemented in several low- and middle-income countries, where trained lay responders contribute to prehospital care systems and improved access to timely care [14–16] (Fig. 1).

Potential risks and safeguards

While the integration of traditional healers into the emergency care continuum presents potential benefits, it also carries significant risks that must be carefully considered. Traditional healing practices may include interventions that are harmful or delay access to appropriate biomedical care. For example, inappropriate fracture management, delayed treatment of infections such as sepsis, and misinterpretation of clinical symptoms may result in worsened patient outcomes. Additionally, the risk of misdiagnosis or delayed referral remains a major concern, particularly in the absence of formal biomedical training. Without clearly defined boundaries, integration efforts could inadvertently legitimize unsafe practices or expand the scope of traditional healers beyond their capacity. Regulatory and medico-legal challenges also arise in defining responsibility, accountability, and standards of care within a shared system. Furthermore, resistance from biomedical practitioners may arise from concerns about patient safety, professional boundaries, and trust in traditional practices. To mitigate these risks, integration efforts should emphasize a **clearly defined and limited scope of practice** for traditional healers. Their role should focus on early recognition of danger signs, provision of basic first aid where appropriate, and prompt referral to formal healthcare facilities.

Expansion into definitive treatment of emergency conditions should be avoided.

Safeguards should include standardized training programs, certification processes, supervision mechanisms, and continuous monitoring and evaluation. Engagement with regulatory bodies and ministries of health will be essential to ensure accountability and alignment with national healthcare policies. These measures can help ensure that integration enhances, rather than compromises, patient safety and quality of care. Situations may arise in which traditional healers and biomedical providers disagree on the appropriate course of action. In such cases, clearly defined referral protocols, communication pathways, and an emphasis on patient safety should guide decision-making, with priority given to timely referral to formal healthcare facilities.

How this proposal differs from previous integration discussions

Previous discussions of traditional healer integration have largely focused on primary care, HIV services, mental health, or oncology referral pathways. Few have explicitly positioned traditional healers within the architecture of emergency care systems. This article reframes traditional healers as potential Tier-1 emergency actors within Uganda's developing EMS framework. By situating them within prehospital emergency response structures, specifically danger-sign recognition and structured referral networks, this proposal shifts the conversation from parallel coexistence to systems-level integration aligned with national emergency care strengthening efforts.

Ethical and cultural considerations

Integration must be respectful and collaborative. Traditional healers should be engaged as stakeholders rather than symbolic participants. Gender dynamics, cultural norms, and community leadership structures should guide implementation. Incentive structures—such as certification, public recognition, and inclusion in community emergency planning—may enhance participation and accountability.

Conceptual Model of Traditional Healer Integration into Uganda's Emergency Care Continuum

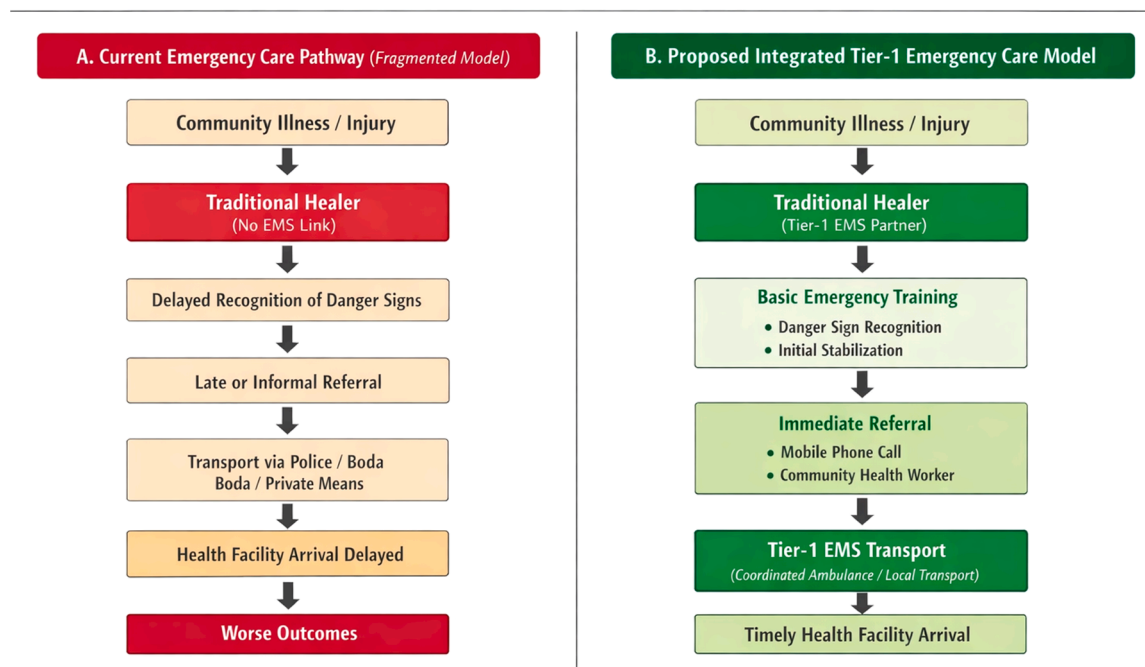


Fig. 1. Conceptual model of traditional healer integration into Uganda's emergency care continuum.

Limitations

This proposal is limited by the absence of Uganda-specific primary data quantifying the emergency caseload managed by traditional healers, referral patterns, and patient outcomes. While several studies have explored traditional healing practices and health-seeking behavior in Uganda, As such, this manuscript should be interpreted as a **conceptual and hypothesis-generating framework**, rather than an evidence-confirmed model. The proposed integration approach is intended to inform future research, pilot implementation studies, and policy discussions aimed at strengthening emergency care systems in Uganda and similar settings. The feasibility of standardized emergency training among traditional healers remains untested in Uganda. Resource constraints and system fragmentation pose additional challenges. Future research should focus on mapping healer caseloads, referral behaviors, and patient outcomes to inform evidence-based integration models.

Conclusion

Traditional healers are not adversaries of emergency medicine; they represent an underrecognized component of Uganda's care-seeking ecosystem. Strategic, culturally grounded integration within Tier-1 emergency frameworks could reduce delays, strengthen referral systems, and improve outcomes. With thoughtful implementation and rigorous evaluation, Uganda has an opportunity to leverage an existing community resource in strengthening its emergency care system.

Declaration of generative AI and AI-assisted technologies in the manuscript preparation process

During the preparation of this work, the authors used an AI-assisted language model (ChatGPT, OpenAI) to support language refinement, organization of responses to reviewers, and improvement of clarity. All content was critically reviewed, edited, and verified by the authors, who take full responsibility for the final manuscript.

Dissemination of results

The findings and conceptual framework proposed in this paper will be shared with emergency care stakeholders in Uganda, including clinicians, policymakers, and academic institutions. The model will be presented at local emergency medicine meetings and academic forums to encourage dialogue on strengthening prehospital care systems. Dissemination through open-access publication will ensure accessibility to other African countries facing similar health system challenges.

Declaration of competing interest

The authors declare no conflicts of interest. This work received no

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