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Epistemic justice and plural healing under South Africa's national health insurance: Qualitative perspectives from Limpopo on traditional medicine integration

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Abstract

This paper explores the integration of African Traditional Medicine (ATM) into South Africa's National Health Insurance (NHI) framework through the lens of indigenous epistemologies and spiritual ecology. Drawing on qualitative data from Limpopo Province, it examines how traditional practitioners conceptualise healing as a restoration of social harmony, ancestral balance and moral order. These ontologies challenge the dominance of biomedical rationality and call for a pluralistic health system that affirms African personhood and philosophical agency. The study argues that recognising ATM within national policy is not merely a technical reform but a transformative act of epistemic justice. It foregrounds the relational, spiritual, and ethical dimensions of care embedded in ATM, highlighting the need for culturally attuned integration models. By centering indigenous voices and cosmologies, the paper contributes to broader debates on decolonising health governance and constructing inclusive frameworks that honour Africa's diverse knowledge systems and healing traditions.

Keywords: African Traditional Medicine; Epistemic Justice; Spiritual Ecology; Indigenous Knowledge Systems; National Health Insurance; Decolonial Health Policy; South Africa

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1. Introduction

South Africa's healthcare system continues to reflect the deep structural inequalities inherited from its apartheid past. Between 1948 and 1994, the state forcibly relocated indigenous peoples into underdeveloped Bantustans and reserves, systematically denying them access to essential services, including healthcare (Chennells and du Toit, 2004). Although the democratic transition in 1994 marked a formal end to apartheid, its socio-economic legacy remains embedded in both rural and urban contexts. The General Household Survey continues to document unequal patterns of health and access to services and facilities across South African households (Statistics South Africa, 2021). These challenges are particularly acute in areas historically marginalised by apartheid planning, where travel costs, long distances and limited facilities continue to impede access to biomedical services. Amid these systemic constraints, ATM remains a vital component of South Africa's plural health system.

While ATM is often associated with rural communities, its presence is equally pronounced in urban centres, where spiritual insecurity and fragmented healthcare provision have given rise to diverse therapeutic practices (Ashforth, 2005). Urban middle-class populations increasingly turn to sangomas, inyangas, apostolic prophets, evangelical healers, and other spiritual practitioners to address health concerns that transcend the biomedical model. This widespread engagement with ATM reflects not only cultural continuity but also a search for holistic care that encompasses physical, emotional, and ancestral dimensions of wellbeing (Ngubane, 1977; Flint, 2008). ATM in South Africa is characterised by its diversity and adaptability. Healing practices vary across ethnic and provincial lines, drawing on IKS that have evolved over generations. Recent research in the Eastern Cape, for example, examined the antibacterial properties of Aloe ferox, Tetradenia riparia and Carpobrotus edulis, plants used in traditional responses to skin conditions (Tshali et al., 2025).

Traditional practitioners are often regarded not only as medical practitioners but also as custodians of cultural identity and spiritual authority. Their role extends beyond symptom management to include rituals, divination, and ancestral mediation, positioning them as central figures in community life (Mufamadi, 2023). Despite its widespread use, ATM remains excluded from South Africa's formal health policy frameworks. The NHI policy, signed into law in 2024, aims to provide universal healthcare coverage and address long-standing inequities in access and quality of care (Mkhwanazi, 2024). By pooling public and private resources, the NHI seeks to eliminate financial barriers and ensure that all South Africans can access essential health services (Mkhwanazi, 2024).

However, a closer reading of the NHI Act reveals that ATM is mentioned only in broad terms. The Act outlines principles of universality, equity and comprehensive service coverage, but it does not specify mechanisms for recognising, contracting or reimbursing traditional practitioners. It does not define how ATM might be incorporated into benefit-package decisions, referral pathways or provider accreditation structures (National Department of Health, 2024). This silence does not amount to explicit exclusion, but it does create a policy vacuum. It is within this vacuum that questions of legitimacy, recognition and integration arise, particularly in a society where plural medical practices are the norm.

Concerns around regulation, safety and scientific validation have often been cited as barriers to integration. However, these concerns must be weighed against the lived realities of communities who rely on ATM as a primary and culturally resonant form of care. The exclusion of ATM from national policy frameworks risks undermining efforts to build a health system that is responsive to the needs and values of South Africa's diverse population. This paper explores the role of ATM within South Africa's plural healthcare landscape and evaluates its potential integration into the NHI. Drawing on qualitative data from Limpopo Province, including interviews with traditional practitioners and community members, the paper examines how ATM is engaged across different settings and how its integration is perceived by stakeholders. While the data is drawn from a

rural context, the analysis is situated within a broader national framework that acknowledges the ubiquity of plural healing practices in both urban and rural areas.

The paper aims to contribute to ongoing debates on decolonising healthcare and constructing a health system that is both inclusive and contextually grounded. It argues that the integration of ATM into the NHI is not merely a matter of expanding access in underserved areas, but a critical step towards recognising the legitimacy of IKS and fostering a more equitable model of nation-building. Foregrounding community voices and cultural values, the paper proposes a phased and culturally attuned approach to integration. The approach must balance safety and accountability with respect for culture and diversity.

2. Literature review

The integration of ATM into South Africa's evolving healthcare system demands a nuanced understanding of its historical, institutional, and epistemological dimensions. The literature review examines the contested terrain of ATM, its plural expressions, and the implications for inclusion within the NHI system.

2.1. Tradition, contestation, and continuity of South African history

The history of ATM in South Africa is deeply intertwined with the country's broader socio-political evolution. ATM has long served as a central pillar of health, identity, and community life for many South Africans. Its resilience and adaptability across generations reflect not only cultural continuity but also a persistent negotiation with dominant biomedical paradigms. Ngubane's (1977) ethnographic study of Zulu medicine remains foundational in understanding how illness is conceptualised within indigenous frameworks. Her work illustrates that health is not merely a biological condition but a reflection of social harmony, spiritual alignment, and ancestral relationships. In this worldview, healing involves restoring balance across these domains, often through ritual, divination, and herbal remedies. Such approaches contrast sharply with Western biomedical models, which tend to isolate disease from its social and spiritual context.

Flint (2008) offers a historical lens on how colonial and apartheid administrations sought to suppress and commodify African healing practices. During these periods, ATM was often dismissed as superstition or folklore, while its pharmacological knowledge was selectively appropriate for scientific research and commercial use. This dual process of marginalisation and extraction contributed to the erasure of indigenous authority, even as ATM continued to thrive informally within communities. In the post-apartheid era, Xaba (2002) criticises the health sector's reform efforts for failing to meaningfully engage with indigenous epistemologies. Despite policy rhetoric around inclusivity, ATM remains peripheral to formal health planning and delivery. Xaba (2002) argues that this exclusion reflects deeper tensions around knowledge legitimacy, where biomedical science is portrayed as neutral and universal, while IKS are treated as culturally specific and therefore secondary.

ATM is not confined to rural areas or impoverished communities. Ashforth (2005) documents the prevalence of spiritual insecurity and plural healing practices in urban townships, where residents often navigate multiple healing options, including clinics, churches, and traditional practitioners to address complex health concerns. This pluralism is not simply a matter of access but reflects a broader search for meaning, moral clarity and holistic care in a rapidly changing society. These scholars reveal ATM as a dynamic and contested field of practice. It is shaped by historical injustices, cultural resilience, and ongoing struggles for recognition. Its persistence across class, ethnic and geographic boundaries suggests that ATM continues to meet needs that formal healthcare systems often overlook. ATM is not a monolithic or static tradition. It encompasses a wide range of practices, practitioners, and philosophies, each rooted in specific cultural contexts. Its marginalisation within policy frameworks is not merely a technical oversight but a reflection of deeper epistemic and political tensions. Recognising ATM's historical significance and contemporary relevance

is therefore essential to any effort aimed at building a more inclusive and legitimate healthcare system in South Africa.

2.2. Curricula, research, and policy engagement

The institutionalisation of ATM within South Africa's higher education and research landscape marks a significant epistemic shift. It challenges biomedical orthodoxy and reclaims IKS as a legitimate domain of intellectual study (Kgope, 2022). ATM has historically existed outside formal academic structures, but recent efforts to embed related knowledge within curricula and research agendas signal growing recognition of its epistemological and therapeutic value. Kgope (2022), for example, develops a model for articulating and promoting complementary, alternative and indigenous knowledge medicine and argues for redressing the marginalisation of related disciplines and communities.

At DUT, homoeopathy training combines curriculum and clinical learning through community health centres; Gwala (2020) reports that students viewed a satellite clinic as a valuable clinical learning environment. Such initiatives illustrate one institutional pathway for teaching complementary medicine, although they do not by themselves establish comprehensive ATM integration across universities. Research institutions have also started to engage more substantively with ATM. The South African Medical Research Council (MRC), in collaboration with Medunsa (now Sefako Makgatho Health Sciences University), has undertaken pharmacological studies into indigenous plants such as Sutherlandia frutescens and Hypoxis hemerocallidea (Mothibe and Sibanda, 2019).

The studies yielded promising insights into their anti-inflammatory and immunomodulatory properties (Mothibe and Sibanda, 2019). However, there is no progress when it comes to translating the laboratory findings into policy formulation. The disconnect shows the underlying tension between scientific validation protocols and the cultural legitimacy of orally transmitted healing knowledge. In addition, the juridical terrain surrounding ATM is contested. For example, the intellectual property debates spearheaded by the University of the Western Cape (UWC) and the University of Cape Town (UCT) researchers illuminated the shortfalls of patent law in recognising communal ownership and oral knowledge transmission (Peek, 2023). These critiques expose the ethical fault lines of bioprospecting and the commodification of indigenous healing. They raise urgent questions about consent, benefit-sharing and epistemic justice (Chennells and du Toit, 2004).

2.3. Healer associations and legitimacy

The question of legitimacy in ATM is political, epistemological, and ontological. The conundrum is premised on the struggle to reconcile ATM with the regulatory imperatives of the modern state. The Traditional Practitioners Organisation (TPO), the African National Healers Association (ANHA) and the Congress of Traditional Practitioners are the key associations in this contested space (Richter, 2003). They advocate formal recognition while simultaneously navigating internal fragmentation and competing claims to authority. These associations play a visible role in national policy dialogues. For example, they were involved in drafting the Traditional Health Practitioners Act 22 of 2007. However, uneven implementation of the Act reveals the complexities of translating pluralistic healing traditions into standardised legal frameworks. The Act has struggled to accommodate the diversity of healing practices and the fluidity of traditional authority structures (Waldron, 2010). Its bureaucratic logic often clashes with the relational, spiritual, and community-embedded nature of indigenous healing. This raises questions about the limits of state-led recognition.

Power dynamics also complicate the position of traditional healer associations. These associations are affected by disputes over certification, leadership and representational legitimacy (Devenish, 2005). The disputes reflect broader tensions around the standardisation of knowledge and the preservation of cultural sovereignty. For some traditional practitioners, regulation provides a pathway to professionalisation and

public credibility (Mullinder, 2023). For others, it may threaten to erode sacred dimensions of healing by reducing ancestral knowledge to technocratic procedure (Mullinder, 2023). These divergent perspectives underscore the epistemic dissonance between state institutions and indigenous cosmologies. The Traditional Health Practitioners Act defines categories and criteria for formal recognition, raising broader concerns about how state classification may interact with fluid, lineage-based forms of authority. More generally, Makanya (2014) calls attention to African theories of health and culturally grounded therapeutic knowledge. Extrapolating from these debates, regulation reflects the collision of cultural sovereignty and institutional rationality.

2.4. Spectrum of practices

ATM constitutes a dynamic and heterogeneous field of healing practices. It traverses botanical, spiritual, ritualistic, and reproductive domains. ATM is characterised by epistemic richness that defies reductive classification and challenges the homogenising tendencies of biomedical discourse. Makanya (2014) and Xaba (2002) explain the various ATM practices and methods of healing. These include diviners (amagqirha) who engage in ancestral communication through bones, dreams, and trance states (Makanya, 2014; Xaba, 2002). They operate within cosmologies that privilege relational and spiritual diagnostics. In contrast, herbalist (inyanga) specialise in phytotherapeutic knowledge (Makanya, 2014; Xaba, 2002). They use ethnobotanical repertoires to treat physical ailments. Traditional birth attendants (ababelethisi) provide maternal care rooted in indigenous understandings of reproduction, kinship, and embodied knowledge (Xaba, 2002).

In certain ritual contexts, practitioners engage with psychoactive substances such as *ubulawu* (sacred cleansing herbs or roots used to enhance dreams, intuition, and spiritual insight) and *Silene capensis* (African Dream Root) (Sobiecki, 2012). These substances are therapeutic and ontological. They are embedded within culturally specific frameworks of initiation, cleansing and spiritual transformation. Their use is deeply symbolic, facilitating altered states of consciousness that are integral to ancestral communication, identity formation, and healing (Sobiecki, 2012). However, when examined through biomedical lenses, they often provoke concern around dosage, safety, and regulatory oversight. Such analysis, while understandable within clinical paradigms, risks obscuring the cultural logic that governs their use. The substances are not administered arbitrarily. They are mediated by ritual specialists whose knowledge is rooted in lineage, cosmology and lived experience. They cannot be assessed solely through biomedical criteria, as this risks overlooking the foundations upon which their efficacy and meaning rest. Their practice is shaped by ethnic and geographical factors. For example, the *Basotho* practitioners often conduct healing rituals in mountainous areas, drawing on the spiritual significance of high-altitude landscapes as sacred spaces for ancestral connection (Skinner, 2022). In contrast, the *Xhosa* practitioners emphasise ancestral lineage, dream interpretation and the metaphysics of spiritual calling (Skinner, 2022). The diversity highlights the need for a culturally sensitive and contextually grounded approach to integration. The integration must resist the impulse to standardise or assimilate ATM into biomedical frameworks without regard for its ontological foundations.

2.5. Pluralism beyond ATM

The healing landscape in South Africa goes beyond ATM. It includes a variety of faith-based and culturally specific healing systems. Apostolic and evangelical churches offer spiritual healing through prayer, prophecy, and deliverance (Kgatle, 2023). They often attract urban populations who are seeking moral and existential clarity. Though less widespread, wiccan and neo-pagan practices reflect an interest in alternative spirituality among middle-class urbanites (Wallace, 2006). Similarly, Boererate, a set of Afrikaner folk remedies, continues to be used in rural farming communities (Blackbeard, 2023). They draw from generational knowledge of herbs, poultices, and home-based treatments. These systems coexist, overlap, and sometimes compete with ATM.

They create a pluralistic field of healing that defies binary distinctions between tradition and modernity. Integration into the NHI must therefore contend with this broader spectrum. It must ensure that policy frameworks are inclusive, contextually grounded, and responsive to diverse health beliefs.

3. Methodology

This study employed a qualitative design using semi-structured interviews and focus group discussions conducted across Vhembe, Mopani, and Capricorn districts in Limpopo Province between June and September 2023. Fieldwork took place in homes, healing spaces and community gathering points, enabling participants to speak within environments that reflected their everyday engagements with ATM. Participants were recruited purposively through community leaders and snowball referrals. Eligibility criteria required individuals to be over 18 years of age, resident in the district for at least five years and either practising ATM or actively using it. Of the thirty-two people approached, twenty-seven agreed to participate, with refusals primarily due to time constraints or discomfort with audio-recording.

The final sample comprised eighteen interviews and three focus groups. Interviews ranged from 45 to 90 minutes, while focus groups lasted between 60 and 90 minutes. Participants included diviners, herbalists, traditional midwives, ritual counsellors, and community members who regularly use ATM. One nurse and one clinical officer also participated. They were the only biomedical practitioners willing to take part, as others declined due to bureaucratic approval requirements or discomfort engaging in discussions about ATM. Although limited in number, their perspectives provided valuable insight into the institutional tensions and epistemic boundaries that shape interactions between ATM and biomedicine. Participants ranged in age from their early twenties to their seventies and included both men and women across the three districts.

As part of the fieldwork process, a biographical profile was developed for each participant, drawing on demographic background, lineage, training history, healing specialisation, religious affiliation, household role, and contextual details shared during interviews. These profiles formed an analytic tool used throughout interpretation. For example, understanding a healer's lineage or initiation pathway helped contextualise their explanations of spiritual causality, while knowing a participant's household caregiving role illuminated their accounts of reproductive or child-related practices.

Ethical approval for this study was obtained prior to data collection from the University of Venda Research Ethics Committee, under which all fieldwork was conducted. All participants provided informed consent after receiving clear explanations of the study's aims, procedures, and confidentiality measures. Pseudonyms and participant identifiers are used in the findings, and all audio files and transcripts were stored securely on encrypted devices accessible only to the research team.

Data were analysed thematically. The researcher engaged closely with the transcripts and fieldnotes, reading and listening repeatedly to identify recurring ideas, contrasts, and culturally grounded meanings. The biographical profiles were integrated into this process by anchoring participants' statements within their social, spiritual and generational trajectories. Themes were generated by examining patterns that appeared consistently across these contextualised accounts and were refined through discussion with two research assistants who had been present during data collection. The final themes reflect both shared and divergent experiences across the dataset and illuminate the epistemic, spiritual and relational dimensions of healing described in the study.

Data collection concluded once thematic saturation had been reached. At the point of the final interviews and the last focus group, no substantively new insights were emerging regarding spiritual causality, trust and lineage, or the perceived tensions and possibilities surrounding the integration of ATM into the NHI framework.

4. Analysis and discussion

4.1. Epistemic pluralism and spiritual causality

Across the interviews, twenty-two of the twenty-seven participants described illness as a phenomenon that extends beyond the physical body into the spiritual, relational, and moral domains. Health, in this worldview, is not merely the absence of disease but a state of equilibrium between the individual, the ancestral realm, the moral order and the broader social fabric. This ontological framing aligns with Ngubane's (1977) foundational work, which posits that in many African cosmologies, illness is often interpreted as a rupture in spiritual or social harmony rather than a purely biological malfunction.

Participants articulated this perspective through concrete narratives grounded in their everyday engagements with ATM. A young man from Giyani (P07, 28 years, community member) offered a vivid account:

> *"I had chest pains for weeks. The clinic gave me pills, but nothing changed. The healer said my ancestors were angry because I had not done the family ritual. After we slaughtered a goat and spoke to them, the pain stopped."*

His narrative reflects a pattern reported by nine participants, who described biomedical treatment as ineffective when the perceived cause of illness was spiritual or relational. For these participants, ritual acts, such as slaughtering, cleansing or speaking to ancestors, were not symbolic gestures but therapeutic interventions that restored relational balance and spiritual coherence.

This relational framing of illness was echoed in multiple accounts. A mother from Thohoyandou explained (P14, 36 years, regular ATM user):

> *"When a baby cries without stopping, we don't just say it's wind or colic. We check if the umbilical cord was buried properly. If not, the ancestors are restless."*

Her statement affirms Flint's (2008) argument that ATM is not simply a collection of remedies but a cosmological system that links bodily symptoms to ancestral obligations and metaphysical order. In this system, the body is not an isolated biological entity but a node in a web of spiritual and social relations.

Traditional healers articulated this logic with clarity. A healer in Polokwane (THP05, 52 years, bone-throwing specialist) elaborated on this point:

> *"Some sickness you can see, like a rash or swelling. But others are hidden. I throw bones to see what's troubling the spirit. Tablets can't fix that."*

Across all 11 healers in the sample, divination was described as a diagnostic modality that accesses dimensions of illness inaccessible to biomedical tools. Bones, dreams, and ancestral communication were framed as legitimate epistemic instruments rather than superstition. Participants expressed frustration with clinical encounters that failed to acknowledge these dimensions. A woman from Makhado (P19, 41 years, undergoing initiation training) recounted,

> *"I told the nurse I was dreaming of snakes and funerals. She said it's just stress. But I knew something was wrong. The healer said it was a calling."*

Her experience highlights the epistemic dissonance between biomedical protocols and indigenous understandings of causality. Dreams, in this context, are not dismissed as psychological noise but interpreted as messages from the ancestral realm, early warnings of spiritual imbalance or unfulfilled obligations.

This divergence in explanatory models raises critical questions about the assumptions underpinning integration efforts. The NHI framework, in its current form, tends to isolate disease from its social and metaphysical context, privileging biomedical knowledge as the default standard. Such an approach risks perpetuating what Fricker (2007) terms "epistemic injustice", the marginalisation of alternative ways of knowing through institutional silencing or dismissal.

A traditional healer from Ga-Sekgopo (THP03, 60 years, diviner) summarised this tension succinctly:

> *"Hospitals treat the body. We treat the spirit. If you only fix one, the person is not healed."*

His statement challenges the compartmentalisation of health into discrete domains and calls for a more holistic and pluralistic approach. Integration, if it is to be meaningful, must engage with the ontological foundations of ATM rather than merely incorporating its practices into a biomedical frame.

4.2. Trust, lineage, and therapeutic authority

Trust emerged as a central theme in participants' relationships with traditional practitioners, with 19 of the 27 participants emphasising that therapeutic authority in ATM is rooted not in formal accreditation but in lineage, continuity, and spiritual familiarity. This form of trust is genealogically anchored, cultivated across generations and embedded within communal memory. It stands in contrast to bureaucratic models of professionalisation that prioritise certification over relational legitimacy. A father from Mopani (P03, 49 years, long-term ATM user) described this intergenerational continuity:

> *"My grandfather used the same healer. My father too. We don't change healers like shoes. That trust is sacred."*

His account reflects a broader pattern in which trust is inherited rather than individually negotiated. This resonates with Makanya's (2014) criticism of state-led standardisation efforts which often fail to accommodate the fluid and lineage-based structures underpinning ATM. For many participants, such trust is not easily transferable. It is embedded within networks of shared history and spiritual familiarity and cannot be replicated through certification alone. A woman (P12, 38 years, community member) from Vhembe explained:

> *"Our healer knows our family. She knows our stories, our ancestors, our problems. That's why we trust her. A stranger with a certificate can't replace that."*

Her account challenges the assumption that licensing and formal training are sufficient to confer therapeutic legitimacy in contexts where authority is relationally constituted and spiritually anchored. For 11 participants, the healer's knowledge of family histories, ancestral dynamics and moral expectations was central to their sense of safety and trust. Traditional practitioners themselves described their roles with clarity, often distinguishing between different forms of expertise within ATM. A herbalist (THP08, 57 years, plant-medicine specialist) from Sekhukhune stated:

> *"I am called n'anga because I know the plants. I help with coughs, wounds, even infertility. But I don't do bones, that's for diviners. My knowledge comes from the forest and from my grandmother."*

His delineation between herbalism and divination underscores the internal diversity of ATM and supports the argument that integration must recognise its multiple epistemic registers. Attempts to homogenise ATM under a singular regulatory framework risk erasing the nuanced ways in which knowledge is acquired, transmitted, and validated within communities. Participants also emphasised the emotional and social labour performed by traditional practitioners. A counsellor from Capricorn District (THP11, 44 years, ritual and family-conflict specialist) described the breadth of her work:

> *"Many young women come to me with problems of abuse, poverty, or family fights. They don't want only medicine. They want someone to listen and to pray with them."*

Her role as both healer and confidante illustrates the relational dimensions of care embedded in ATM, challenging narrow definitions of healthcare that dominate policy discourse. For 14 participants, healers were described not merely as providers of remedies but as custodians of communal ethics and spiritual wellbeing. A young woman from Tzaneen (P21, 26 years, undergoing initiation) reflected on this moral dimension:

> *"Our healer doesn't just give medicine. She tells us how to live well, how to respect elders, how to keep peace in the home."*

Such accounts suggest that therapeutic authority in ATM is inseparable from moral and spiritual leadership. This complicates efforts to regulate traditional practitioners through clinical metrics alone and calls for a more expansive understanding of what constitutes legitimate care. In participants' accounts, healing is not simply a technical act, but a relational and ethical practice deeply embedded in the social and spiritual life of the community.

4.3. Gendered knowledge and reproductive care

Across the study, women described ATM as central to how they navigate maternal and reproductive health. Sixteen women described practices grounded in kinship, ritual and embodied knowledge that complemented, rather than replaced, biomedical care. These practices were not framed as alternatives to biomedical care, but as culturally embedded systems of support that attend to the spiritual, emotional, and relational dimensions of reproduction.

A traditional midwife (THP09, 63 years, ababelethisi lineage) from Mopani described her role with clarity:

> *"My gift is childbirth. I don't mix herbs. I only help women deliver safely when the clinic is far or the baby comes too fast."*

Her account aligns with Xaba's (2002) work on *ababelethisi* (traditional birth attendants or midwives), who are recognised not merely as birth attendants but as custodians of indigenous reproductive epistemologies. For four traditional midwives in the study, childbirth was understood as a spiritually guided practice shaped by intuition, ancestral instruction and intergenerational teaching, forms of expertise rarely acknowledged in formal health discourse. The significance of family support during pregnancy was emphasised by a grandmother from Nzhelele (P10, 67 years, caregiver, and ritual custodian):

> *"She came to stay with me. I watched her dreams, made sure she didn't eat certain things, and prayed with her. That is how we protect mother and child."*

Her narrative reflects a culturally embedded understanding of pregnancy as a spiritually vulnerable period requiring both ritual and family oversight. The monitoring of dreams, dietary taboos and prayer were described by nine participants as central to safeguarding maternal wellbeing. Such accounts point to the limitations of clinic-based models that often neglect the emotional and cultural dimensions of childbirth. Participants also described rituals for newborns that were perceived as essential to ensuring the child's vitality and spiritual integrity. A woman from Malamulele (P18, 33 years, mother of two) explained,

> *"After birth, we wash the baby in herbs. It's not just for smell. It gives strength and protects from bad spirits."*

For these participants, the herbal wash was not cosmetic but protective. It is a means of fortifying the child against unseen forces and ensuring a harmonious entry into the world. Seven women described similar rituals, underscoring the need for NHI integration strategies to accommodate culturally specific forms of care without reducing them to folklore or marginalising their epistemic value. Reproductive challenges were also addressed through ATM, often involving both herbal remedies and spiritual consultation. A participant from Giyani (P06, 31 years, seeking fertility support) said:

> *"I struggled to conceive. The healer gave me herbs and told me to speak to my grandmother's spirit. After that, I fell pregnant."*

Her account illustrates the layered causality within ATM, where infertility is not solely a biological issue but also a spiritual one. The intervention was dual, botanical, and ancestral. This duality reflects a broader logic in which reproductive health is situated within a moral and spiritual landscape, requiring attention to both the body and the spirit. A young woman from Bolobedu (P22, 24 years, recently bereaved) recounted her experience of pregnancy loss,

> *"When I lost my baby, the clinic said it was miscarriage. But the healer said it was a curse from someone jealous. We did a cleansing, and I felt peace."*

Her narrative reveals how ATM provides not only therapeutic interventions but also explanatory frameworks that help individuals make sense of suffering. The cleansing ritual was not merely a response to grief but a means of restoring spiritual balance and emotional clarity. For five participants, such rituals offered a parallel logic that addressed the existential and affective dimensions of reproductive health, dimensions that biomedical explanations alone could not fully resolve.

4.4. Syncretism and pragmatic pluralism

Across all three districts, 20 of the 27 participants described a pragmatic and contextually grounded approach to health-seeking, characterised by the blending of ATM with biomedical and faith-based modalities. This syncretic orientation was not perceived as contradictory or confused; rather, participants framed it as a practical response to the layered and multifaceted nature of illness. A man from Polokwane (P05, 54 years, living with diabetes) explained,

> *"The doctor gives me pills for sugar [diabetes], but I also drink holy water from church. Both help me. I don't choose one, I use what works."*

His account exemplifies Ashforth's (2005) notion of "spiritual insecurity," wherein individuals navigate multiple therapeutic systems to address the full spectrum of their needs. This blending of modalities was echoed by a woman from Sekhukhune (P16, 42 years, regular ATM, and church healer user):

> *"We mix. We use herbs for cleansing, church oil for protection, and go to the clinic for injections. It depends on the problem."*

Her narrative reflects a flexible orientation to healing, one that resists rigid boundaries between tradition and modernity. Kgatle (2023) similarly observes that Apostolic and evangelical healing practices frequently coexist with ATM, particularly in urban and peri-urban areas where spiritual and existential anxieties are heightened. Participants did not frame this pluralism as epistemic indecision, but rather as a form of wisdom, a way of drawing on the strengths of different systems to meet diverse and evolving needs. A young mother from Tzaneen (P20, 29 years, mother of two) said,

> *"When my child is sick, I start with herbs. If it doesn't work, I go to the clinic. If it's still bad, I ask the pastor to pray. That way, I cover all sides."*

Her account reveals a layered logic of care, one that seeks to address not only the physiological symptoms but also the underlying spiritual and emotional dimensions of illness. This therapeutic pragmatism was described by 13 participants, who emphasised that healing must be responsive to context, history and lived experience. Other participants described the use of Boererate remedies, such as "mielie meal poultices and garlic for flu" (P11, 47 years, Malamulele) or the healing power of prayer and prophecy. A woman from Tzaneen (P23, 35 years, evangelical church member) explained,

> *"We believe sickness can be cast out through faith. When the pastor prays over me, I feel healed, even without medicine."*

These accounts complicate the binary between biomedical and traditional systems, suggesting that integration must be capacious enough to accommodate a wide range of healing logics. The coexistence of herbal remedies, spiritual rituals and biomedical interventions reflects a pluralistic ethic of care that is responsive to individual and communal needs. A healer from Vuwani (THP06, 58 years, diviner-herbalist) described his practice as "walking with both feet, one in the forest, one in the clinic." He elaborated,

> *"The doctor sees sugar in the blood. I see the spirit that causes it. We both see something, just in different ways."*

His account challenges the assumption that integration must involve epistemic convergence. Instead, it suggests a model of parallelism, wherein different systems coexist and complement one another without collapsing into a singular framework. This perspective calls for an integrative approach that respects the

distinct ontologies and diagnostic logics of each system. This pragmatic pluralism was not confined to individual choices but extended to household and community practices. A grandmother from Ga-Molepo (P09, 63 years, household caregiver) explained,

> *"In our house, we keep herbs, Panado and holy water. We don't argue about which is better. We use what helps."*

Her statement reflects a household-level ethic of care that values efficacy over ideology. The presence of multiple therapeutic resources within the same domestic space illustrates a practical orientation to health that privileges outcomes and relational trust over categorical allegiance to any one system. Importantly, participants did not view this pluralism as a sign of epistemic weakness or confusion. Rather, it was framed as a strength, a way of navigating uncertainty with humility, discernment, and resourcefulness. A young teacher from Makhado (P24, 27 years) put it plainly,

> *"No one knows everything. That's why we try different ways. Sometimes the healer sees what the doctor misses. Sometimes the church sees what both miss."*

Her words call for a model of integration that honours epistemic humility and supports individuals in making informed, context-sensitive choices. Such a model must recognise that health-seeking is not merely a technical exercise, but a deeply human process shaped by belief, experience, and relational trust.

4.5. Concerns around regulation and authenticity

While many participants expressed support for the integration of ATM into the formal health system, 17 of the 27 participants also highlighted concerns regarding the risks of fraud, commodification, and epistemic dilution. These concerns were not framed as opposition to collaboration, but as cautionary reflections on the potential consequences of formalisation without cultural sensitivity. A teacher in Polokwane (P04, 35 years, secondary school educator) expressed this tension:

> *"I believe in our culture, but some healers are fake. They just want money. At least the clinic has rules."*

Her comment reflects a tension between cultural loyalty and the desire for regulatory safeguards. While regulation may increase public trust, it also risks undermining the sacred dimensions of healing by subjecting them to technocratic scrutiny (Mullinder, 2023). The implication is that standardisation, if imposed without nuance, may strip ATM of its spiritual and relational depth. This concern was echoed by a young woman from Giyani (P08, 25 years, community member):

> *"Some people wear beads and call themselves healers, but they don't know anything. They copy what they see on TV. That is dangerous."*

Her account highlights the risk of performative healing, where individuals adopt the outward symbols of ATM without the requisite training, lineage, or spiritual calling. Such practices not only erode trust within communities but also pose tangible risks to patient safety. For nine participants, this distinction between authentic and opportunistic practice was not merely technical but deeply moral, with implications for both community trust and patient safety. Participants also expressed anxiety about the potential loss of spiritual integrity through formalisation. A healer from Bolobedu (THP07, 56 years, diviner) explained:

> *"If the government wants to register us, they must understand that our work is not just medicine. It is spirit. You cannot put spirit in a form."*

His statement challenges the assumption that ATM can be neatly codified through licensing and regulation. The sacred, in this worldview, is not a matter of belief alone but a mode of knowing that resists bureaucratic capture and institutional metrics. Attempts to formalise ATM without engaging its ontological foundations risk

flattening its epistemic richness. A nurse from Mopani (BM01, 40 years, primary healthcare nurse) raised a more fundamental concern,

> *"We treat diseases with tests and diagnosis. They treat spirits. If both are put together, how do we decide who is right?"*

Her question underscores the ontological divergence between biomedical and traditional systems, a divergence that cannot be resolved through policy harmonisation alone. Waldron (2010) argues that Western medicine has marginalised African indigenous healing traditions through epistemological hierarchies, illustrating the difficulty of reconciling divergent logics within formal systems. The nurse's reflection points to the epistemic friction that arises when systems with fundamentally different assumptions about causality and evidence are expected to operate within a single regulatory framework.

This tension was echoed by a young clinical officer in Tzaneen (BM03, 29 years):

> *"Sometimes patients come with herbs in their bags. We don't know what's in them. If something goes wrong, who is responsible?"*

His concern reflects the practical dilemmas faced by frontline health workers who must navigate blurred boundaries between systems without clear guidelines or shared epistemic ground. The lack of standardised protocols for cross-system engagement leaves practitioners vulnerable to liability and uncertainty, even as patients continue to move fluidly between therapeutic modalities. Participants also worried about the erosion of lineage-based authority through standardisation. A healer from Ga-Mphahlele (THP10, 61 years, hereditary healer) said:

> *"My gift comes from my grandmother. She taught me with dreams and rituals. If the government says I must go to school to be a healer, they are saying my grandmother was wrong."*

His account reveals how formalisation can inadvertently delegitimise indigenous pedagogies and ancestral transmission, replacing them with institutional metrics that may not align with community values. The healer's concern is not about resisting learning but about preserving the integrity of knowledge systems that are relational, spiritual, and intergenerational. Despite these concerns, some participants expressed cautious optimism about the potential for respectful collaboration. A traditional healer from Vuwani (THP06, 58 years, diviner-herbalist) offered a more hopeful vision,

> *"We don't want to replace doctors. We want to walk together. Let each one do what they know best. The patient will choose."*

His statement gestures towards a pluralistic ethic of co-existence, not one of assimilation, but of respectful parallelism. It invites policymakers to consider integration not as a merger but as a dialogue between knowledge systems, each with its own integrity and scope. The emphasis is on complementarity rather than convergence. A community elder from Nzhelele (P10, 67 years, ritual custodian) summarised the dilemma,

> *"We want recognition, not control. Let the healers be healers. Let the doctors be doctors. But let them talk to each other."*

Her words call for a model of integration grounded in mutual respect, epistemic humility, and cultural sensitivity. Integration must honour the diversity of healing logics without flattening them into a single framework. The challenge, as these narratives suggest, is not merely technical but philosophical. How can bridges be built between the two systems without erasing the foundations upon which they stand?

5. Recommendations

Building on the findings of this study, the following recommendations aim to guide the inclusive integration of ATM within South Africa's NHI framework.

5.1. Inclusive policy architecture for plural healing systems

The National Department of Health (NDoH), working with the NHI Benefits Advisory Committee, should lead the development of a policy architecture that recognises the full spectrum of healing systems used by South Africans, including ATM, Apostolic and evangelical healing, Boererate remedies and other syncretic practices. This requires mapping community health-seeking patterns, establishing a Plural Health Systems Advisory Forum and ensuring that benefit-package decisions reflect lived therapeutic pluralism rather than privileging biomedical systems.

5.2. Co-designed regulatory frameworks with healer associations

The Traditional Health Practitioners Council (THPC), supported by NDoH and provincial health departments, should co-develop regulatory mechanisms with healer associations to ensure legitimacy, cultural sensitivity, and public accountability. This includes a tiered registration system recognising lineage-based healers, diviners, herbalists, and midwives. It also includes establishing joint complaints panels for resolving disputes. In addition, a shared adverse-event reporting platform should be accessible to both THPC and NHI district offices.

5.3. Strengthening curricula and research engagement

Higher Education Institutions, in partnership with the Medical Research Council, the National Department of Health and the Traditional Health Practitioners Council, should expand interdisciplinary curricula and research programmes that engage ATM on its own epistemic terms. This includes modules on cosmology and plural health systems, joint research projects between biomedical and traditional practitioners, and systematic documentation of existing collaborative models such as those developed at Chiawelo Day Hospital.

5.4. Minimum referral protocol between THPs and clinics

District Health Management Teams, in collaboration with local healer associations, should implement a minimum referral protocol that enables safe, bidirectional movement between THPs and clinics. This protocol should include standardised referral forms, red-flag criteria requiring urgent biomedical intervention, written feedback loops, and quarterly case-review meetings.

5.5. Safeguarding measures for fraud, harmful products and child protection

The NDoH Inspectorate, THPC and South African Health Products Regulatory Authority should jointly implement safeguarding measures that protect communities while respecting cultural practice. These include tamper-proof practitioner identification to prevent fraud, risk-based testing of commonly used herbal mixtures, mandatory reporting pathways for suspected child harm and district-level public education campaigns on recognising legitimate practitioners.

5.6. Pilot integration programme

The NHI Contracting Unit for Primary Health Care, together with District Health Management Teams and THPC, should implement a three-year pilot in Vhembe District to assess structured collaboration between THPs and clinics.

- Year 1 should focus on co-designing governance structures and referral tools.
- Year 2 on implementing referral pathways, joint case reviews, and incident-reporting systems.
- Year 3 on evaluation and refinement.

Evaluation indicators should include referral volumes, patient satisfaction, adverse-event reduction, staff attitudes, and cost-effectiveness.

5.7. Long-term evidence building

The MRC, NHI Research Unit and partner universities should lead a long-term research agenda examining the effects of integrated care on chronic illness management, mental health outcomes, treatment adherence, and healer–patient relationships. This work should include economic evaluations and longitudinal studies to ensure that integration remains evidence-driven.

6. Conclusion

The paper examined the evolving landscape of ATM in South Africa. It traced its institutionalisation through curricula, research, and policy engagement. The paper also examined the lived experiences of practitioners navigating plural medical systems. Drawing on both scholarly literature and empirical fieldwork, the analysis highlighted the epistemic richness of ATM, its contested legitimacy and the diversity of practices that span herbalism, midwifery, divination, and ritual healing. The findings revealed a dynamic health system shaped by cultural, spiritual, and socio-political factors.

The integration of ATM into the NHI framework presents both opportunities and risks. While policy points toward inclusion, meaningful integration requires more than administrative recognition. It demands a reconfiguration of regulatory models, curricular structures, and research paradigms to honour IKS and practitioner agency. The voices of practitioners in this study underscore the need for co-designed frameworks that respect lineage, spiritual calling, and community validation. Moreover, the paper calls for a broader conceptualisation of healing that includes apostolic, evangelical, and syncretic traditions, reflecting the full spectrum of South Africa's plural medical landscape.

Overall, the paper argues that ATM is not a peripheral or residual system. It is a vital and evolving domain of health knowledge and practice. Its integration into NHI framework must be guided by principles of epistemic justice, cultural humility, and inclusive development. Centering practitioner narratives and engaging critically with institutional structures, South Africa can move toward a health system that reflects its historical depth, cultural complexity, and democratic aspirations.

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