

Risk and liability in collaborative mental healthcare between psychologists, psychiatrists and traditional healers in South Africa

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Background. South Africa (SA)'s pluralistic mental health system reflects a coexistence of biomedical and traditional healing paradigms. While this plurality enhances cultural accessibility and patient trust, it also raises ethical and legal uncertainty regarding professional accountability and liability. The absence of harmonised governance between the Health Professions Council of South Africa and the Traditional Health Practitioners Council complicates interprofessional collaboration and increases the risk of professional exposure.

Objectives. To explore how psychologists, psychiatrists and traditional health practitioners (THPs) understand risk, liability and accountability in pluralistic mental healthcare, and to identify areas where ethical and legal frameworks could be strengthened to support culturally responsive and legally coherent collaboration.

Methods. A qualitative exploratory-descriptive design was employed. Semi-structured interviews were conducted with 19 practitioners, comprising psychologists, psychiatrists and THPs. Data were analysed using Braun and Clarke's thematic framework to identify shared and divergent understandings of professional responsibility, ethical practice and legal accountability.

Results. Three overarching themes emerged: ambiguity in professional accountability, ethical tensions arising from cultural responsibility, and the need for policy and legal reform. Practitioners recognised the value of pluralistic care, but cited an absence of clear ethical guidance, referral systems and shared documentation protocols. Psychologists and psychiatrists expressed concern about malpractice liability, while THPs highlighted marginalisation within formal regulation. Participants emphasised the importance of ethical frameworks that respect cultural pluralism while protecting professional integrity and patient safety.

Conclusion. Pluralistic collaboration is an established feature of mental healthcare in SA, but remains ethically and legally underdefined. Aligning the Health Professions Act 56 of 1974 and the Traditional Health Practitioners Act 22 of 2007 through joint policy development would clarify accountability and reduce liability risk. Interprofessional ethics education and formal referral mechanisms are essential to integrate cultural legitimacy with legal coherence.

Keywords: pluralism, mental health, ethics, liability, South Africa, traditional health practitioners, psychiatry, psychology

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South Africa (SA)'s mental healthcare system operates within a pluralistic framework in which patients commonly consult both biomedical practitioners and traditional health practitioners (THPs). This plurality reflects deeply rooted cultural understandings of illness and healing, and forms an important part of how many communities conceptualise wellbeing.^[1-3] While the coexistence of these systems offers opportunities for culturally congruent care, it also introduces significant ethical and legal complexities.

Traditional healing remains widely practised across SA and is formally recognised under the Traditional Health Practitioners Act 22 of 2007.^[4] THPs provide holistic care encompassing physical, psychological and spiritual dimensions, often addressing conditions perceived to have social or ancestral origins.^[5-7] Biomedical professionals, regulated under the Health Professions Act 56 of 1974, practise within Western clinical frameworks grounded in diagnostic

and evidence-based approaches.^[8,9] Although both systems serve overlapping patient populations, collaboration between them remains largely informal and insufficiently regulated.^[3-10]

National policy frameworks acknowledge the importance of cultural diversity in healthcare. The National Health Act 61 of 2003^[11] and the National Department of Health (NDoH)'s Ethics in Health Research guidelines (2024)^[12] emphasise the ethical obligation of practitioners to respect cultural practices in health service delivery. In practice, however, the absence of integrated governance mechanisms creates uncertainty regarding professional accountability, informed consent and liability when patients engage with multiple healing systems.^[13-15] Psychologists and psychiatrists frequently encounter patients receiving concurrent care from THPs, but often lack institutional guidance on how to navigate these plural relationships ethically and legally.

Existing research suggests that interprofessional mistrust and legal ambiguity hinder effective referral and collaboration between biomedical practitioners and traditional healers.^[2,3,7,16] Biomedical practitioners report concerns about professional liability when patients engage in unregulated treatments, while THPs often experience exclusion from formal decision-making processes despite their recognised role in community health systems.^[6,7,17] Similar challenges have been observed in other low- and middle-income countries (LMICs) where pluralistic healthcare systems operate without harmonised regulatory frameworks.^[13,18]

From an ethical perspective, pluralistic healthcare raises complex questions regarding autonomy, beneficence and justice within culturally diverse contexts. Beauchamp and Childress^[19] argue that ethical principles are culturally mediated and require contextual interpretation. In many SA communities, collective and spiritual understandings of wellbeing influence treatment decisions, sometimes diverging from Western biomedical concepts of individual autonomy.^[3,7,19] The divergence between Western individual autonomy and collective, spiritually informed decision-making practices creates tension between professional codes grounded in universal ethical principles and practices rooted in communal responsibility.

Legal frameworks further complicate this landscape. The Health Professions Council of South Africa (HPCSA) regulates biomedical practitioners under the Health Professions Act,^[9] while THPs are regulated under the Traditional Health Practitioners Act.^[4] However, these regulatory systems operate independently and provide limited guidance on shared documentation, consent processes or liability in collaborative care. As a result, practitioners may face disciplinary or civil consequences when complications arise across paradigms.^[9,14]

Additional challenges arise in relation to data protection. The Protection of Personal Information Act 4 of 2013 (POPIA) regulates the handling and sharing of personal health information.^[15] In practice, the absence of formal record-keeping systems in many traditional healing contexts creates uncertainty for biomedical practitioners when sharing patient information across care systems. This fragmentation increases professional risk and may undermine efforts to provide co-ordinated and culturally responsive mental healthcare.

Against this background, the present study explored how psychologists, psychiatrists and THPs conceptualise professional risk and liability within SA's pluralistic mental healthcare system. The research examined how current legal and ethical frameworks shape collaborative practice, and considered potential policy or educational interventions that may strengthen professional accountability and patient protection.

Methods

Study design

A qualitative methodology was employed to explore how mental health practitioners understand and manage professional risk and liability within SA's pluralistic mental healthcare context. The study adopted an exploratory-descriptive design aimed at documenting practitioners' understandings of risk and liability in pluralistic care rather than developing a phenomenological account of lived experience. Such designs are commonly used where limited prior research exists and the aim is to generate conceptual insight into emerging practice issues.^[20] This approach was considered appropriate as it enabled the researchers to explore and describe practitioners'

experiences and ethical reasoning across both biomedical and traditional healthcare systems without imposing predetermined theoretical frameworks.^[21,22]

Participants and sampling

Nineteen practitioners participated in the study: seven psychologists, four psychiatrists and eight THPs practising in Eastern Cape Province, SA. Psychiatrists and psychologists were registered with the HPCSA, while traditional healers were recruited through the Traditional Healers Association of South Africa. Participants were drawn from both public and private healthcare settings. The psychologist group comprised four clinical psychologists employed in public hospitals and three counselling psychologists in private practice, while the psychiatrists were all in private practice.

Purposive and snowball sampling were used to recruit practitioners with relevant experience across professional and cultural contexts. Inclusion criteria required at least 3 years of clinical or community practice and experience with patients who had consulted across both biomedical and traditional healthcare systems. Practitioners without experience in mental healthcare or exposure to pluralistic patient care were excluded. Recruitment occurred through professional associations, referrals and community networks to support trust and voluntary participation.^[23]

Data collection

Semi-structured interviews were conducted via encrypted online platforms to accommodate participants across the Eastern Cape. All interviews were conducted in English, although participants were encouraged to use culturally specific terminology where relevant; such terms were retained in transcripts to preserve contextual meaning. Interviews lasted between 60 and 90 minutes.

The interview guide explored themes related to professional accountability, ethical responsibility, liability awareness, and collaboration between practitioners. It was informed by the study objectives and relevant literature on pluralistic healthcare and professional ethics. Probing questions encouraged participants to reflect on clinical scenarios involving shared patient care or cross-referral.^[2,16,19] The guide was piloted with one psychologist and one traditional healer, after which minor adjustments were made to improve clarity and flow.

Interviews were audio-recorded with informed consent and transcribed verbatim. Field notes captured contextual observations, tone and emphasis. Data collection continued until thematic saturation was reached, with no new themes emerging from subsequent interviews.

Data analysis

Data were analysed using Braun and Clarke's^[24] six-phase framework for thematic analysis. This process involved familiarisation with the data, generation of initial codes, identification of patterns, theme development, review and definition. Coding was both inductive and reflexive, allowing themes to emerge from the data while remaining informed by the research focus on professional risk and liability. NVivo software version 14 (Lumivero, USA) supported data management and organisation.

Peer debriefing was conducted through independent coding of selected transcripts by members of the research team. Coding

interpretations were compared and discussed until consensus was reached regarding theme development. An audit trail documenting coding decisions and thematic revisions was maintained to ensure methodological transparency.^[25] The principal investigator (LY-S) is an academic researcher and not a practising psychologist; reflexive awareness of this positionality was maintained throughout data collection and analysis.

Ethical considerations

Ethical clearance was granted by the Nelson Mandela University Research Ethics Committee (Human) (ref. no. H22-HEA-PSY-002). The study complied with the National Health Act,^[11] the NDoH's Ethics in Health Research guidelines,^[12] and POPIA.^[15]

All participants provided informed consent after receiving information about the study's purpose, procedures and data management processes. Confidentiality was ensured by anonymising transcripts and storing digital files on encrypted drives. Participants were informed of their right to withdraw from the study at any time without consequence.

Trustworthiness

Trustworthiness was ensured through Lincoln and Guba's^[25] criteria of credibility, transferability, dependability and confirmability. Credibility was supported through prolonged engagement and participant validation of emerging interpretations. Dependability was maintained through an audit trail documenting methodological decisions. Transferability was supported by detailed contextual descriptions of practitioner backgrounds and practice settings, while confirmability was enhanced through reflexive journaling documenting the researcher's assumptions and positionality.

Data management

Data were stored securely in accordance with institutional and statutory data protection requirements. Only the researcher and authorised supervisors had access to raw data. Data will be retained for 5 years following publication and thereafter permanently deleted from encrypted storage systems in line with institutional data management policies.

Results

Overview of participants

Nineteen practitioners participated in the study: seven psychologists, four psychiatrists and eight THPs. Participants represented diverse cultural, linguistic and professional backgrounds and practised in both urban and rural contexts in SA. They included male and female practitioners aged 34 - 68 years, with professional experience ranging from 5 to 35 years. All participants had encountered cross-paradigm patient care through referral, shared treatment or informal consultation.

Three overarching themes emerged from the data:

1. Ambiguity in professional accountability
2. Ethical tensions and cultural responsibility
3. The need for legal and policy reform.

These themes reflect participants' understandings of professional duty, perceptions of risk, and the influence of SA's pluralistic legal landscape on collaborative mental healthcare.

Ambiguity in professional accountability

Participants expressed concern that collaboration with THPs could expose biomedical practitioners to disciplinary action under the Health Professions Act,^[9] particularly section 41, which empowers the HPCSA to institute disciplinary proceedings for unprofessional conduct. Several psychologists reported occasionally referring patients informally to traditional healers when clients attributed symptoms to spiritual causes. However, psychologists and psychiatrists were uncertain whether such referrals could be interpreted as conduct falling outside recognised professional standards.

Participants also referred to the HPCSA Ethical Rules of Conduct.^[8] Particular concern was raised regarding rule 2, which requires practitioners to act in patients' best interests and maintain professional standards; rule 21, which governs professional relationships; and rule 27A, which restricts misleading claims or endorsements regarding treatment efficacy. Practitioners feared that formal referral to traditional healers, shared treatment planning, or documented collaboration could be interpreted as endorsing treatments not recognised within biomedical evidence-based practice.

Several participants indicated that such actions could expose them to allegations of negligence or malpractice should harm occur following traditional treatment. Consequently, many reported limiting collaboration to informal interactions initiated by patients rather than engaging in formal referral or shared-care arrangements.

One psychologist explained:

'If something goes wrong with the patient after I have referred them to a traditional healer, I would still be the one held accountable. As practitioners we are regulated by the HPCSA, and that creates uncertainty about how collaboration with traditional healers would be viewed legally.' (Psychologist)

Similarly, a psychiatrist noted:

'Even if the patient chooses to see a traditional healer, if I am seen as supporting that decision professionally, it could be interpreted as endorsing something that falls outside the scope of evidence-based practice.' (Psychiatrist)

THPs described accountability differently, emphasising responsibility to ancestral authority and community expectations rather than statutory regulatory bodies. Some THPs reported feeling excluded from policy discussions about mental healthcare, despite their recognised role in community healing practices.^[2,3,7]

Although both groups recognised the potential value of collaboration, the absence of clear legal frameworks was widely viewed as a barrier to safe co-operation.

Ethical tensions and cultural responsibility

Participants described ethical tensions arising from differing understandings of illness, healing and professional responsibility. Psychologists and psychiatrists expressed respect for cultural beliefs, but found it challenging to reconcile indigenous explanatory models of illness with Western diagnostic frameworks. Several participants noted that ethical principles such as autonomy and beneficence can be difficult to operationalise when treatment decisions are influenced by collective or spiritual considerations.^[19]

THPs emphasised the importance of holistic healing approaches that address both physical and spiritual dimensions of illness. They argued that excluding ancestral consultation or ritual practices could undermine patient recovery. While some biomedical practitioners were open to integrating culturally sensitive practices into therapeutic work, others felt constrained by professional codes that discourage endorsement of unregulated treatments.

Both practitioner groups noted that limited interprofessional ethics training contributes to misunderstanding and mistrust between systems of care. Participants suggested that clearer ethical guidance is needed to support pluralistic collaboration. Although the NDoH's Ethics in Health Research guidelines outline general ethical principles,^[12] they do not provide specific guidance for collaboration between biomedical practitioners and THPs. As a result, practitioners reported relying on personal judgement rather than institutional policy when navigating pluralistic care.

Need for legal and policy reform

Participants across all practitioner groups expressed a strong need for clearer legal and policy frameworks to support collaboration and reduce liability risks. Psychologists and psychiatrists suggested that the HPCSA should develop formal guidance on engagement with THPs, including standardised referral procedures, consent documentation, and data-sharing protocols.

THPs emphasised the need for greater recognition of their role in mental healthcare and called for stronger collaboration between the Traditional Health Practitioners Council and the HPCSA.^[4,8] Some suggested that joint accreditation mechanisms or collaborative governance structures could legitimise interprofessional engagement and reduce professional disputes.

Participants also highlighted challenges related to confidentiality and informed consent in collaborative care. Biomedical practitioners reported uncertainty about sharing patient information with practitioners operating outside formal regulatory systems. One counselling psychologist noted:

'If a patient asks me to communicate with their traditional healer, I have to be very careful about confidentiality. Our professional guidelines require us to protect patient information, but there are no clear procedures for how that information should be shared outside the healthcare system.' (Counselling psychologist)

Similarly, a psychiatrist reflected on the complexity of consent in pluralistic care:

'Even if the patient agrees to the collaboration, there is still the question of whether they fully understand how information might be shared between practitioners who work in very different systems.' (Psychiatrist)

Participants also expressed uncertainty regarding compliance with POPIA^[15] when traditional healers lacked formal data management systems. This gap was viewed as a potential source of legal liability.

Despite these concerns, some practitioners described pragmatic strategies for supporting patients who engaged with both healing systems. These included discussing traditional healing practices during consultations, encouraging disclosure of concurrent treatments, and ensuring that patients retained control over whether information was shared between practitioners.

One clinical psychologist explained:

'In reality many of our patients consult traditional healers whether we acknowledge it or not. Sometimes the best approach is to have an open conversation about it so that we understand what the patient is doing and can support them safely.' (Clinical psychologist)

Summary of findings

Across all themes, participants demonstrated a commitment to culturally responsive care, but reported significant structural and ethical constraints. The interaction between statutory law, professional ethics and traditional authority created overlapping yet poorly defined zones of accountability. While practitioners recognised that pluralistic collaboration is both common and necessary in SA's mental health landscape, the absence of harmonised legal and ethical frameworks leaves such collaboration professionally risky and inconsistently implemented.

Discussion

The findings illustrate how professional risk and liability are negotiated within SA's pluralistic mental health system, where psychologists, psychiatrists and THPs operate within distinct yet intersecting frameworks. Participants expressed a shared commitment to patient wellbeing, but reported limited institutional or legal guidance for collaborative practice. The findings suggest that the primary barrier to collaboration is not resistance to pluralistic care itself, but the absence of governance structures that enable safe and accountable co-operation.

Participants consistently reported that patients frequently consult both biomedical practitioners and traditional healers, often without formal co-ordination between practitioners. This response aligns with previous research indicating that pluralistic help-seeking is common in many African health systems, where individuals engage with multiple therapeutic systems simultaneously.^[26,27] The present findings therefore suggest that pluralism already exists in practice but operates largely through informal and unregulated interactions. Such arrangements create uncertainty for practitioners, who must balance culturally responsive care with professional regulatory obligations.

These findings should also be interpreted alongside emerging literature on collaboration between biomedical practitioners and traditional healers. Increasing recognition has been given to the role of traditional healers in improving access to culturally responsive healthcare in SA. Similarly, evidence from several LMICs indicates that structured collaboration between traditional healers and biomedical practitioners can improve referral pathways, treatment engagement and community trust when supported by clear governance frameworks and defined professional roles.^[16,28]

Professional accountability in pluralistic contexts

Ambiguity regarding professional accountability emerged as the most prominent concern across practitioner groups. Biomedical practitioners operate under the Health Professions Act^[9] and the HPCSA Ethical Rules of Conduct,^[8] which require practitioners to practise within defined scopes and maintain professional independence. These frameworks were developed primarily for single-paradigm healthcare environments and do not explicitly

address collaboration with practitioners outside the biomedical regulatory system. Consequently, biomedical practitioners may perceive that liability defaults to the regulated professional when treatment outcomes are contested.^[2,3,10,14]

THPs, by contrast, fall under the Traditional Health Practitioners Act,^[14] which establishes professional registration and disciplinary processes, but provides limited mechanisms for co-ordinated oversight with biomedical councils. Operational challenges within the Traditional Health Practitioners Council have further contributed to inconsistent regulatory enforcement.^[2,3,7] This regulatory fragmentation reinforces divisions between healing systems and leaves practitioners uncertain about shared accountability when patients move between systems of care.

These findings reflect broader concerns in health governance literature, which emphasises that effective accountability requires co-ordination between parallel regulatory systems.^[13,16,29] Without referral pathways, shared documentation protocols or mechanisms for joint responsibility, practitioners remain exposed to perceived liability risks even when acting in good faith. Clearer protocols defining shared duty of care may therefore be essential to support pluralistic collaboration while safeguarding patient safety.

Ethical pluralism and cultural responsibility

The ethical tensions identified in this study reflect deeper epistemological differences between Western biomedical and indigenous healing systems. Biomedical ethics in SA is largely informed by principlism, emphasising autonomy, beneficence, non-maleficence and justice.^[19] These principles underpin both HPCSA ethical rules^[8] and national health research ethics frameworks.^[12] Traditional healing systems, however, often conceptualise ethics through communal and spiritual responsibility, prioritising collective wellbeing and ancestral guidance.^[3,7,30]

These differing ethical orientations complicate collaboration. For example, informed consent – a central principle in biomedical ethics – may be interpreted differently in contexts where decision-making is communal and mediated through family or spiritual authority.^[14,31] Participants expressed uncertainty about how to respect cultural autonomy while maintaining compliance with legal consent requirements under the National Health Act.^[11]

Importantly, practitioners did not reject traditional healing practices themselves. Many acknowledged their cultural legitimacy and recognised that patients frequently integrate spiritual and biomedical explanations of illness. Rather, concerns centred on the absence of clear legal and ethical frameworks defining professional responsibility in shared-care contexts. Given the shortage of mental health professionals in SA and the continued role of traditional healers in community-based healthcare, pluralistic help-seeking behaviours may represent pragmatic responses to limited access to formal mental health services.

Legal and policy implications

The findings highlight the need for stronger policy and governance mechanisms to support collaboration within SA's pluralistic healthcare system. Evidence from other areas of healthcare demonstrates that collaboration between biomedical practitioners and traditional healers is possible when supported by structured governance frameworks. In SA, traditional healers have been incorporated into public health

initiatives addressing HIV and tuberculosis through defined roles, referral pathways and training programmes.

In contrast, mental healthcare collaboration appears to occur largely in the absence of comparable governance structures. Current legislation – including the Health Professions Act, Traditional Health Practitioners Act and National Health Act – operates largely in parallel rather than through integrated regulatory mechanisms. This fragmentation contributes to practitioner uncertainty regarding professional accountability when patients receive treatment across multiple healing systems.

Another structural factor that may influence collaboration relates to the public-private divide within SA's healthcare system. Public mental health services are largely state funded, whereas traditional healers typically operate as independent providers whose services are paid for directly by patients. Although this issue did not emerge prominently in participant accounts, differences in funding structures may complicate referral relationships and sustained collaboration between practitioner groups.

Developing a harmonised policy framework could mitigate these challenges. Internationally, the World Health Organization's Traditional Medicine Strategy (2014 - 2023) provides guidance for integrating traditional and biomedical systems through regulation, training and ethical oversight.^[18] In the SA context, implementation would require co-ordinated engagement between the NDoH, the HPCSA and the Traditional Health Practitioners Council to establish referral protocols, consent standards and mechanisms for collaborative documentation.

Participants' concerns regarding confidentiality also highlight the need to ensure that compliance frameworks such as POPIA extend to pluralistic healthcare interactions. Policies governing information sharing must balance cultural sensitivity with statutory requirements for patient privacy and data protection.

Integrating cultural legitimacy and legal coherence

Taken together, the findings suggest that practitioners may be willing to collaborate but remain constrained by systemic barriers. Ethical pluralism within mental healthcare therefore requires institutional commitment to regulatory clarity, professional protection and cross-system dialogue. Recognising the legitimacy of traditional healing within national health strategies while establishing clear standards for collaborative accountability may help bridge the current gap between cultural practice and legal governance.

Strengthening regulatory co-ordination, ethical dialogue and professional education could reduce perceived liability risks while expanding access to culturally appropriate mental health services.

Conclusion

This study highlights the ethical and legal uncertainties shaping psychologists' and psychiatrists' perceptions of collaboration with THPs in SA. While practitioners recognise the cultural significance of traditional healing and its potential role in mental healthcare, concerns regarding professional liability, regulatory ambiguity and confidentiality remain significant barriers to formal collaboration. Clearer policy guidance and co-ordinated regulatory frameworks may help facilitate ethically sound collaboration between biomedical practitioners and traditional healers while safeguarding patient welfare.

Limitations and recommendations

This study has several limitations. The qualitative exploratory design and relatively small sample limit generalisability. Participants were recruited through purposive and snowball sampling, which may have introduced selection bias towards practitioners more willing to discuss pluralistic care. In addition, the study explored practitioner perceptions rather than examining legal cases or policy implementation directly. The findings should therefore be interpreted as reflecting practitioner experiences within a specific professional and geographical context.

Future research should examine patient perspectives on pluralistic mental healthcare and evaluate collaborative models that clarify professional accountability while supporting culturally responsive care.

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