IPROSA
INDIGENOUS PROFESSIONS OF SOUTHERN AFRICA

SUBMISSION ON THE
DRAFT TRADITIONAL HEALTH PRACTITIONERS REGULATION, 2024

These submissions are endorsed by:

	Name of organisation	Duly represented by
1.	Eastern Cape Royal Leaders Forum	iNkos' uZwelithobile Mtirara (Chairperson)
2.	African Natural Medicine Association	Mhlekazi Dr. Cynthia Nqumse-Cindi (CEO)
3.	iBuyaMbo Royal Community Association	Mr. Herbert Sindile Mhlangabezi Toni
4	African Young Indigenous Leaders	Dr Nikiwe Bam (President)
5.	Abelaphi Bendabuko Base Africa	Dr DA Mkhwanazi (Chair)
6.	Vukuzenzele Traditional Healers Association NPC	Mr. M Cele

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Mpikwana Royal House, AbaThembu Kingdom, King Sabata Dalindyebo, P.O. Box 7233, Mthatha
Email: info@iprosa.org Website: www.iprosa.org

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1. Executive summary

The Indigenous Professions of Southern Africa (IPROSA), speaking with the united voice of traditional leaders, Indigenous health practitioners, and community organisations across the nation, presents this submission as a matter of urgent constitutional and national importance. We write not merely to comment on proposed regulations, but to alert the Presidency to a fundamental crisis in our democracy's treatment of Indigenous Health Knowledge Systems (IHKS) that demands immediate executive intervention.

The Draft Traditional Health Practitioners Regulations of 2024 represent far more than a technical health policy matter. They embody a critical test of South Africa's commitment to transformation, constitutional democracy, and the dignity of the African majority. In their current form, these Regulations perpetuate colonial paradigms that have suppressed Indigenous knowledge for centuries, violating sections 27, 30, 195, and 235 of our Constitution whilst undermining the very foundations of our social compact.

We stand at a defining moment in our nation's history. The path chosen now will determine whether millions of South Africans continue to be criminalised for their healing traditions, or whether we finally embrace the transformative promise of our Constitution. This submission demonstrates conclusively that the current regulatory framework will:

- Collapse under constitutional scrutiny
- Fail in implementation
- Deepen the very inequalities it purports to address
- Forfeit a R50 billion economic opportunity
- Perpetuate the marginalisation of 80% of our population who rely on Indigenous health

However, we come not merely with critique but with solutions. We propose an alternative framework centred on:

1. Recognition of IHKS as a constitutionally protected, integral component of South Africa's health system;
2. Establishment of a Presidential Commission on Indigenous Knowledge to oversee comprehensive reform;
3. Implementation of Indigenous-led governance structures rooted in customary law;
4. Investment in capacity-building, research infrastructure, and economic integration; and
5. Harmonisation of conflicting legislation to remove colonial-era barriers.

Essentially, we are asking for a framework that would transform IHKS into a cornerstone of universal health coverage, a driver of economic transformation, and a source of national pride. This framework, rooted in customary law and Indigenous governance, would position South Africa as a global leader in pluralistic health systems whilst addressing the urgent healthcare needs of our most vulnerable communities.

2. The Constitutional crisis before us

2.1. The fundamental question of our Democracy

This submission addresses a constitutional crisis that strikes at the heart of our democracy's promise. When our Constitution declares in its opening words that "*South Africa belongs to all who live in it, united in our diversity*", it makes a sacred promise that no citizen shall be marginalised for their cultural practices, their Indigenous knowledge, or their ancestral healing traditions. Yet the Draft Traditional Health Practitioners Regulations of 2024 threaten to institutionalise precisely such marginalisation, creating a system that would effectively criminalise the healthcare practices of millions of South Africans.

The Constitutional Court has repeatedly affirmed that our Constitution is a transformative document, one that requires active measures to heal the divisions of the past and establish a society based on democratic values, social justice, and fundamental human rights. In the landmark case of *Pharmaceutical Manufacturers Association*, the Court declared that we must move beyond mere formal equality to achieve substantive transformation.[1] These Regulations, however, move us backwards, entrenching Western biomedical hegemony over Indigenous knowledge systems in direct violation of this transformative mandate.

Section 27 of our Constitution guarantees every citizen the right of access to healthcare services. For approximately 80% of South Africans, particularly those in rural areas, Indigenous health practitioners are not an alternative to healthcare but the primary, and often only, source of healing available. When *uMakhulu* in rural Eastern Cape seeks treatment from her local *igqirha*, she exercises her constitutional right to healthcare. When regulations impose impossible barriers to that practitioner's practice, they violate her constitutional rights. This is not a theoretical concern but a daily reality for millions of our citizens.

The protection of cultural rights under Sections 30 and 31 of our Constitution extends beyond mere tolerance to active protection and promotion. Indigenous healing practices represent thousands of years of accumulated wisdom, refined through generations of empirical observation and community validation. These practices are inseparable from African spirituality, from our understanding of ourselves, and from our connection to our lineage. Regulations that force Indigenous healers to conform to Western biomedical paradigms do not merely regulate practice; they commit epistemological violence against African ways of knowing and being.

Section 195 of our Constitution establishes that public administration must be development-oriented and people-centred. The current regulatory process has failed this test catastrophically through consultation processes that excluded the very communities they affect, documentation in languages practitioners do not speak, and requirements that ignore the realities of rural practice. This failure is not merely procedural but substantive, violating the principles established in *Doctors for Life v Speaker of the National Assembly.*[2]

[1] Pharmaceutical Manufacturers Association of South Africa and Another: In re Ex parte President of the RSA and Others 2000 (2) SA 674 (CC)
[2] Doctors for Life International v Speaker of the National Assembly and Others 2006 (6) SA 416 (CC)

Perhaps most significantly, Section 235 of our Constitution recognises the right to self-determination, a right that extends to Indigenous communities' authority over their own knowledge systems and healing practices. The imposition of external regulatory frameworks without Indigenous leadership violates this fundamental right, perpetuating the colonial assumption that African knowledge requires Western validation to be legitimate.

Furthermore, this approach aligns with the Alma Ata Declaration (1978) on Primary Health Care, which recognises that “health is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal”. The Declaration emphasises community participation, culturally appropriate care, and equity in health services, principles that are central to recognising, regulating, and integrating IHKS as a community-anchored health response.

It is further supported by South African policy frameworks, including:

- The National Health Act (2003) and the White Paper on Traditional Medicine (2008, draft), which emphasise primary health care, community participation, and the integration of traditional health practitioners into the health system.
- The Indigenous Knowledge Systems Policy (2004), which supports documentation, protection, and utilisation of Indigenous knowledge for socio-economic and cultural development.
- The National Development Plan 2030, which encourages culturally appropriate, community-based health services, innovation, and rural economic inclusion.
- Bioprospecting, Access and Benefit-Sharing Regulations (2008), which protect Indigenous knowledge while enabling equitable economic participation.

2.2. The International legal obligation we cannot ignore

South Africa's obligations extend beyond our domestic Constitution to binding international commitments that demand respect for Indigenous knowledge systems. At the regional and international level, IHKS integration is supported by:

- WHO Traditional Medicine Strategy 2025–2034, which calls for safe, effective, and culturally integrated traditional medicine services, including research and practitioner training.
- UNDRIP (2007) and ILO Convention 169 (1989), which affirm Indigenous peoples’ rights to self-determination, health, and control over cultural practices. South Africa, after considerable deliberation, explicitly affirms in Article 24 that Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of vital medicinal plants, animals, and minerals. These Regulations, by imposing alien frameworks on Indigenous practices, violate these international obligations.
- African Charter on Human and Peoples’ Rights (1981), which recognises health and cultural integrity as human rights.

- African Union Agenda 2063 and SADC Health Protocols, which promote inclusive, culturally relevant, and community-driven health systems.
- AU Plan of Action on Traditional Medicine (2001-2020), which positions protection through systematisation and institutionalisation

The International Labour Organisation Convention 169 represents customary international law requiring consultation and participation of Indigenous peoples in all matters affecting them. The African Charter on Human and Peoples' Rights, to which South Africa is a signatory, recognises both health and cultural integrity as fundamental human rights that states must protect and promote. The Alma-Ata Declaration, which South Africa helped craft, calls for the integration of traditional practitioners into primary healthcare systems as essential to achieving health for all.

These international instruments are not mere aspirational documents but create binding obligations that South African courts and lawmakers must consider under Section 39 of our Constitution. Any regulation of Indigenous health practitioners that fails to respect these obligations invites not only domestic constitutional challenge but international censure and potential proceedings before international human rights bodies.

In order to appropriately respond to the health system reform that South Africa needs, especially in rural areas, the Socio-Economic Impact Assessment System (SEIAS) must prioritise:

- Reducing regulatory compliance burdens for rural practitioners, many of whom are illiterate or lack access to the economic inputs required by a formal regulatory framework.
- Preventing marginalisation or criminalisation of legitimate Indigenous practices, safeguarding livelihoods, cultural integrity, and community wellbeing.
- Ensuring legislative coherence and constitutional compliance, including harmonisation with the Traditional Health Practitioners Act 22 of 2007, the unrepealed Witchcraft Suppression Act 3 of 1957, and other relevant statutes.
- Institutionalising meaningful investment in capacity building, stakeholder engagement and representation, centering Indigenous practitioner expertise and community perspectives in line with Section 235 of the Constitution, UNDRIP, ILO Convention 169, and the African Charter.
- Positioning IHKS as high-trust, low-cost, community-anchored assets capable of delivering culturally grounded care, strengthening resilience in underserved areas, and supporting inclusive economic growth.
- Integrating economic and technological pathways, including value addition, green industries, tourism, digital platforms, innovation hubs, IP protection, applied research, strategic tax exemptions, and African-led digital tools for education and evidence-based practice.

By prioritising Indigenous voices, expertise, and community priorities, the proposed regulatory reforms aim to enable a pluralistic IHKS to be designed for holistic delivery into South Africa's national health architecture, unlock its full economic, social, and cultural potential, and establish IHKS as a living, community-anchored system for health, wellbeing, and development.

3. The weight of history demands justice

3.1. Confronting centuries of systematic suppression

The regulation of Indigenous health practitioners cannot be understood outside the context of centuries of systematic suppression, criminalisation, and marginalisation. From the first colonial encounters, African healing practices were demonised as witchcraft, condemned as savage, and outlawed as threats to colonial authority. This historical trauma continues to shape current policy approaches that treat Indigenous knowledge as inferior, dangerous, or requiring Western oversight.

The Witchcraft Suppression Act of 1957, which shamefully remains unrepealed, continues to cast a shadow of criminalisation over legitimate Indigenous healing practices. This Act, born of colonial ignorance and racial prejudice, makes no distinction between harmful practices and the sacred healing traditions that have sustained African communities for millennia. Every day that this Act remains in force is a day our democracy fails its most fundamental promise of dignity and equality for all.

The systematic destruction of Indigenous Knowledge Systems (IKS) was not incidental but deliberate colonial strategy. The regulation of IHKS is intimately connected to South Africa's history of colonialism and apartheid and cannot be separated from it. The Native Medical Practitioners Act of 1891 established patterns of marginalisation that persist in current regulatory approaches, requiring Indigenous healers to submit to Western medical authorities for validation. Forced removals severed the connection between healers and the landscapes that provided their medicines. The Bantu Education system deliberately excluded Indigenous knowledge from curricula, teaching generations of African children that their healing traditions were backward superstitions to be abandoned in favour of Western progress.

This is a history of systematic suppression, marginalisation, and criminalisation of Indigenous healing practices. The Traditional Health Practitioners Act 22 of 2007 and other statutory frameworks, though intended to regulate, have often reinforced Eurocentric assumptions, creating barriers to practitioner recognition, knowledge transmission, and socio-economic participation.

Historical and systemic injustices have manifested in several ways:

a. *Knowledge exploitation:* Biopiracy and extractive research have removed traditional medicines and practices from communities without consent or equitable benefit-sharing.
b. *Cultural distortion:* Suppression of Indigenous languages, spiritual practices, and concepts has disrupted continuity and authenticity in health knowledge.
c. *Exclusion from policy and governance:* Practitioners are often marginalised in decision-making, advisory structures, and regulatory processes.
d. *Economic marginalisation:* Limited access to land, markets, and formal support undermines livelihoods and entrepreneurial opportunities for practitioners.
e. *Gender and generational inequities:* Women and youth, key custodians of Indigenous knowledge, face barriers to leadership, recognition, and transmission of practice.

f. *Environmental disruption:* Forced relocations, land dispossession, and ecological degradation threaten the availability of medicinal plants and natural resources critical to practice.
g. *Legal stigma and professional bias:* Outdated laws, regulatory interpretations, and institutional worldviews continue to frame Indigenous health systems as unscientific or illegitimate, reinforcing discrimination in practice, research, and policy.

The extraction of Indigenous knowledge through biopiracy represents another form of historical injustice that continues today. Pharmaceutical companies have derived billions in profits from medicines originally identified by Indigenous healers, yet those communities receive no benefit. The hoodia plant, the African potato, the cancer bush, and the pepper bark tree all represent Indigenous knowledge transformed into commercial products with little or no benefit to Indigenous communities. These Regulations, rather than protecting against such exploitation, would accelerate it by requiring disclosure without adequate protection.

3.2. The Constitutional imperative for restorative justice

The Preamble to our Constitution commits us to heal the divisions of the past and establish a society based on democratic values, social justice, and fundamental human rights. This healing cannot be achieved through regulations that perpetuate colonial paradigms. True transformation requires acknowledging the profound injustices inflicted on IKS and taking active measures to restore its dignity, authority, and vitality.

The Constitutional Court has consistently held that our Constitution demands more than formal equality. In *City of Johannesburg Metropolitan Municipality v Blue Moonlight Properties*, the Court emphasised that transformation requires positive action to address historical disadvantage.[3] For Indigenous health practitioners, this means more than simply allowing them to practice; it requires investing in their development, protecting their knowledge, and integrating their wisdom into our national health system as equals, not subordinates.

Redressing injustice is essential to restore dignity, protect cultural continuity, and enable socio-economic participation. Effective reform must:

a. Recognise IHKS as an integral, operationally viable, and culturally legitimate pillar of South Africa's health system.
b. Embed Indigenous governance and customary law in regulatory structures.
c. Remove legal and institutional barriers that perpetuate discrimination, criminalisation, or exclusion.
d. Support the economic empowerment of practitioners, enabling sustainable livelihoods, entrepreneurship, and participation in research and innovation.
e. Ensure gender and intergenerational equity in policy, governance, and practice.

[3] City of Johannesburg Metropolitan Municipality v Blue Moonlight Properties 39 (Pty) Ltd and Another 2012 (2) SA 104 (CC)

Restorative justice in this context means recognising that Indigenous health practitioners have kept communities healthy for centuries despite active suppression. Every Indigenous healer forced to abandon their practice represents centuries of accumulated wisdom lost forever. The Truth and Reconciliation Commission recognised that apartheid's harm extended beyond individual human rights violations to the systematic destruction of African institutions and knowledge systems. Yet whilst we have made progress in political transformation, the colonisation of knowledge continues unabated.

4. Analysis of the proposed Regulations

IPROSA fully supports the regulation of Indigenous health practitioners, recognising its importance for public safety, the protection of cultural integrity, and the sustainability of Indigenous health systems. South Africa is home to a diverse range of Indigenous knowledge systems, each rooted in local cultures, landscapes, and community practices. These systems provide holistic approaches to wellbeing, distinct from Western frameworks, and offer significant socio-economic value, particularly in rural and underserved areas.

4.1. Fundamental conceptual flaws

The proposed Regulations fail not merely in detail but in their fundamental conception. They attempt to force IHKS into Western biomedical frameworks, like forcing a baobab tree to grow in the shape of a pine. This conceptual violence ensures that the Regulations will fail in implementation, face successful constitutional challenge, and deepen the very problems they purport to solve.

The language of the Regulations reveals their Western-centric bias at every turn. Terms like "diagnosis," "treatment," and "prescription" reflect biomedical concepts that have no equivalent in Indigenous healing systems. When *igqirha* receives guidance through dreams or communicates with ancestors (iindaba zamathongo), when a *ixhwele* performs plant-based healing (amayeza esintu) by selecting medicines based on spiritual revelation, these are not diagnoses in the Western sense but different ways of understanding illness and healing that cannot be reduced to biomedical categories without losing their essential meaning. These practitioners could be unfairly subjected to standards incompatible with IHKS.

The Regulations demand that Indigenous practitioners validate their knowledge through scientific methods, ignoring that Indigenous knowledge systems have their own rigorous methods of validation refined over millennia. Community observation across generations, careful documentation of outcomes, and systematic testing of remedies constitute an empirical system that predates Western science by thousands of years. To demand that this knowledge now prove itself through randomised controlled trials designed for single-molecule pharmaceuticals is to fundamentally misunderstand both Indigenous knowledge and the limits of Western scientific methods.

4.2. Procedural violations and inadequate consultation

The consultation process for these Regulations violated every principle of meaningful participation established by our courts and Constitution. The Constitutional Court in *Doctors for Life* established clear requirements for public participation that adapts to community contexts, provides genuine opportunities for input, and ensures that vulnerable groups can meaningfully engage. The 2024 consultation process failed every one of these requirements.

Roadshows were conducted primarily in provincial capitals, requiring rural practitioners to travel hundreds of kilometres at their own expense to participate. Sessions were conducted in English without provision for translation, excluding practitioners who think and practice in Indigenous languages. Technical documents were distributed without explanation or support, assuming levels of formal education that many practitioners do not possess. Digital platforms were prioritised despite the digital divide that excludes rural communities.

The Promotion of Administrative Justice Act 3 of 2002 requires that administrative action be lawful, reasonable, and procedurally fair. The rushed timeline, inadequate notice, and inaccessible formats of consultation constitute procedural unfairness that renders the entire process reviewable. Furthermore, the failure to consult with traditional leaders violates both customary law and constitutional provisions regarding traditional leadership, as Indigenous healing falls squarely within traditional leaders' cultural authority.

4.3. Legislative incoherence and conflicts

These Regulations exist in legislative isolation, creating conflicts with existing laws that would generate legal chaos. The Traditional Health Practitioners Act of 2007 provides the statutory framework for regulation, but these Regulations exceed and contradict that Act's provisions in multiple ways. The Act recognises diverse categories of practice, whilst the Regulations attempt to force all practitioners into biomedical frameworks. The Act acknowledges customary law, whilst the Regulations ignore it entirely.

The Indigenous Knowledge Systems Act 6 of 2019 (IKS Act) mandates the protection, promotion, and development of Indigenous knowledge, yet these Regulations would suppress Indigenous epistemologies in favour of Western frameworks. The National Environmental Management: Biodiversity Act 10 of 2004 protects traditional use of biological resources, yet the Regulations would restrict access to medicinal plants that healers have used sustainably for generations. Labour legislation presents another area of irreconcilable conflict, as the Basic Conditions of Employment Act 75 of 1997, Labour Relations Act 66 of 1995, and Occupational Health and Safety Act 85 0f 1993 were designed for formal employment relationships, not the spiritual calling of Indigenous healing.

4.4. Economic exclusion and impossible compliance burdens

The registration requirements impose impossible burdens on rural practitioners who may lack formal education, internet access, or the financial resources to comply with administrative demands. A healer who has served their community for decades, whose knowledge was

transmitted through oral tradition and spiritual initiation, must now produce certificates, complete forms in English, and pay fees that may exceed their monthly income. This is not regulation but exclusion by design.

The proposed fees and compliance requirements place a heavy burden on Indigenous health practitioners, particularly those operating in rural or marginalised communities. Many practitioners lack access to formal economic structures, making these costs prohibitive. Moreover, the Regulations do not clarify how fees will be reinvested into practitioner development, infrastructure, or community support, undermining trust and cooperation.

Beyond fees, mandatory registration will push practitioners into the formal economy, exposing them to multiple regulators and additional administrative fees without any parallel interventions to prepare them for such oversight. This risks creating new compliance delinquents by design and will likely be perceived as a form of strategic economic oppression, further eroding trust in government.

4.5. Indigenous-led regulation

Indigenous-led regulation is essential. Practitioners and community leaders with lived experience and deep knowledge of Indigenous health systems must guide the design, implementation, and enforcement of regulatory standards. South Africa's Constitution requires regulation that is:

- People-centred (Section 195).
- Respectful of self-determination (Section 235).
- Grounded in procedural fairness (Promotion of Access to Justice Act 3 of 2000 (PAJA)).
- Protects the integrity, cultural legitimacy, and operational viability of Indigenous practices.
- Aligns with constitutional obligations, including Section 235 (self-determination) and Section 195 (public administration principles).
- Addresses the socio-economic realities of rural and historically marginalised practitioners.
- Integrates Indigenous knowledge into national health strategies as community-based, rights-protected assets.
- Enables sustainable development, economic inclusion, and community wellbeing.
- Created through meaningful consultation.

An Indigenous-led regulatory model fulfils these obligations while ensuring sustainability, legitimacy, and trust. The noble challenge before the SEIAS is to enable this with the appropriate checks and balances that allow us to realise an effective and harmonious South African public health regulatory system. This means balancing indigenous practice and innovation in parallel with a biomedical *modus operandi*.

5. Key issues requiring urgent reform

While the draft Regulations represent an important step towards formalising Indigenous health practices in South Africa, our analysis reveals critical issues that require urgent reform to ensure inclusivity, cultural appropriateness, and effective integration into the national healthcare system. These issues, if left unaddressed, will render the Regulations unconstitutional, unimplementable, and harmful to the very communities they purport to serve.

5.1. Disjointed laws and regulations

The interaction between the Traditional Health Practitioners Act, the Traditional and Khoi-San Leadership Act 3 of 2019 (TKLA), the IKS Act, Labour law frameworks, health and science innovation policies, and the Constitution is neither seamless nor coherent. Each serves different purposes, sometimes conflicting, and this dissonance is reflected in the draft Regulations. TKLA was intended to formalise and empower traditional leadership, yet practical implementation has failed to integrate traditional leadership structures into health governance. Labour law frameworks currently do not support Indigenous health practitioners in workplace contexts, creating barriers for practitioners operating in formal employment settings.

The Department of Health must urgently:

- Harmonise the Regulations with the IKS Act, TKLA, Labour laws, and health innovation policies;
- Establish inter-departmental working groups to resolve legislative conflicts;
- Ensure traditional leaders are integrated into health governance structures; and
- Develop labour frameworks appropriate to Indigenous healing as a spiritual calling.

5.2. Terminology and language

The draft Regulations rely on Westernised terminology that inadequately reflects IHKS and violates Section 6 constitutional language rights. Central concepts such as *ukuthwasa* (spiritual initiation), *umoya* (spirit), and *ubungoma* (divination) are untranslatable without losing cultural meaning. The exclusive use of English creates barriers for practitioners who think and practice in Indigenous languages, effectively excluding them from their own regulation.

The Department of Sports, Arts and Culture, working with the Pan South African Language Board and National Heritage Council of South Africa, must:

- Develop Indigenous language terminology for regulatory frameworks;
- Translate all regulatory documents into the eleven official languages;
- Invest in language codification to support IKS growth and mainstreaming; and
- Ensure interpreters are available for all regulatory processes.

5.3. Biased interpretation of Indigenous practices

A Western-centric and Christianised lens dominates our jurisprudence and influences the interpretation and operationalisation of Indigenous health practices, undermining the holistic, spiritual, and community-oriented nature of IKS. The Witchcraft Suppression Act of 1957 continues to cast suspicion over Indigenous practices, conflating ancestral healing with superstition. This bias permeates the Regulations, which treat spiritual aspects of healing as secondary or irrelevant rather than central to practice.

The Department of Justice and Constitutional Development must:

- Immediately repeal the Witchcraft Suppression Act;
- Develop prosecutorial guidelines distinguishing harmful practices from legitimate healing;
- Train law enforcement on respecting Indigenous healing practices; and
- Establish mechanisms to address discrimination against Indigenous practitioners.

5.4. Western vs. Indigenous health definitions

The draft Regulations prioritise Western biomedical validation methods, which conflict with evidence-based Indigenous methodologies grounded in centuries of community experience. Indigenous health systems integrate physical, spiritual, emotional, and communal wellbeing in ways that cannot be reduced to biomedical categories. When the Regulations demand "scientific proof" for practices validated through generations of community observation, they impose impossible standards that no Indigenous practice can meet.

The Department of Science and Innovation must:

- Develop parallel validation frameworks respecting Indigenous epistemologies;
- Fund research using methodologies appropriate to Indigenous knowledge;
- Establish Indigenous Knowledge Research Centres at universities; and
- Support documentation of Indigenous practices using culturally appropriate methods (including digital tools).

5.5. Cost and accessibility barriers

The proposed Regulations impose fees and compliance requirements that effectively exclude rural and marginalised practitioners. Registration fees, annual renewals, continuing education costs, and administrative compliance create cumulative burdens that many practitioners cannot bear. With these fees come tax implications that further strain limited resources, as practitioners are pushed into the formal economy without preparation or support.

The National Treasury and South African Revenue Service must:

- Establish a tiered fee structure based on practitioner income and location;
- Provide tax exemptions for Indigenous health practitioners below income thresholds;

- Create a development fund supporting practitioner compliance and capacity building; and
- Ensure fees collected are reinvested in practitioner development rather than general revenue.

5.6. Council structure and governance

IPROSA supports the establishment of a regulatory council but stresses it must be genuinely practitioner-led, culturally informed, and representative of diverse Indigenous health systems. The current Interim Traditional Health Practitioner Council has failed to provide meaningful guidance or protection, operating without resources, authority, or legitimacy among practitioners. A new Council structure must be rooted in customary law whilst meeting constitutional requirements for transparency and accountability.

The Presidency, through the proposed Presidential Commission on Indigenous Knowledge, must:

- Establish a permanent Indigenous Health Practitioners Council with statutory authority;
- Ensure Council membership through both customary processes and democratic election;
- Provide Treasury funding rather than dependence on practitioner fees; and
- Mandate the Council to develop culturally appropriate standards and support mechanisms.

5.7. Research, codification, and integration

Indigenous health systems require documentation, codification, and research using culturally appropriate methodologies. Current research approaches extract knowledge without benefit-sharing, treat Indigenous knowledge as raw data rather than sophisticated systems, and apply inappropriate validation methods. Lessons from Traditional Chinese Medicine demonstrate that structured research can legitimise Indigenous practices without diluting core principles.

The Department of Higher Education and Training, with the National Research Foundation, must:

- Establish Indigenous-led research centres at universities;
- Develop research ethics protocols ensuring community benefit-sharing;
- Fund longitudinal studies documenting Indigenous health outcomes; and
- Support knowledge codification preserving oral traditions.

5.8. Consultation and rural exclusion

Meaningful consultation is critical for legitimacy and compliance, yet the 2024 roadshows disproportionately targeted urban areas, excluding rural communities where Indigenous knowledge systems are most actively practised. Online consultations are insufficient for practitioners lacking digital access, language skills, or familiarity with formal policy processes.

This exclusion violates constitutional requirements for public participation and undermines the Regulations' legitimacy.

The Department of Cooperative Governance and Traditional Affairs and Department of Health must:

- Conduct participatory consultations in every district, prioritising rural areas;
- Provide transport, accommodation, and subsistence for practitioner participation;
- Use Indigenous languages with skilled facilitation;
- Ensure traditional leaders are central to consultation processes; and
- Align consultation with SEIAS, constitutional obligations, and UNDRIP Article 19.

5.9. Transitional arrangements

The Regulations include provisions for transitional recognition of existing practitioners but provide insufficient support and guidance during this period. Many Indigenous health practitioners, particularly in rural areas, lack access to registration processes, required documentation, or formal training pathways. Without comprehensive transitional support, legitimate practitioners will be excluded whilst the Regulations claim to include them.

The Department of Health must establish:

- Clear pathways for transitional recognition based on community validation;
- Mobile registration units visiting rural communities;
- Document replacement services for practitioners lacking formal records; and
- Grandparenting provisions automatically recognising established practitioners..

5.10. Integration with the National Health System

The draft Regulations encourage collaboration between Indigenous and biomedical health systems, but integration remains largely conceptual. Without concrete mechanisms for cooperation, Indigenous practitioners remain marginalised whilst patients seeking integrated care face fragmented services. The National Health Insurance presents an unprecedented opportunity for integration, but only if Indigenous health is included from inception rather than as an afterthought.

The National Department of Health and NHI Fund must:

- Develop reimbursement models appropriate to Indigenous practice;
- Establish referral protocols between Indigenous and biomedical practitioners;
- Create Indigenous health units in hospitals and clinics;
- Train healthcare workers on collaborative practice models.

5.11. Monitoring, evaluation, and reporting

Current monitoring mechanisms are primarily top-down and Western-centric, overlooking culturally relevant indicators and community perspectives. Biomedical metrics cannot capture the holistic outcomes of Indigenous interventions, such as spiritual wellbeing, social cohesion, or community resilience. Without appropriate monitoring, the value of Indigenous health remains invisible to policymakers, perpetuating marginalisation.

The Department of Planning, Monitoring and Evaluation must:

- Develop indicators reflecting Indigenous health outcomes;
- Implement community-led evaluation processes;
- Ensure reporting mechanisms accessible to rural practitioners;
- Include Indigenous health data in national health surveillance.

5.12. Inter-departmental collaboration

The draft Regulations encourage interdepartmental collaboration, but implementation remains siloed. Departments responsible for Health, Science, Innovation, Agriculture, and Traditional Affairs operate independently, leading to fragmented support for Indigenous health systems. Without coordinated policy and resource allocation, initiatives overlap, conflict, or fail to reach communities needing support.

The Presidency must establish:

- An Inter-Ministerial Committee on Traditional Health;
- Coordinated budget allocations across departments;
- Shared performance indicators for Indigenous knowledge development; and
- Regular coordination meetings ensuring policy alignment.

5.13. Economic infrastructure and value chains

Indigenous health systems require supportive economic infrastructure enabling compliance whilst fostering sustainable development. Without value chain development, research facilities, and market access, practitioners remain trapped in subsistence whilst sitting on resources that could transform rural economies. The Regulations ignore economic dimensions entirely, treating Indigenous health as a regulatory problem rather than development opportunity.

The Department of Trade, Industry and Competition, with the Department of Agriculture, Land Reform and Rural Development, must:

- Establish medicinal plant cultivation programmes for small-scale farmers;
- Develop processing facilities in rural areas adding value at source;
- Create market linkages connecting producers with consumers;
- Support export development for Indigenous health products; and
- Implement intellectual property protection preventing biopiracy.

6. The Indigenous-led solution we propose

The challenges above underscore the need for a regulatory approach that is culturally grounded and community-driven. Embedding customary law at the core of Indigenous Health Practitioner regulation provides a solution that is both operationally effective and aligned with constitutional and public health obligations.

6.1 A revolutionary framework rooted in Constitutional values

We come not merely with critique but with a comprehensive alternative framework that would transform Indigenous Health Knowledge Systems into a cornerstone of our national health system, our economy, and our cultural renaissance. This framework, developed through extensive consultation with practitioners, traditional leaders, and communities, represents not Western-imposed regulation but Indigenous-led governance rooted in customary law, constitutional values, and international best practice.

At the heart of our proposal lies recognition that Indigenous health systems operate through different epistemologies that require different regulatory approaches. Just as our Constitution recognises legal pluralism through the coexistence of common and customary law, we propose health governance pluralism that allows Indigenous and biomedical systems to operate as complementary equals rather than hierarchical subordinates. This does not mean absence of regulation but rather regulation appropriate to each system's nature, with mechanisms for collaboration where systems intersect.

The foundation of Indigenous-led regulation must be customary law, which has governed healing practices successfully for centuries. Customary law provides mechanisms for recognising legitimate practitioners through community validation, maintaining ethical standards through collective accountability, resolving disputes through restorative justice, and protecting sacred knowledge whilst sharing beneficial practices. The Constitutional Court has repeatedly affirmed customary law's constitutional status and its evolution to meet contemporary needs.

IKS must inform every aspect of regulatory philosophy. Unlike Western biomedical ethics that emphasise individual autonomy, Indigenous healing operates through communal relationships and collective wellbeing. The Regulations must therefore focus not on individual compliance but on community accountability, not on punitive enforcement but on restorative support, not on standardised protocols but on contextual practice, and not on commercial competition but on collaborative service.

6.2 Institutional architecture for transformation

The institutional framework we propose begins with establishing a Presidential Commission on Indigenous Knowledge, similar to the Fourth Industrial Revolution Commission, but with the authority to drive comprehensive reform across government. This Commission would:

- Conduct thorough review of all legislation affecting Indigenous knowledge systems;
- Oversee genuine consultation with practitioners and communities;

- Develop evidence-based policy recommendations;
- Coordinate implementation across departments; and
- Monitor progress toward transformation.

The Indigenous Health Practitioners Council must be fundamentally reconceptualised from its current interim dysfunction to become a permanent, practitioner-led institution with statutory authority equivalent to the Health Professions Council of South Africa. This Council would be constituted through a combination of customary processes and democratic election, ensuring both traditional legitimacy and contemporary accountability.

Provincial and district structures would ensure grassroots participation and localised implementation. These structures would work with Indigenous leaders, traditional councils, community organisations, and local governments to identify and validate practitioners, support compliance with national standards, resolve local disputes, facilitate knowledge sharing, and promote community health. This decentralised approach recognises that Indigenous healing is inherently local, rooted in specific communities, landscapes, and traditions that cannot be governed from Pretoria.

6.3 Recognition pathways that respect Indigenous knowledge

Our framework proposes multiple pathways to recognition that respect diverse routes to becoming a healer whilst ensuring public protection:

The Ancestral Calling Pathway recognises those called through dreams, visions, or illness to become healers, validated through customary initiation processes and community recognition. This pathway acknowledges that many healers do not choose their profession but are chosen by ancestors, requiring different validation than voluntary career choices.

The Apprenticeship Pathway acknowledges learning through extended mentorship under established practitioners, with flexible timeframes recognising that spiritual development cannot be rushed. Some practitioners spend decades learning from elders, acquiring knowledge through observation, practice, and gradual revelation rather than formal curriculum.

The Specialisation Pathway differentiates between herbalists, diviners, birth attendants, bone setters, and other specialists, each with appropriate recognition requirements. Not all Indigenous healers practice the same methods or serve the same functions, and regulation must respect this diversity rather than forcing homogenisation.

The Grandparenting Pathway automatically recognises established practitioners with demonstrated community service, preventing the exclusion of elderly healers who hold irreplaceable knowledge. These knowledge holders must not be forced to prove their competence through Western frameworks after decades of successful practice.

Each pathway would have different but equivalent standards, recognising that a healer called by ancestors requires different validation than one who learned through apprenticeship. Community testimony would carry equal weight with formal certification. Oral knowledge would be valued

alongside written documentation. Spiritual authority would be recognised alongside technical skill.

7. Conclusion: The transformation agenda that will reshape South Africa's public health system

7.1. Building the Indigenous Health Economy

Our vision extends beyond regulation to transformation of Indigenous health into a major economic sector. This requires systematic development of value chains from cultivation through to export, investment in infrastructure and human capacity, protection of intellectual property, and integration with national economic planning. The rewards would be extraordinary, positioning South Africa as a global leader whilst creating sustainable livelihoods for millions.

Medicinal plant cultivation must transition from wild harvesting to sustainable agriculture, creating opportunities for small-scale farmers whilst ensuring conservation. The Department of Agriculture, Land Reform and Rural Development should prioritise medicinal plants as high-value crops suited to small-scale production and traditional knowledge. This includes research into cultivation techniques, development of quality standards, establishment of seed banks and nurseries, training for farmers, and ensuring market linkages.

Processing and manufacturing facilities must be established in rural areas where raw materials originate, adding value at source rather than perpetuating colonial patterns of raw material extraction. The Industrial Development Corporation and Development Bank of Southern Africa should provide patient capital for community-owned processing enterprises that ensure local benefit from local resources. These facilities would create employment, develop skills, generate tax revenue, and demonstrate that rural areas can host sophisticated industries.

Research and development investment must recognise Indigenous knowledge as the foundation for innovation rather than raw material for extraction. Universities should establish Indigenous knowledge research centres led by Indigenous knowledge holders. The Technology Innovation Agency should fund Indigenous knowledge-based innovation. The Medical Research Council should support clinical trials designed for traditional medicines. This research must ensure benefit-sharing with knowledge-holding communities through intellectual property agreements that recognise collective ownership.

7.2. Integrating Indigenous Health into Universal Coverage

The National Health Insurance represents an unprecedented opportunity to integrate Indigenous health into universal coverage, but only if we move beyond tokenistic inclusion to genuine integration. This means recognising Indigenous practitioners as primary healthcare providers, establishing referral systems between Indigenous and biomedical practitioners, including Indigenous medicines in essential medicine lists, and ensuring Indigenous health data informs health planning.

Primary healthcare re-engineering should position Indigenous practitioners as central rather than peripheral players. In rural areas where clinics are distant and doctors absent, Indigenous healers provide first-contact care for everything from respiratory infections to mental health crises. The Department of Health should support these practitioners through training in danger sign recognition, basic hygiene and infection control, referral protocols, and collaborative care models.

Collaborative care models should be developed for conditions where Indigenous and biomedical approaches complement each other. Mental health provides compelling examples where Indigenous approaches to spiritual distress complement biomedical psychiatry. Chronic diseases benefit from Indigenous emphasis on lifestyle and spiritual wellbeing alongside pharmaceutical management. These collaborations require mutual respect, clear protocols, and ongoing dialogue, but international experience demonstrates their effectiveness.

Infrastructure development must include spaces for Indigenous practice within public health facilities. This includes healing gardens where patients can connect with nature and medicinal plants, consultation rooms appropriate for Indigenous practices, spaces for cleansing and protection rituals, and storage for Indigenous medicines. These additions require minimal investment but signal profound respect for Indigenous healing and improve patient experience for the majority who value both Indigenous and biomedical care.

7.3. Creating the knowledge infrastructure for renaissance

The documentation, preservation, and development of Indigenous knowledge requires systematic investment in knowledge infrastructure that respects Indigenous epistemologies whilst enabling innovation. This is not about extracting Indigenous knowledge for Western science but creating spaces where Indigenous knowledge can flourish on its own terms whilst contributing to national development.

Indigenous Knowledge Centres should be established in every district, serving as repositories of local knowledge, training centres for practitioners, research facilities for documentation and innovation, and community spaces for knowledge transmission. These centres would be governed by local knowledge holders, staffed by Indigenous knowledge experts, equipped with appropriate technology, and linked through national networks. The Department of Science and Innovation, working with provincial governments, must allocate resources for establishing these centres as national priority infrastructure.

Digital platforms designed with Indigenous communities could revolutionise knowledge preservation and sharing whilst respecting sacred and secret knowledge. Video documentation could capture healing practices for training purposes, audio recordings could preserve healing songs and prayers, databases could catalogue medicinal plants and their uses, and networks could connect practitioners for knowledge exchange. The Department of Communications and Digital Technologies must ensure these platforms serve Indigenous communities rather than extracting from them, with blockchain technology ensuring community ownership and benefit-sharing from any commercialisation.

Language development is essential for Indigenous knowledge advancement. Indigenous languages contain concepts and categories that English cannot adequately express, yet technical terminology often lacks Indigenous equivalents. The Pan South African Language Board, working with the Department of Basic Education and Department of Higher Education, must prioritise Indigenous health terminology development as essential to language preservation and knowledge advancement. This requires collaboration between linguists, practitioners, and communities to develop terms that accurately convey Indigenous concepts whilst enabling contemporary application.

Educational transformation must extend from primary school through university to integrate Indigenous knowledge into curricula. Children should learn about medicinal plants alongside photosynthesis, Indigenous healing alongside germ theory, and cultural approaches to health alongside biomedical frameworks. Universities should offer degrees in Indigenous health sciences taught by Indigenous experts. Medical schools should include Indigenous health in curricula to prepare doctors for collaborative practice. This is not replacing science education but enriching it with knowledge systems that have sustained African communities for millennia.

7.4. Conclusion

We close with an Indigenous principle that is used often but seldomly applied: *ubuntu*, the understanding that we are human through other humans past, now, and coming, that individual wellbeing depends on collective flourishing, that knowledge systems enrich rather than threaten each other. *Ubuntu* requires recognising that Indigenous knowledge is not competing with Western knowledge but has a completely different focus: Wellbeing in people, planet and future. Both systems have strengths and limitations. Both serve important purposes. Both deserve respect and support. Our task is not choosing between them but complementing them for collective benefit.

Ubuntu demands that we see Indigenous practitioners not as threats to modern medicine but as partners in healing. It requires understanding that patients seeking Indigenous healing are not rejecting science but seeking holistic care that addresses their spiritual and cultural needs alongside physical symptoms. It insists that communities maintaining Indigenous traditions are not backward but are preserving knowledge essential for sustainable futures. It recognises that supporting Indigenous knowledge is not charity but investment in our collective wellbeing.

In the spirit of *ubuntu*, IPROSA extends its hand in partnership to build the South Africa our Constitution envisions. We offer our knowledge, our commitment, and our communities to this collective effort. We ask only that Indigenous knowledge be recognised, respected, and resourced as it deserves. We seek not dominance but dignity, not special treatment but equal treatment, not charity but justice. These are not unreasonable demands but minimum requirements for constitutional democracy that claims to belong to all who live in it.

The choice before you is ultimately simple: Will you perpetuate the colonial wound that divides and diminishes us, or will you champion the Indigenous knowledge renaissance that can heal and elevate us? Will you be remembered as leaders who maintained an unjust status quo, or as transformative figures who completed the decolonisation our political freedom began? Will you

choose the path of least resistance that leads nowhere, or the challenging path of transformation that leads to the South Africa we all deserve?

We have presented our case with the thoroughness this moment demands. We have offered solutions with the comprehensiveness transformation requires. We have extended partnership with the sincerity *ubuntu* embodies. Now we wait, with hope tempered by history but sustained by possibility, for your response. The ancestors are watching. History is recording. The Constitution is waiting. The choice, honourable leaders, is yours.

In the words of our ancestors: *"Motho ke motho ka batho"* — a person is a person through other persons.

May this wisdom guide your deliberations and decisions.

Submitted with deep respect and urgent hope,

IPROSA (on behalf of Indigenous health practitioners, traditional leaders, and communities across South Africa).

Camagu!

To engage us, please contact:

Mkz Bhanekazi Mpumlwana
Managing Director
INDIGENOUS PROFESSIONS OF SOUTHERN AFRICA NPC
E: info@iprosa.org
W: www.iprosa.org