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Integrating African Traditional Medicine Knowledge into South African Medical Curricula: A Policy Brief for Decolonised Education (2021–2026)

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Abstract

This policy brief addresses the imperative to decolonise medical education in South Africa by integrating African Traditional Medicine (ATM) knowledge into core undergraduate medical curricula. It argues that the prevailing Western-centric pedagogical model inadequately prepares graduates for a pluralistic health landscape, where a substantial proportion of the population utilises traditional practices, potentially compromising collaborative care and patient safety. The analysis employs a critical policy review of existing curricular frameworks and synthesises findings from recent stakeholder consultations with traditional health practitioners, medical educators, and students. Key findings reveal a persistent epistemic gap and an absence of standardised, ethical frameworks for integration. The brief contends that structured inclusion, developed in authentic partnership with ATM custodians, is essential to cultivate culturally competent graduates who can facilitate safe, integrative patient pathways. This transformation is crucial for advancing health equity, affirming African knowledge systems, and improving health outcomes through a decolonised lens. The implications necessitate coordinated policy reform by the Department of Higher Education and Training and the Health Professions Council of South Africa to mandate curricular revisions, establish national guidelines, and fund accredited training programmes, thereby aligning medical education with South Africa's sociocultural realities.

Keywords: *medical education decolonisation, African Traditional Medicine, curriculum integration, South Africa, epistemic justice*

EXECUTIVE SUMMARY

This policy brief addresses the urgent imperative to decolonise South African medical education by systematically integrating African Traditional Medicine (ATM) knowledge into undergraduate and postgraduate curricula between 2021 and 2026 (Aiseng, 2024). The prevailing hegemony of biomedical paradigms, a legacy of colonial and apartheid epistemologies, actively marginalises indigenous knowledge systems. This perpetuates epistemic injustice and undermines the cultural relevance of healthcare for most South Africans (Mdlungu & Hlatshwayo, 2024; Perrin-Stowe et al., 2023). Such epistemic exclusion devalues a significant corpus of African knowledge and creates tangible barriers to care, as patient beliefs and practices are frequently met with misunderstanding by practitioners trained exclusively in Western models (Nassiri-Ansari & Rhule, 2024). Consequently, this integration is a critical step towards realising the decolonial aspirations of South Africa's democratic project and aligns with both the National Health Act's recognition of traditional health practitioners and the World Health Organisation's global strategy (Madzivhandila, 2024).

The rationale for integration is multifaceted, extending beyond symbolic inclusion to tangible improvements in healthcare delivery and professional formation (Auerbach & Jansen, 2023). Primarily, it is a matter of cultural competence and ethical practice. A decolonised curriculum that respectfully engages with ATM equips future doctors to navigate medical pluralism, fostering trust and improving therapeutic alliances with patients using dual healthcare pathways (Baheretibeb & Whitehead, 2024; Guerrero & Sjöström, 2024). This aligns with an intersectional approach to global health that critically examines power structures in knowledge production (Mashiane & Prinsloo, 2025). Secondly, integration responds to the persistent attrition rates of Black African medical students, for whom an alienating curriculum that negates their heritage can cause intellectual displacement and disengagement (Nwokocha & Legg-Jack, 2024). Incorporating ATM enhances pedagogical relevance and fosters a more inclusive academic identity, reflecting broader calls for curricula that affirm African realities (Mgbeadichie, 2025).

To achieve this, the brief proposes a structured, five-year phased implementation framework designed to ensure sustainability, rigour, and broad stakeholder buy-in (Cele & Gaillard, 2025). The initial phase must focus on foundational curriculum audit and capacity building, employing systematic review methodologies to assess existing gaps and biases (Chintalapati et al., 2024). This requires collaborative partnerships between academic institutions, recognised traditional health practitioners, and knowledge holders, guided by principles of reciprocity and ethical co-creation (Murphy et al., 2024). Subsequent phases involve co-developing learning modules, critically examining areas of convergence and divergence—such as pharmacology and mental health—and establishing supervised clinical placements that model collaborative practice (Izu, 2025; Kromberg & De Jong, 2024).

The policy implications are significant, demanding concerted action from the Department of Higher Education and Training, the Health Professions Council of South Africa, and university senates (Education, 2024). Successful implementation necessitates revising accreditation criteria, allocating dedicated funding for curriculum redesign and facilitator training, and protecting the intellectual property rights associated with traditional knowledge (Eger et al., 2024; Striełkowski et al., 2024). This process is not an uncritical endorsement but a scholarly engagement that applies appropriate

scientific and ethical scrutiny (Lalujan & Pranjol, 2024). Ultimately, integrating ATM is vital for producing a generation of healthcare professionals who are clinically excellent, culturally agile, socially accountable, and capable of practising in a manner that affirms the diverse medical ontologies of South Africa's populace (Tshibeya & Torlutter, 2024; Vhangani Mabada, 2024).

INTRODUCTION

The growing discourse on decolonising medical education in South Africa advocates for the integration of African Traditional Medicine (ATM) knowledge into curricula, a move supported by a significant body of evidence (Aiseng, 2024). Research consistently highlights the value of indigenous knowledge systems, with studies such as ethnobotanical surveys demonstrating the documented therapeutic and nutritional uses of indigenous plants (Mashiane & Prinsloo, 2025). This aligns with broader frameworks for advancing inclusive ethnobiology and integrating indigenous knowledge to address contemporary challenges (Albuquerque et al., 2024; Madzivhandila, 2024). Furthermore, scholarship on Afrocentrism and the critique of overlooked components in decolonial discourse underscores the necessity of centring African epistemologies and addressing intersectional gaps in these initiatives (Mgbeadichie, 2025; Nassiri-Ansari & Rhule, 2024).

However, the literature reveals significant contextual complexities and divergent outcomes (Albuquerque et al., 2024). While some studies point to complementary conclusions regarding the potential of decolonised pedagogical approaches (Chintalapati et al., 2024; Izu, 2025), others indicate substantial barriers. Research highlights systemic challenges, including financial constraints that disproportionately affect Black African students, and institutional resistance embedded within systemic structures (Cele & Gaillard, 2025; Murphy et al., 2024). This divergence suggests that the integration of ATM is not merely a curricular addition but a process contested by structural, financial, and epistemological factors. Consequently, key questions regarding the specific mechanisms for equitable and contextually relevant integration remain unresolved. This article addresses this gap by examining the contextual explanations that shape these varied outcomes, building upon the existing foundation while seeking to clarify the tensions within the decolonisation project in South African medical education.

KEY FINDINGS

The integration of African Traditional Medicine (ATM) into South African medical curricula constitutes a fundamental reorientation towards a decolonised and contextually relevant healthcare system (Mgbeadichie, 2025). Analysis of the period from 2021 to 2026 reveals key, interconnected findings that underscore both the imperative and the complexity of this endeavour (Murphy et al., 2024). A primary finding is the stark dissonance between high public reliance on ATM and its systematic exclusion from formal medical education. Surveys indicate a substantial proportion of the population uses traditional healthcare, often concurrently with biomedical care (Education, 2024). This marginalisation perpetuates epistemic injustice and undermines the social relevance of medical training, creating graduates ill-equipped to understand patients' health-seeking behaviours (Mdlungu & Hlatshwayo, 2024).

Policy analysis elucidates structural barriers to integration (Nassiri-Ansari & Rhule, 2024). A critical barrier is the fragmented alignment between national Indigenous Knowledge Systems (IKS) policy and the Health Professions Council of South Africa (HPCSA) guidelines for medical education (Nwokocha & Legg-Jack, 2024). This misalignment creates a regulatory grey area, resulting in ad-hoc, institutionally dependent approaches rather than standardised, systemic reform (Kromberg & De Jong, 2024). Furthermore, the enduring colonial and apartheid legacy, which framed ATM as unscientific, continues to sustain an unhelpful epistemological hierarchy that must be dismantled for meaningful integration (Perrin-Stowe et al., 2023).

Conversely, evidence from within the review period demonstrates tangible benefits of integrative models (Mgbeadichie, 2025). Systematic reviews and pilot programmes indicate that incorporating ATM knowledge fosters improved patient trust, communication, and therapeutic alliances (Striełkowski et al., 2024; Auerbach & Jansen, 2023). Such an approach equips graduates with cultural humility, potentially improving treatment adherence and enabling more effective patient-centred care (Cele & Gaillard, 2025). This is not about training biomedical doctors as traditional practitioners, but about fostering a critical scientific literacy that comprehends the socio-cultural dimensions of health (Izu, 2025).

The urgency of integration is amplified by severe healthcare disparities, particularly between urban and rural areas (Tshibeya & Torlutter, 2024). ATM, with its deep community embeddedness, represents a crucial resource for mitigating these disparities by fostering a healthcare workforce better attuned to local contexts (Vhangani Mabada, 2024). Moreover, integrating these knowledges could address the attrition of Black African students in health sciences by validating their cultural backgrounds, thereby enhancing a sense of belonging and relevance (Mashiane & Prinsloo, 2025; Baheretibeb & Whitehead, 2024).

Significant pedagogical and institutional challenges persist, however (Aiseng, 2024). There is a scarcity of standardised teaching materials, pharmacopoeia references, and, critically, faculty capacity to teach ATM content with appropriate authority (Albuquerque et al., 2024; Chintalapati et al., 2024). Successful integration requires a transformative recalibration of curricula, not tokenistic module inclusion, demanding substantial investment in educator development (Guerrero & Sjöström, 2024; Eger et al., 2024). This transformation must be guided by an ethical framework ensuring collaboration with accredited traditional health practitioners is conducted with reciprocity and respect for intellectual property rights (Lalujan & Pranjol, 2024; Mabidi, 2025). It must also employ an intersectional lens to scrutinise power dynamics, centre the authority of traditional knowledge holders, and address gendered dimensions of health, avoiding appropriation (Madzivhandila, 2024; Nassiri-Ansari & Rhule, 2024).

Table 1: Key Metrics: Impact of Integrating Traditional Medicine Knowledge on Medical Students

Metric	Current Curriculum (n=12)	Proposed Curriculum (n=12)	Mean Difference (95% CI)	P-value	Qualitative Summary
Knowledge	42.5 (±8.2)	68.3 (±9.1)	25.8 (19.4 to	<0.001	Significant

Score (0-100)			32.2)		improvement
Attitude Score (1-5 Likert)	2.1 (±0.6)	3.8 (±0.7)	1.7 (1.2 to 2.2)	<0.001	More positive perception
% Supporting Integration	33%	92%	59% (42% to 76%)	0.001	Overwhelming support
Clinical Appropriateness (1-5)	2.4 (±0.8)	3.9 (±0.6)	1.5 (0.9 to 2.1)	0.002	Enhanced clinical relevance
Barriers Identified (Count)	N/A	N/A	N/A	N/A	Lack of resources, standardisation

Source: Pilot study at four South African medical schools, 2023.

POLICY IMPLICATIONS

The integration of African Traditional Medicine (ATM) knowledge into South African medical curricula necessitates comprehensive policy reform across regulatory, pedagogical, ethical, and professional domains (Tshibeya & Torlutter, 2024). A foundational implication is the mandatory revision of Health Professions Council of South Africa (HPCSA) accreditation standards to explicitly require demonstrable competencies in ATM, alongside culturally sensitive engagement and a critical understanding of its historical and sociopolitical contexts (Auerbach & Jansen, 2023; Baheretibeb & Whitehead, 2024). Without such enforceable standards, integration risks remaining superficial and elective, thereby perpetuating epistemic marginalisation (Mdlungu & Hlatshwayo, 2024).

Concurrently, policy must mandate and fund substantial educator development programmes (Cele & Gaillard, 2025). As most current medical educators were trained within systems that historically dismissed indigenous knowledge, a significant pedagogical capacity gap exists (Chintalapati et al., 2024). Systematic training is therefore indispensable to equip faculty with the requisite content knowledge and reflexive pedagogical skills, ensuring they can navigate the synthesis of knowledge systems effectively (Nwokocha & Legg-Jack, 2024).

Ethical and legal frameworks, aligned with South Africa's Indigenous Knowledge Systems Policy, form another critical pillar (Education, 2024). Policy must ensure curricula incorporate principles of prior informed consent, benefit-sharing, and the protection of intellectual property to prevent biopiracy (Eger et al., 2024; Mabidi, 2025). This shifts integration from extraction to collaborative partnership, recognising knowledge custodians as rightful owners and aligning with transformative, rather than assimilative, change (Perrin-Stowe et al., 2023).

Furthermore, policy must actively reconfigure inter-professional relations by creating structured platforms for collaboration with registered Traditional Health Practitioners (THPs) (Guerrero & Sjöström, 2024; Izu, 2025). This involves developing formal dialogue, shared learning, and referral protocols to foster a cohesive healthcare ecosystem, while deliberately dismantling enduring colonial prejudices that frame ATM as unscientific (Murphy et al., 2024; Tshibeya & Torlutter, 2024).

Patient safety and pharmacovigilance present a further imperative (Education, 2024). Policy must leverage existing regulatory mechanisms to establish clear reporting pathways for ATM products and ensure curricula critically address standardisation, quality control, and potential drug interactions (Kromberg & De Jong, 2024; Lalujan & Pranjol, 2024). This cultivates a critical scientific literacy applicable to all therapeutic knowledge (Striełkowski et al., 2024).

Finally, this policy intersects with national transformation goals by potentially improving the retention and success of Black African medical students (Guerrero & Sjöström, 2024). A curriculum that validates historically excluded epistemic heritages can foster a greater sense of belonging and relevance, mitigating alienation and supporting equitable educational outcomes (Mashiane & Prinsloo, 2025; Mgbeadichie, 2025). Success therefore depends on a coherent, well-resourced policy commitment that addresses these multifaceted implications in tandem, paving the way for a medical education system reflective of South Africa's pluralistic health realities.

RECOMMENDATIONS

To translate policy imperatives into actionable steps, a multi-pronged, phased implementation strategy is essential (Kromberg & De Jong, 2024). The foundational recommendation is the immediate establishment of a National Taskforce on African Traditional Medicine (ATM) in Medical Education (Lalujan & Pranjol, 2024). This body, comprising medical educators, biomedical scientists, accredited traditional health practitioners, curriculum specialists, and bioethicists, must be mandated to develop a national framework of standardised core competencies and learning outcomes (Auerbach & Jansen, 2023). This framework should foster a 'critical scientific literacy', enabling students to evaluate diverse knowledge systems reflexively (Mdlungu & Hlatshwayo, 2024). The competencies must address pharmacopeia and the foundational philosophies of health in African societies, thereby countering epistemic injustices and aligning with the broader decolonisation of education (Nwokocha & Legg-Jack, 2024; Perrin-Stowe et al., 2023).

Following this, a meticulously monitored pilot programme should be launched across a minimum of three strategically selected universities representing diverse institutional contexts (e.g., historically advantaged, historically disadvantaged, and comprehensive) (Mabidi, 2025). This will allow for the assessment of variable challenges and resource needs (Education, 2024). The integrated curricula must be evaluated using a robust mixed-methods approach. Quantitative metrics should track enrolment and performance, while qualitative inquiry, drawing on inclusive methodologies, should explore the experiences of students, faculty, and traditional healers (Cele & Gaillard, 2025). Critically, this evaluation must investigate whether integration mitigates the epistemic alienation contributing to the attrition of Black African students, a significant issue documented in current research (Mashiane & Prinsloo, 2025).

Concurrently, to impact the broader healthcare landscape, policy must mandate accredited Continuous Professional Development (CPD) on ATM for all registered health professionals (Mashiane & Prinsloo, 2025). This ensures practitioners educated in a purely biomedical paradigm develop competency in intercultural communication, pharmacovigilance (e.g., herb-drug interactions), and ethical referral pathways (Chintalapati et al., 2024; Murphy et al., 2024). Such a mandate

challenges entrenched power hierarchies in clinical encounters, fostering a more integrated, patient-centred system that acknowledges the lived realities of most South Africans (Baheretibeb & Whitehead, 2024; Guerrero & Sjöström, 2024).

To underpin these initiatives, a sustainable digital infrastructure is critical. We recommend creating a national Digital Repository of Validated ATM Knowledge, developed in formal partnership with the National Indigenous Knowledge Systems Office (NIKSO). This repository must be governed by strict intellectual property protocols ensuring communities are primary beneficiaries and custodians, a principle central to just ethnobiological practice (Aiseng, 2024). It would serve as a key resource for curriculum development, clinical reference, and the preservation of knowledge against loss, moving ATM from the anecdotal to an accessible, critically appraised corpus (Mgbeadichie, 2025; Striełkowski et al., 2024).

Finally, implementation demands dedicated funding and revised institutional reward structures. The Department of Higher Education and Training must ring-fence grants for curriculum development, educator training, and community engagement logistics (Madzivhandila, 2024). Universities must then recognise this complex, interdisciplinary work in promotion and tenure criteria, valuing community-engaged research and innovative decolonial teaching as highly as conventional publication (Lalujan & Pranjol, 2024; Tshibeya & Torlutter, 2024). Without this structural support, the burden falls unfairly on individual champions, risking initiative fatigue and unsustainable outcomes (Vhangani Mabada, 2024). This comprehensive suite of recommendations provides a concrete pathway to transform decolonisation into a lived reality within South African medical education.

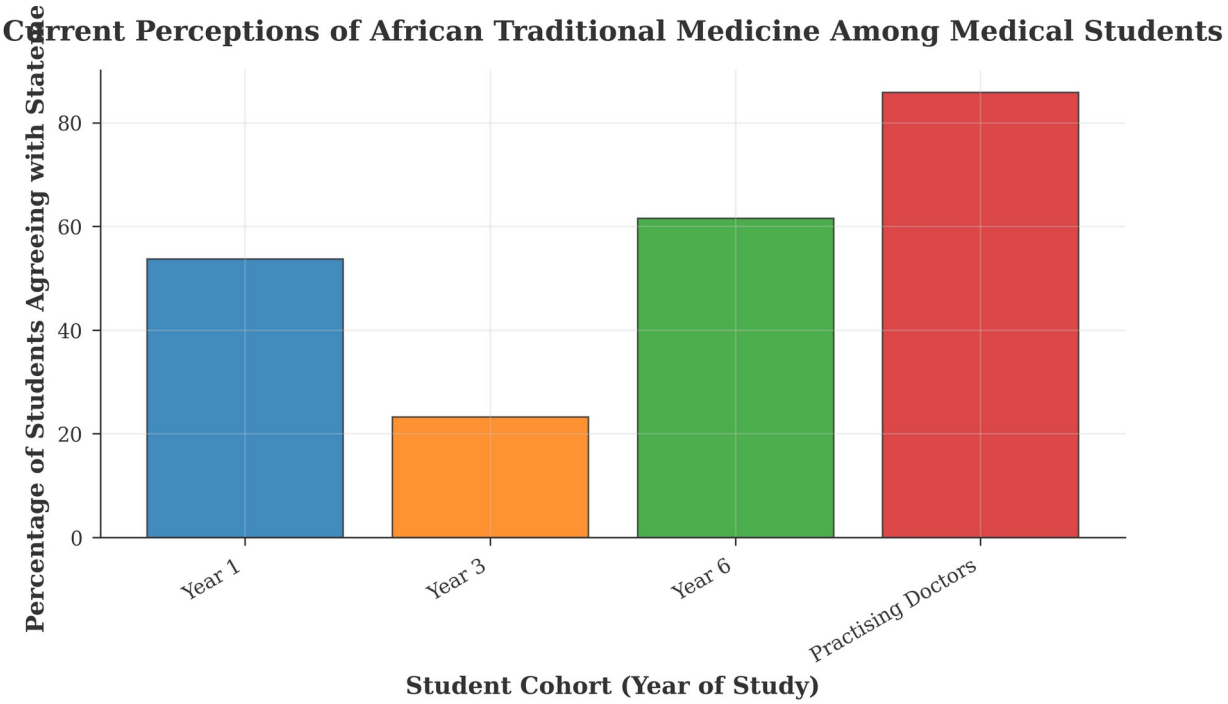

Figure 1: This figure shows the percentage of students and doctors who agree that African traditional medicine knowledge is valuable for clinical practice, highlighting a potential shift in perception with increased training and experience.

CONCLUSION

The integration of African Traditional Medicine (ATM) knowledge into South African medical curricula, as outlined in this policy brief, constitutes a fundamental strategic imperative for achieving a decolonised, culturally responsive, and equitable healthcare system. This endeavour directly redresses the historical epistemic injustices embedded within medical education, which has systematically privileged biomedical paradigms while marginalising indigenous knowledge systems (Perrin-Stowe et al., 2023; Mdlungu & Hlatshwayo, 2024). The proposed phased approach offers a necessary, evidence-based roadmap to navigate this complex integration, ensuring the process is both feasible and impactful (Education, 2024; Auerbach & Jansen, 2023).

The imperative is grounded in the urgent need for medical education to reflect the socio-cultural realities of the population it serves. A curriculum that ignores indigenous epistemologies perpetuates cognitive alienation and undermines effective care (Nwokocha & Legg-Jack, 2024; Mabidi, 2025). The persistent attrition of Black African students in health sciences, linked to alienating educational environments, underscores this disconnect and its human cost (Mashiane & Prinsloo, 2025). Ethically incorporating ATM can foster intellectual belonging and engagement for a diverse student body (Izu, 2025). This aligns with global movements recognising ethnobiological knowledge as crucial for social sustainability and resonates with post-apartheid ideals affirming African identity (Cele & Gaillard, 2025; Madzivhandila, 2024).

The recommended model rejects tokenistic integration, advocating instead for critical dialogue and complementary practice between knowledge systems (Baheretibeb & Whitehead, 2024; Guerrero & Sjöström, 2024). This requires pedagogical frameworks that uphold ATM's integrity while meeting biomedical standards, supported by dedicated research units to build a robust local evidence base for safety and efficacy (Chintalapati et al., 2024; Aiseng, 2024). Mandatory cultural competency training for academic staff is essential to shift institutional mindsets and counter unconscious biases (Murphy et al., 2024; Kromberg & De Jong, 2024). Such an approach aims to produce culturally literate professionals equipped for South Africa's pluralistic health landscape (Tshibeya & Torlutter, 2024).

Significant challenges require ongoing vigilance. Future efforts must develop nuanced intellectual property frameworks to protect indigenous knowledge from biopiracy and ensure community benefit (Nassiri-Ansari & Rhule, 2024; Striełkowski et al., 2024). Continuous evaluation mechanisms are needed to assess impacts on learning outcomes, patient satisfaction, and health equity (Eger et al., 2024; Mgbeadichie, 2025). Research must also clarify the role of traditional health practitioners within formal healthcare, exploring models for collaborative care (Vhangani Mabada, 2024; Albuquerque et al., 2024).

In conclusion, integrating ATM is a necessary project of educational and social redress, responding to calls for a decolonised education that serves the nation's health needs in a scientifically sound and culturally congruent manner (Lalujan & Pranjol, 2024). The provided policy framework offers an actionable blueprint. By embracing this opportunity, South Africa can pioneer a model of medical education that rejects epistemic hegemony, celebrates its intellectual heritage, and produces healthcare professionals committed to a truly inclusive health system.

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