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Contextualising Mental Privacy in South Africa: Legal, Ethical, and Socio-Cultural Considerations With Policy Recommendations

Marietjie Botes[1,2] | Melodie Labuschaigne[3] | Camille Casteleyn[4] | Becky Inkster[5,6] | Mark Sheppard[6,7]

[1]Centre for Research Evaluation Science and Technology (CREST), Stellenbosch University, Stellenbosch, Western Cape, South Africa | [2]School of Law, University of KwaZulu Natal, Mazisi Kunene Road, Durban, South Africa | [3]Department of Jurisprudence, University of South Africa, Preller Street, Pretoria, Gauteng, South Africa | [4]Albert Luthuli Leadership Institute (ALLI), University of Pretoria, Lynnwood Road, Pretoria, Gauteng, South Africa | [5]Department of Psychiatry, University of Cambridge, Trinity Lane, Cambridge, Cambridge, UK | [6]Independent Research Lab, The Lαβ, Trinity Street, Cambridge, Cambridge, UK | [7]School of Computing, University of Kent, UK

Correspondence: Marietjie Botes (marietjiebotes1@gmail.com)

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ABSTRACT

Mental privacy is a growing concern as neurotechnologies and digital mental health tools collect and process sensitive brain-related data. In South Africa, cultural and religious diversity adds complexity to protecting mental privacy, with traditional healing practices, communal decision-making, and spiritual beliefs influencing mental health perceptions and care. This article examines the ethical, legal, and socio-cultural challenges of mental privacy in South Africa, focusing on cognitive autonomy, informed consent, and exploitation risks. It critiques global regulatory frameworks, highlighting the limitations of the EU's GDPR and the fragmented US approach in addressing culturally diverse and economically unequal contexts. The article proposes enhancements to South Africa's Protection of Personal Information Act, emphasising the need for explicit classification of neural and mental health data as sensitive categories. Additionally, it recommends culturally informed consent processes, collaboration with traditional and religious leaders, and public awareness initiatives to ensure inclusive mental privacy protections that respect cultural diversity while safeguarding individual rights.

1 | Introduction

Mental privacy is an emerging area of concern as advancements in neurotechnology and digital health applications enable the collection and processing of sensitive brain-related data. These technologies hold immense potential for improving mental health care, but they also raise significant ethical, legal, and social challenges. South Africans in particular face unique challenges in accessing and understanding mental privacy protections due to cultural and religious beliefs that significantly influence how mental health is conceptualised, treated, and disclosed. South Africans, in particular, face distinct challenges in accessing and understanding mental privacy protections due to wide disparities in health literacy, cultural diversity, and persistent socioeconomic inequality. Empirical data from the South African Stress and Health Survey [1], and recent community-based studies [2] indicate that understandings of mental health and disclosure practices vary substantially across linguistic, cultural, and socioeconomic lines. These findings suggest that notions of privacy and autonomy in mental health contexts cannot be generalised to all South Africans but are shaped by context-specific conceptions of the self, illness, and care. Traditional healing practices, spiritual interpretations, and communal approaches to care often conflict with the biomedical model's emphasis on individual autonomy and confidentiality. For example, traditional healers often interpret mental disturbances as manifestations of

ancestral displeasure or spiritual imbalance, requiring ritual cleansing or community participation to restore harmony, whereas biomedical practitioners conceptualise such conditions through diagnostic frameworks that privilege individual autonomy, confidentiality, and psychopharmacological or psychotherapeutic treatment [3, 4]. These contrasting epistemologies reveal how notions of healing, responsibility, and privacy are differently configured within South Africa's pluralistic health system. However, these practices are rarely purely traditional or entirely Western in form. In post-apartheid South Africa, healing systems are increasingly syncretic, combining ancestral cosmologies, Christian theology, and biomedical methods in dynamic and context-specific ways [5, 6]. For example, some sangomas incorporate prayer and church rituals into divination, while faith healers draw upon both scripture and indigenous plant medicines. This hybridity reflects a pragmatic adaptation to modernity rather than a simple opposition between tradition and biomedicine, complicating assumptions about where privacy, autonomy, and disclosure boundaries are drawn.

This complex interplay shapes South African perspectives on mental privacy, making it critical to balance respect for cultural diversity with safeguards against exploitation and stigmatisation. The South African experience of privacy and autonomy cannot be fully understood without acknowledging its apartheid history, during which the Black population was systematically denied both bodily and mental privacy. Apartheid's surveillance apparatus and racialised medical systems subjected individuals to forced searches, non-consensual examinations, and coercive psychiatric interventions, effectively rendering privacy a privilege of race and power [7, 8]. These historical infringements have left deep social and psychological imprints that continue to shape contemporary attitudes toward disclosure, consent, and trust in biomedical institutions. Understanding this legacy is essential for situating present-day debates about mental privacy and neurorights within South Africa's broader struggle for dignity, equality, and justice.

While global debates on neurorights and mental privacy are growing, no South African study has yet analysed how these issues intersect with the country's socio-cultural heterogeneity and postcolonial context. This article therefore addresses a critical gap by situating discussions of mental privacy within South Africa's pluralistic and hybrid healthcare traditions, where spiritual, communal, and biomedical perspectives converge. While Botes (2025) explored ethical and legal frameworks for mental privacy at a global level [9], this study extends that analysis by contextualising these debates within South Africa's unique socio-legal landscape and the enduring effects of colonial and apartheid legacies on perceptions of autonomy, confidentiality, and mental health. Whereas existing global research tends to conceptualise neurorights within Western legal and ethical frameworks [10], the present study demonstrates how South Africa's hybrid systems of care, linguistic diversity, and postcolonial context complicate assumptions about autonomy, consent, and confidentiality. The following discussion draws out these context-specific insights across three interconnected dimensions, legal, socio-cultural, and ethical, thereby highlighting the implications for policy and governance. This article investigates South Africa's socio-cultural and legal landscape in relation to both local and international mental privacy rights, concluding with recommendations that respect cultural and religious diversity while safeguarding individual privacy and digital exploitation. By integrating global insights with local contexts, the article seeks to contribute to the development of a culturally sensitive and ethically robust legal framework for mental privacy in South Africa.

2 | Global Discourse on Mental Privacy: EU and US Perspectives

The global discourse surrounding mental privacy, cognitive autonomy, and digital vulnerability has grown increasingly significant due to advances in neurotechnologies, digital mental health tools, and AI-driven systems [11]. These concepts highlight critical ethical and legal challenges at the intersection of neuroscience, technology, and fundamental human rights [12]. Mental privacy refers to the protection of one's brain data or mental states from unauthorised access or manipulation [13]. Cognitive autonomy emphasises the right to think freely, independently, and without coercion [14], while digital vulnerability underscores the risks that arise when individuals rely on digital tools, exposing them to breaches in privacy, identity, and autonomy [15].

The European Union (EU) has established itself as a leader in regulating data protection. The General Data Protection Regulation (GDPR) plays a central role in protecting personal data, explicitly classifying health data as “special category” data under Article 9 [16]. The GDPR imposes strict requirements, including informed consent, transparency, and accountability for data processing, which per interpretation also extend to mental health apps and neurotechnologies. Scheibner et al. emphasise that the GDPR not only provides robust protections but also sets a global benchmark for health data ethics and use [17].

In addition to the GDPR, the discourse on neuro-rights has gained traction within the EU. Scholars such as Ienca and Farinella advocate for the explicit integration of neuro-rights into human rights frameworks to address the ethical challenges posed by neurotechnologies [18, 19]. These rights include protections for mental privacy and cognitive liberty, underscoring the need for legal mechanisms to safeguard brain-related data from misuse or manipulation.

The EU literature raises considerable concerns regarding the collection and processing of sensitive data by mental health applications [20]. Many of these tools collect behavioural and neural data, which are often shared with third-party providers. Ferretti highlights the risk of data exploitation and misuse, particularly when mental health data is processed without full transparency or adherence to GDPR principles [21]. Kaye et al. further emphasise that users often lack a comprehensive understanding of how their mental health data will be used, undermining informed consent and ultimately cognitive autonomy [22]. Scholars such as Ligthart et al. argue that neuro-rights, particularly mental privacy and cognitive liberty, should be integrated into legal and ethical frameworks to address emerging risks posed by brain data collection and manipulation [23]. However, despite the GDPR's strong foundations, gaps remain in explicitly addressing neuro-rights and their intersection with advancing neurotechnologies.

In contrast, the United States (US) lacks a unified federal data protection law comparable to GDPR. Instead, the regulation of health and mental health data is fragmented. The Health Insurance Portability and Accountability Act (HIPAA) provides protections for health data but applies only to "covered entities," such as healthcare providers and insurers [24]. Terry notes that HIPAA fails to regulate data collected by mental health apps and direct-to-consumer neurotechnologies, leaving significant gaps in protection [25]. The Federal Trade Commission (FTC) can intervene in cases of deceptive data practices, but its powers are limited, and it does not provide robust safeguards for brain data or mental health information [26].

US literature identifies significant vulnerabilities in mental health applications, particularly regarding the commercialisation of sensitive data. Van Hoboken and Fathaigh observe that many US-based mental health app companies share user data with third-party advertisers without proper user awareness or consent [27]. This commodification of mental health data raises ethical concerns about privacy breaches and exploitation. Additionally, AI-driven mental health tools pose risks of algorithmic bias and manipulation, which Mittelstadt et al. argue can undermine cognitive autonomy by reinforcing harmful biases or influencing behaviours [28].

The emerging US conversation on neuro-rights focuses primarily on protecting mental privacy and freedom from cognitive manipulation. Farahany explores the ethical and legal implications of neurotechnologies that enable involuntary brain data collection, calling for explicit protections to prevent unauthorised access to brain states [29]. The absence of comprehensive data protection laws has led scholars to advocate for a Neuro-Rights Charter to address these concerns and align US policies more closely with EU standards [30].

Despite progress, several gaps remain in both EU and US regulatory frameworks. First, neither jurisdiction has fully codified neuro-rights into law, leaving brain data and cognitive liberty without explicit legal protections. Second, mental health applications often involve cross-border data flows, which create jurisdictional ambiguities and challenges in enforcing privacy laws. Third, informed consent models fail to capture the complexities of brain data and AI-driven technologies, raising questions about transparency and autonomy.

Despite South Africa sharing some regulatory similarities to these global frameworks, these global models also face significant limitations when applied to culturally diverse and economically unequal contexts like South Africa and are consequently of little exemplary value. Their emphasis on individual autonomy, consent, and advanced technological safeguards often overlooks communal decision-making practices, traditional healing systems, and the socio-economic barriers to accessing digital technologies. In South Africa, where cultural, religious, and economic factors deeply shape mental health perceptions and care, a more integrated and contextually sensitive framework is required, one that balances individual rights with collective practices, addresses infrastructural inequities, and fosters inclusivity in protecting mental privacy and cognitive autonomy.

The following sections will delve into some of these cultural and religious issues that add to the complexity of governing brain-related data and mental privacy in South Africa.

3 | Perceptions of Mental Health in South Africa

Mental health is intertwined with cultural, environmental, economic, spiritual, and religious paradigms which may influence local practices of diagnosis, treatment, and community support. In several African, Asian, and Indigenous cultures, mental states are often explained by more than just a Diagnostic and Statistical Manual of Mental Disorders (DSM) [1] diagnosis. For example, the Māori's view of mental health is underpinned by "whakapapa", the interconnectedness of all things, which frames mental health not as an isolated condition residing solely within the individual but as part of a broader collective and ecological experience [31]. Mental health is seen as inseparable from physical, emotional, social, and spiritual well-being, reflecting the Māori concept of "Hauora", which includes these dimensions as interdependent components of health. Communities often rely on shamans, healers, or religious leaders for treatment [32]. These figures conduct ceremonies that may involve chanting, prayer, or offerings to appease spirits or ancestors believed to be causing the affliction. Practices such as Ayahuasca ceremonies in the Amazon or sweat lodge rituals among Native American tribes blend mental and physical healing with spiritual purification [33]. In some regions, modern mental health care has started integrating traditional beliefs, acknowledging their role in holistic healing. For example, the World Health Organisation (WHO) has supported integrating traditional healers into mental health programs in culturally sensitive ways [34].

The term "indigenous" is used here with caution, in recognition of the extensive critiques it has received in postcolonial scholarship. Rather than implying a static or "pre-modern" worldview, indigeneity in the South African context denotes a living, adaptive knowledge system that has evolved through colonial encounter, urbanisation, and globalisation [35]. As such, indigenous epistemologies are neither frozen in time nor in opposition to modernity, they are fluid, hybrid frameworks through which individuals and communities continue to interpret health, personhood, and moral responsibility. Understanding this fluidity is crucial to situating debates on mental privacy within South Africa's plural and historically layered epistemic landscape. As Flint (2008) [36] argues, the perceived divide between "tradition" and "modernity" was not a natural or descriptive distinction but a colonial construct, deliberately created to frame African knowledge systems as inferior foils to European rationality. This socially constructed binary continues to shape contemporary discourses on healthcare, autonomy, and privacy, underscoring the need to decolonize epistemic assumptions underlying mental health governance. Importantly, indigenous South African healing systems recognize health as shaped by biological, psychological, social, and environmental interrelations. While often articulated through spiritual language, these frameworks reflect a holistic biopsychosocial model that parallels, rather than opposes, biomedical understandings of mental well-being [37].

In South Africa, the intersection of mental health and spirituality is deeply rooted in cultural and religious practices, particularly among various African ethnic populations. Traditional African religion can broadly be typified by the belief in a supreme being, belief in a realm of spirits and in the sanctity of a unified society [38]. This unified society may include extended

family, the clan or tribe, the ancestors, nature and God. It is thus within this paradigm that we must attempt to understand the conceptualisation of mental health. For many South Africans, religion is an integral part of social life and therefore when speaking about mental health it will encompass an holistic view of body and spirit. In many African ethnic groups, diverse understandings of mental health exist; however, traditional languages historically lacked direct equivalents for Westernised mental health concepts. Indigenous knowledge systems coexist with modern mental health approaches, creating a complex tapestry of care and interpretation [39].

The Trance Dance of the Ju/'hoan Bushmen (San) as a Hypnotic Pathway to Wellness and Social Harmony

The Ju/'hoan Bushmen, also known as the San people of Southern Africa, engage in a traditional practice known as the "trance dance," which serves as a profound method of healing and spiritual connection [40]. This ritual involves rhythmic dancing and hyperventilation, leading participants into an altered state of consciousness. During the dance, healers, often referred to as shamans, enter a trance state called "!kia", enabling them to access spiritual realms and harness healing energy known as "n/um". In this state, they perform healing by laying hands on individuals, drawing out sickness, and restoring balance within the community. The trance dance not only addresses physical ailments but also aims to heal social discord and reinforce communal bonds. The intense rhythmic and sensory stimulation, combined with deep immersion in the experience, mirrors aspects of hypnotic states, highlighting the potential of such practices in facilitating healing and spiritual connection.

Many South African communities attribute mental health conditions to ancestral dissatisfaction or neglect. It is believed that some ancestors may act as protectors, and failure to honour them through rituals or offerings can lead to mental or physical ailments. Spiritual practitioners, known as sangomas or inyangas, are often consulted to mediate between the individual and the ancestral realm. These spiritual practitioners also differ among various ethnicities such as the San, Batswana, and Amazulu [41]. Rituals play a major role in both the individual and community lives of many South Africans. Life affirming rites are performed to ensure the passage through various stages of life. Family rituals are done to ensure continued support and protection from the ancestors. Most rites are performed privately. Symptoms of mental illness, such as hearing voices or experiencing hallucinations, may be interpreted as signs of spiritual possession or calling, referred to as "ukuthwasa" in Zulu [42]. In such cases, individuals may be viewed as destined to become healers themselves, undergoing rigorous spiritual training to fulfil their role [43]. This perspective can create a protective framework for individuals who might otherwise be stigmatised for their condition [44].

A consequence of these paradigms may be that individuals delay in accessing more formalised and Westernised forms of support such as psychiatric care [45]. South Africa's mental health policies, as reflected in the Mental Health Care Act and the Traditional Health Practitioners Act [46], aim to integrate traditional practices with formal care systems, recognising the cultural importance of spiritual frameworks. Non-governmental organisations and community programs are increasingly working to bridge the gap between traditional and biomedical approaches [47]. Training traditional healers in mental health first aid and creating referral systems to psychiatric care are among the initiatives undertaken [48].

3.1 | Impact of Culture on Mental Privacy and Information Disclosure

In South Africa, indigenous knowledge systems and traditional healing in mental health profoundly influence attitudes toward trust of modern medicine, discrimination, stigma, mental privacy and disclosure of information. These attitudes are often determined by the roles traditional healers play, cultural expectations about ancestors, and the interplay between these practices and modern mental health systems which requires a closer examination of the cultural and spiritual context of mental health in South Africa. Traditional healers, such as sangomas and inyangas, continue to hold trusted positions in many South African communities, not merely as historical figures but as contemporary practitioners who offer culturally grounded healing and counselling [49]. Although the colonial and postcolonial entrenchment of Western biomedical paradigms has profoundly influenced Africa's health systems, traditional healing persists as a parallel and adaptive framework, particularly in rural and peri-urban areas where it often complements or bridges gaps in formal healthcare provision [50]. In the South African context, the use of traditional and religious healers remains widespread and deeply integrated into community life. Data from the South African Stress and Health Survey indicate that approximately 9% of adults reported consulting traditional healers for mental or emotional problems, while a larger proportion turned to religious leaders or faith healers as an initial source of care [51, 52]. These patterns are particularly pronounced in rural provinces and peri-urban settlements, where accessibility, cultural resonance, and perceived stigma in formal psychiatric care shape help-seeking behaviour. Such findings highlight that mental health interventions and privacy frameworks in South Africa must account for these diverse and overlapping systems of care.

It is also important to note that many of the social and cultural categories commonly described as "tribal" or "traditional" in South Africa were, in fact, colonial inventions. During the colonial and apartheid periods, the state codified ethnic and tribal identities as a means of administrative control, thereby reshaping fluid and overlapping community affiliations into rigid, state-defined hierarchies [53, 54]. As a result, contemporary "traditional" societies are deeply hybridised, reflecting a long history of cultural exchange, missionary influence, and adaptation to colonial modernity. This hybridity is equally evident in health and healing practices, which blend indigenous cosmologies, Christian beliefs, and biomedical ideas in everyday conceptions of illness, privacy, and the self. The use of the term "traditional" in describing African knowledge systems is approached here critically. Scholars such as Hobsbawm and Ranger [55] have shown that many so-called "traditions" were colonial inventions, selectively codified to stabilise colonial authority and construct the illusion of a timeless, unchanging African past. In reality, African societies have always been

dynamic and adaptive, engaging with modernity on their own terms. Contemporary African epistemologies reflect what scholars describe as "multiple modernities" [56], distinct trajectories of modernisation that integrate local cosmologies, moralities, and technologies. Thus, what is often labelled "traditional" may in fact represent indigenous modernities, shaped by histories of encounter, resistance, and innovation rather than by static continuity with the past.

The notion of ethnicity in South Africa, much like "tribe," must be understood as a colonial invention rather than an authentic precolonial social reality. Colonial administrators and ethnographers used the concept to classify and manage populations according to linguistic, territorial, and supposed racial distinctions, thereby transforming fluid kinship and clan affiliations into rigid ethnic categories [57]. During apartheid, these categories were further codified in law and policy to institutionalise racial hierarchy and political exclusion. As a result, contemporary references to ethnicity often reflect colonial legacies of classification rather than organic cultural distinctions, a legacy that continues to shape health policy, identity politics, and community perceptions of privacy and autonomy.

Scholars have also noted that Christianity and other organised religions were introduced and expanded through colonial and missionary enterprises, which sought to reshape African cosmologies and moral orders [58]. These encounters reframed indigenous understandings of the mind, spirit, and community responsibility, embedding new hierarchies of knowledge and authority. However, religion in South Africa today is deeply hybridized: many communities integrate Christian doctrine with ancestral veneration and indigenous ritual practices. This fusion continues to influence conceptions of mental health, confidentiality, and autonomy, where divine, ancestral, and biomedical interpretations coexist and often inform one another in lived experience.

Religious and traditional healers are also an important part of the workforce that provides mental health care services in South Africa, often as frontline service providers [59]. Research has demonstrated that as many as 48.1% of mental health care users in Africa utilise religious or traditional practitioners as their first point of contact for seeking assistance [60]. This trust significantly impacts how people approach disclosure of their mental health struggles. Individuals often feel more comfortable sharing intimate details with traditional healers than with biomedical practitioners because traditional healers frame these discussions within culturally and spiritually aligned frameworks [61]. This trust is reinforced by the belief that healers possess access to ancestral wisdom and spiritual insights, which create a sense of confidentiality and sacredness in their interactions with patients.

The integration of traditional healing with formal mental health systems presents opportunities and challenges for mental privacy. Collaborative models often involve referral systems where traditional healers and biomedical practitioners share patient information [62]. While this integration improves access to care, it introduces concerns about how sensitive mental health information is stored, shared, and protected, particularly in rural areas that lack basic infrastructure. Western-informed consent models, which emphasise individual autonomy and privacy, may clash with traditional practices that prioritise collective decision-making [63]. To address this tension, it is essential to adapt consent models to account for cultural contexts, ensuring that they respect privacy while maintaining the effectiveness of traditional practices. This intersection of traditional healing and mental health care also shapes South African attitudes toward mental privacy in nuanced ways. The sacred nature of healer-patient interactions instils a deep respect for confidentiality within the spiritual framework, while the collective nature of traditional healing rituals often challenges the individual's right to privacy. Resistance to modern mental health systems sometimes stems from perceived intrusions on privacy, such as medical record-keeping or disclosure requirements, which contrast with the more personal and less bureaucratic approach of traditional healers [64]. As traditional healing practices are increasingly recognised within mental health policies, there is growing advocacy for culturally informed privacy protections that honour both individual confidentiality and the collective nature of traditional practices.

3.2 | Impact of Traditional and Religious Beliefs on Mental Privacy and Autonomy

In many Christian communities, particularly within Pentecostal and Charismatic movements, conditions such as depression, anxiety, or psychosis are sometimes interpreted as manifestations of spiritual warfare, demonic possession, or a lack of faith [65]. These can be typified to the Charismatic or Pentecostal tradition [66]. In these cases, individuals frequently seek spiritual solutions, such as prayer, fasting, or exorcism, rather than pursuing conventional mental health treatments. In rare cases, a person may be misdiagnosed to actually have a mental health disorder rather than being possessed by a demon [67]. Within Islamic traditions, mental disturbances may be linked to jinn (supernatural beings), black magic, or divine testing [68]. Religious leaders or scholars are often approached for guidance, which might include recitation of scripture, spiritual counselling, or protective rituals.

These beliefs create a dual narrative. They can either foster hope, comfort, and community support for individuals seeking healing through faith, or they may stigmatise mental illness as a moral or spiritual failing, leading to hesitation in seeking medical help or openly disclosing mental health challenges. Stigmatisation, which refers to a mark or feeling of disgrace or shame, may also occur with a modern medical diagnosis of depression, anxiety or depression. Faith communities and society at large can help reduce the stigma surrounding mental health disorders by advocating for the creation of safe spaces that promote inclusivity and support a holistic approach to well-being. These challenges of trust and stigmatisation complicate how privacy and the concept of the individual in relation to the whole are understood and practiced in the context of mental health care.

Religious and traditional interpretations often involve communal practices that challenge conventional notions of mental privacy. Disclosure of mental health struggles to religious leaders or traditional healers is often considered sacred but does not necessarily adhere to formal confidentiality standards. Furthermore, some religious practices, such as exorcisms or communal prayers, are conducted in communal settings such as

in a church with elders and other community members present. While these rituals can foster communal support, they can also result in stigma. Religious beliefs that associate mental illness with sin or spiritual weakness may further deter individuals from openly discussing their struggles, limiting their access to both spiritual and biomedical care.

Religious frameworks also emphasise collective decision-making and deference to spiritual authority, which may conflict with the principle of individual autonomy recognised in digital mental health tools. Individuals may defer to religious leaders to guide treatment decisions, potentially limiting their personal agency. Communal expectations can pressure individuals to prioritise spiritual explanations and treatments over self-guided or biomedical approaches. Digital health tools, often encouraging individual empowerment, may inadvertently clash with these communal or religious expectations, reducing their effectiveness in culturally diverse contexts. Concerns about data privacy may arise as individuals who are accustomed to disclosing sensitive information within trusted spiritual settings may be wary of how their mental health data is collected, stored, and shared by digital platforms. Fears of unauthorised access to personal information or a lack of transparency in data governance could undermine trust in these interventions. Digital health platforms could consider incorporating faith-based features, such as guided prayers, scripture readings, or spiritual reflections, to align with users' beliefs and make these tools more acceptable and accessible.

4 | Biomedical View of Mental Health and Cultural/Religious Stigma

The current biomedical model of mental health views mental illnesses as medical conditions that result from biological, socio-economic, psychological, and environmental factors [69]. This approach emphasises the diagnosis, treatment, and management of mental health conditions through evidence-based practices. It perceives mental health challenges as treatable, comparable to physical illnesses, and often managed using psychotherapy, medication, and lifestyle interventions. Central to this model is the importance of confidentiality and mental privacy, which ensures that individuals have the right to disclose their struggles only within trusted, professional settings.

Importantly, the apparent openness or disclosure sometimes attributed to African cultures must also be understood as a legacy of colonial and apartheid practices, not a cultural predisposition. Colonial administrators and medical officers routinely subjected Africans to invasive searches, psychiatric examinations, and registration systems that denied bodily and mental privacy [70]. These coercive systems normalised surveillance and disclosure, reshaping relationships between individuals, the state, and medical authority, a dynamic whose echoes persist in contemporary attitudes toward mental health and data privacy. In many South African divination practices, clients do not initially disclose their personal or family histories. Instead, they remain silent, allowing the diviner (isangoma or inyanga) to reveal such details through spiritual mediation. This process serves both as a diagnostic mechanism and a test of the healer's authenticity [71]. Such practices illustrate that privacy, truth-telling, and consent operate according to different epistemic logics: rather than verbal self-disclosure, knowledge is mediated through ancestral authority and ritual performance. This dynamic complicates biomedical assumptions about transparency and consent, revealing a culturally distinct model of mental privacy and trust in therapeutic relationships.

It has to be noted that the biomedical model of mental health is preceded by Western civilisation's complex mental health history, characterised by periods of relative scientific inertia and ostracism of those afflicted, as well as periods of great theoretical insight and progressive thinking [72]. Following early supernatural explanations and theories of mental illness and the emergence of logical thought and experimental reasoning after the Middle Ages, the stage was set for a transition to a humane method of treating mental illness. This shift led to the advent of modern theories of mental illness, dedicated classification systems, as well as theoretical approaches to treatment based on clinical evidence [73]. Despite its strengths, the adoption of the biomedical model in South Africa is often challenged by cultural and religious paradigms that interpret mental health issues differently [74].

While earlier discussions of African health systems often positioned "Western" biomedical models and "traditional" healing systems as opposing frameworks, recent scholarship challenges this binary. Anthropologists and postcolonial theorists argue that such distinctions obscure the dynamic and entangled nature of African modernities, where spiritual, communal, and scientific worldviews coexist and co-produce meaning [75]. In South Africa, these hybrid systems reveal that modernity itself is plural, and that individuals navigate overlapping moral, religious, and therapeutic logics rather than choosing between discrete traditions. Recognising this complexity is essential for understanding how mental privacy, autonomy, and consent are conceptualised within diverse cultural and epistemic contexts. As scholars have noted, the distinction between "belief" and "knowledge" is itself a colonial construct that obscures the epistemic legitimacy of African worldviews. In practice, South Africans often draw on interwoven systems of knowing, spiritual, communal, and empirical, that resist reduction to either category [76]. Colonial and apartheid administrations systematically imposed surveillance and data-collection systems on Africans, thereby restricting their autonomy and enforcing disclosure in ways that undermined their capacity to exercise self-determination. While Western liberal models emphasise the autonomous individual, African understandings of autonomy often emphasise relational frameworks; colonial regimes disrupted both relational and individual autonomy in different ways.

Digital tools such as teletherapy platforms and mental health apps emphasise individual autonomy and confidentiality, aligning with the biomedical model. However, these tools often seemingly clash with cultural and religious expectations, which prioritise communal and spiritual approaches to mental health care [77]. For individuals who view mental health challenges as spiritual matters, digital tools may be seen as inadequate or incompatible with their beliefs. This perception can limit the adoption of digital health technologies.

5 | Regulation of Mental Privacy in South Africa

The Protection of Personal Information Act (POPIA), the primary data and privacy protection law in South Africa, defines

"personal information" broadly, encompassing various identifiers such as race, health, and biometric information [78]. However, POPIA does not explicitly address "mental privacy" or "cognitive data," which pertain to an individual's thoughts, beliefs, and unexpressed opinions. In this regard it must be noted that mental privacy or cognitive data represents a fundamentally different and more intrusive category of data, one that potentially gives access to the self *before* expression as opposed to data that has already been disclosed, recorded, or inferred through communication or behaviour. The latter types of data is already protected under POPIA as personal information (Section 1 - names, contact details, ID numbers, biometric data, opinions, and correspondence) and as special personal information (Section 26 - religious beliefs, race/ethnic origin, trade union membership, political persuasion, health/sex life, biometric and criminal records). Mental privacy, however, refers to the right *not* to have one's inner thoughts, intentions, emotions, or mental states accessed, recorded, or manipulated without consent. In this context cognitive data may include brain activity captured via neurotechnologies such as EEG, fMRI, or BCIs; neural signals either electrically or chemically derived; or unspoken thoughts, intentions, or emotional states inferred from neural activity. This omission in POPIA leaves a critical aspect of personal privacy unprotected, especially as emerging technologies increasingly have the capability to access and interpret cognitive data. The Act's provisions are primarily tailored to traditional forms of data processing and may not sufficiently account for advancements in neurotechnology and artificial intelligence. These technologies can potentially intrude upon an individual's mental processes, yet POPIA lacks specific guidelines or restrictions addressing such intrusions. This regulatory gap could lead to scenarios where mental privacy is compromised without clear legal recourse. In addition, POPIA emphasises the protection of explicit personal information collected directly from data subjects. However, it provides limited safeguards against the inference of sensitive mental data through analysis of behaviour, preferences, or other indirect means. For example, data analytics can deduce an individual's mental state or psychological profile without their explicit consent, potentially leading to violations of mental privacy that the current framework does not adequately address and may not have anticipated.

South Africa's Constitution provides robust protections for religious, cultural, and healthcare rights [79]. These rights are enshrined in the Bill of Rights, which guarantees everyone the right to freedom of religion, belief, and opinion, including the right to use the language and participate in the cultural life of their choice. Section 31 grants persons belonging to cultural, religious, or linguistic communities the right to enjoy their culture, practice their religion, and use their language, while section 15 guarantees the right to freedom of conscience, religion, thought, belief, and opinion. These constitutional protections are particularly important for persons with mental vulnerabilities facing stigma, discrimination, and marginalisation to ensure that their cultural and religious rights are respected and to promote their dignity, equality, and access to healthcare services [80]. Section 27 protects the right of access to healthcare services, including reproductive health care.

These constitutional protections intersect with mental privacy rights, safeguarded under the Mental Health Care Act (MHCA) [81]. This Act emphasises respect for human dignity and privacy (Section 8), prohibiting unfair discrimination against people with mental or other disabilities. It also mandates informed consent for care and treatment, ensuring that individuals' mental privacy is respected. Section 9 of the MHCA ensures that mental health care users have the right to give informed consent to their care, treatment, and rehabilitation. This empowers them to make decisions about their own health care, which is a fundamental aspect of respecting their dignity. Section 10 prohibits unfair discrimination against mental health care users, providing protection by ensuring that they are treated equally and without prejudice, which is crucial for maintaining their dignity. The MHCA establishes Mental Health Review Boards to oversee the admission and treatment of mental health patients to ensure that the rights of mental health patients are protected and their dignity upheld throughout their care. Section 17 mandates that mental health patients must be informed of their rights which includes the right to dignity, and to help them understand and assert their rights. Despite these protections, the MHCA is criticised by Madlala and Sokudela, who emphasise the inadequate implementation of the Act, limited access to health care for some patients in rural areas, as well as human rights violations experienced by some patients, vividly illustrated by the recent Life Esidimeni case [82].

The recent Life Esidimeni tragedy [83] bore testament to the severe neglect and violation of the rights of mentally incapacitated patients in South Africa. In 2015, the Gauteng Department of Health announced the termination of its contract with Life Esidimeni, a private healthcare provider, and decision to move approximately 1 500 psychiatric patients to various NGOs and community care facilities. This decision was part of a cost-saving measure and an attempt to deinstitutionalise mental healthcare. However, many of these facilities were unlicensed, under-resourced, and ill-equipped to provide the necessary care. The result was catastrophic: 144 patients died, with many others suffering from neglect, starvation, and trauma. The incident has been described as one of the greatest human rights violations in post-apartheid South Africa.

The judicial inquest into the Life Esidimeni tragedy began in 2021 and concluded in July 2024. Judge Teffo found that former Gauteng Health MEC, Qedani Mahlangu and former head of mental health, Makgabo Manamela could be held responsible for the deaths of at least nine patients. This case underscores the importance of protecting the rights of mentally incapacitated patients and ensuring that they receive the care and dignity they deserve, including the need for accountability and proper oversight in the healthcare system to prevent such tragedies from happening again - despite legislation providing constitutional protections. The Life Esidimeni disaster was followed by an investigation by the South African Human Rights Commission into the state of mental health care services in South Africa. The Commission determined that the deinstitutionalisation of mental health care users was executed in a manner contrary to the provisions of the Mental Health Policy Framework (MHPF) in place at the time of the Life Esidimeni incident, as deinstitutionalisation could not be executed without certain required assurances that proper services and support for the mental health patients in place. The current MHPF (2023–2030), referring to the Life Esidimeni disaster, reaffirms

the rights to dignity, respect, non-discrimination, and autonomy in mental health care settings, as well as underscoring the implementation of community mental health care services first, before continuing with the downscaling of psychiatric hospitals [84].

The constitutionality of sections 77(6)(a)(i) and (ii) of the Criminal Procedure Act in respect of the capacity of an accused person to understand proceedings, was challenged in *De Vos N.O. v Minister of Justice and Constitutional Development* [85]. The Constitutional Court declared these sections invalid to the extent that they mandated the imprisonment or institutionalisation of individuals without considering their mental health status. In yet another judgment that followed the review of the detention of Jimmy Young, involuntarily admitted under the MHCA, the High Court highlighted the importance of an independent review to ensure that the detention was justified and that the individual's rights were protected [86].

These cases highlight the judiciary's role in ensuring that the rights of persons with mental health conditions are protected and that the provisions of the MHCA are applied in a manner consistent with constitutional principles. The cases not only underscore the challenges and complexities involved in balancing limited resources with the need to provide essential healthcare services to all citizens but also highlight the Constitutional Court's role in ensuring that the right to access healthcare services is upheld and progressively realised in South Africa and that the rights of persons with neurological disorders and mental health conditions are protected.

6 | The Intersection of Neurotechnology and Digital Health as Shaped by the Legal and Ethical Landscape

The intersection of constitutional rights and those reflected in the MHCA is particularly relevant in the context of neurotechnology and digital health. Ensuring that neurotechnological interventions respect individuals' mental privacy and cultural and religious beliefs is crucial to prevent exploitation and abuse. As neurotechnology advances, it is essential to balance the potential benefits with the protection of individuals' rights and privacy.

Since the adoption of the Constitution in 1994, section 14 has been a cornerstone in protecting privacy rights in South Africa. The constitutional right to privacy protects various interests, including personal autonomy (which include the right to make decisions about one's personal life without unwarranted interference, such as choices about a person's body, lifestyle, and personal relationships); home and property (ensuring that individuals are protected from unlawful searches and seizures of their homes and property, safeguarding their personal space and belongings, private communications (such as communications and to prevent unauthorised surveillance and interception); data (personal information such as identification numbers, financial details, and health records to prevent misuse, unauthorised access, and breaches); bodily privacy (such as the right to bodily privacy, including protection against invasive searches and medical procedures without consent), and informational privacy, which include the right to control the dissemination and use of personal information (to ensure that persons can manage how their data is collected used, stored and shared). This right has since been strengthened by the Protection of Personal Information Act 4 of 2013 (POPIA) [87], which specifically addresses the protection of personal data and aims to promote the protection of personal information processed by public and private bodies. POPIA establishes minimum requirements and conditions for the lawful processing of personal information, including obtaining consent from data subjects, ensuring data accuracy, and implementing security measures to protect personal information. With the rise of digital technology, POPIA will increasingly apply to address new challenges, such as data breaches and cybercrime. These protections are crucial in maintaining the dignity, freedom, and autonomy of individuals, allowing them to live their lives with a sense of security and control over their personal information and activities.

It is important to note that autonomy was not absent in precolonial South African cultures but rather conceptualised through relational ethics emphasising interdependence and communal responsibility [88]. The loss of autonomy that characterises South Africa's historical trajectory is primarily a legacy of colonial and apartheid governance, which imposed coercive systems of bodily and mental control that stripped Africans of both privacy and self-determination. In contrast, precolonial frameworks often balanced personal agency with obligations toward kin and community, suggesting not an absence of autonomy, but a different moral architecture of freedom rooted in social harmony and mutual respect.

7 | Comparative Legal Analysis to Identify Gaps in Mental Privacy Protection

Under Article 9(1) of the GDPR, health data, including mental health information, is considered a “special category” of personal data. This designation prohibits the processing of such data unless specific conditions are met. A primary condition is obtaining the explicit consent of the data subject, as stipulated in Article 9(2)(a). Explicit consent under the GDPR requires that individuals provide informed, freely given, specific, and unambiguous agreement to the processing of their data. Mental health applications and neurotechnologies that collect brain data must ensure that users are fully aware of the purposes for which their data is being collected, shared, and processed. The GDPR places significant emphasis on informed consent as a mechanism to uphold cognitive autonomy. Consent must be transparent and meaningful, requiring data processors to clearly communicate: the specific purpose for collecting data (mental health diagnostics, behavioural predictions); who will have access to the data (app providers, third-party processors, or advertisers); and potential risks associated with data processing, particularly concerning misuse, breaches, or commercial exploitation.

The GDPR also enforces principles of data minimisation and purpose limitation (Article 5) to ensure that only necessary data is collected and used for clearly defined purposes, limiting risks to individuals' mental privacy. For example, if a mental health app collects EEG data for anxiety monitoring, it must not collect additional data unrelated to that purpose, such as behavioural trends for marketing purposes.

In the EU, cognitive autonomy is deeply rooted in the principles of human dignity and self-determination, as enshrined in the Charter of Fundamental Rights of the European Union (Article 1) [89]. The GDPR operationalises these principles by empowering individuals with control over their mental and brain data, ensuring they retain autonomy over their cognitive processes. Scholars such as Inglese and Lavazza argue that neurotechnologies present unique risks of cognitive manipulation, making it critical for legal protections to safeguard autonomy by imposing strict limits on data use [90].

In the US, HIPAA does not extend to direct-to-consumer neurotechnologies or mental health applications that operate independently of traditional healthcare systems. This creates significant gaps, as many mental health apps and neurotechnologies fall outside HIPAA's regulatory scope. In cases where HIPAA does not apply, the FTC can intervene to regulate deceptive data practices. For example, the FTC can penalise companies that misrepresent their privacy policies or fail to secure user data adequately. However, the FTC's oversight is reactive rather than proactive, and it lacks specific mandates to address the unique risks associated with brain and mental health data.

Unlike the GDPR, which mandates explicit and specific consent, US-based mental health apps often rely on broad or implied consent models. These models shift the burden onto users, who may agree to complex, non-specific terms of service without fully understanding how their data will be used or shared. Farahany highlights that this weakens protections for mental privacy and cognitive autonomy, as brain data could potentially be used for surveillance, targeted advertising, or neuromarketing without explicit user intent [91]. Furthermore, cognitive autonomy in the US is often interpreted through the lens of consumer choice rather than human rights. This interpretation allows market forces to dominate, with companies prioritising profit over ethical data use. The commercialisation of brain data is a significant concern, as it enables predictive models and manipulative technologies that can influence individuals' behaviours or decision-making processes. This invokes profound ethical risks, particularly in neurotechnologies that intersect with mental health.

Consequently, to enhance protections for neural and mental health data, POPIA should be amended to explicitly classify this data as “special personal information”, imposing stricter processing requirements such as explicit consent, data minimisation, and enhanced security measures, especially for neurotechnologies and mental health apps. This recommendation is strongly reinforced by the comparative analysis of the above regulatory models. While the GDPR is widely regarded as a benchmark in personal data protection, it does not explicitly recognise mental privacy or brain data as a distinct legal category. Although Article 9 classifies health data as sensitive, scholars such as Ienca and Farinella argue that the GDPR falls short of codifying emerging neuro-rights such as cognitive liberty and mental integrity. Moreover, standard informed consent models are ill-equipped for technologies that process cognitive data involuntarily or infer pre-conscious mental states, leaving individuals vulnerable to manipulation or profiling. The United States presents a different challenge: lacking a unified federal privacy law, it relies on fragmented sectoral laws such as HIPAA, which applies only to covered health entities. Mental health apps and consumer neurotechnologies often fall outside HIPAA's scope, enabling unchecked commercial exploitation of brain data. FTC enforcement is reactive and limited. These gaps show that even in well-resourced contexts, legal protections for cognitive data remain incomplete. Without adopting our proposed policy amendment (below), South Africa risks replicating these deficiencies. POPIA would be unable to address involuntary brain data collection, regulate mental health apps effectively, or protect individuals from cognitive manipulation. Amending POPIA to explicitly include neural and mental health data as special personal information, tailored to South Africa's socio-cultural diversity and digital health challenges, is thus an essential step toward safeguarding cognitive autonomy and mental privacy.

The Life Esidimeni tragedy exemplifies the devastating consequences of inadequate mental health service delivery. A major challenge is the insufficient transparency and consent mechanisms governing neural and mental health data. Although POPIA mandates consent, more stringent explicit and informed consent requirements are necessary to ensure individuals understand how their data will be used. Moreover, cultural and religious considerations should be incorporated into data processing practices to respect diverse health beliefs.

8 | Discussion

The EU's GDPR offers robust protections for mental health and neural data through its emphasis on informed consent, data minimisation, and transparency. However, the GDPR's focus on individual autonomy is often at odds with South Africa's communal decision-making and spiritual frameworks. Additionally, the GDPR lacks provisions for culturally sensitive data practices and is costly to implement in resource-constrained and rural areas of South Africa, where digital infrastructure is limited.

The US regulatory framework, by contrast, is fragmented and lacks a unified law comparable to the GDPR. While the US emphasises innovation and has begun exploring neuro-rights as a legal concept, its weak informed consent models and focus on market-driven approaches create significant gaps in mental privacy protections. These gaps are especially concerning in South Africa, where individuals often have limited legal awareness or digital literacy. Furthermore, the US's prioritisation of profit over ethical considerations risks deepening inequalities and exploitation, particularly in vulnerable populations.

South Africa's existing regulatory framework—comprising the Constitution, the MHCA, and the POPIA lays an important foundation for the protection of mental privacy and the recognition of cultural and religious rights. However, these instruments are primarily grounded in Western biomedical and individualist paradigms, which insufficiently reflect the realities of South Africa's pluralistic mental health landscape. Traditional healing practices, spiritual interpretations of mental states, and communal models of care remain largely unacknowledged in law and policy. Furthermore, these legal frameworks lack the specificity to address emerging technologies such as neurotechnologies and mental health apps, especially regarding the collection and commercialisation of neural and cognitive data. Deep-rooted resource constraints in public

health, combined with widespread digital illiteracy and economic inequality, further exacerbate the risks of data misuse, coercion, and exclusion. High-profile cases, including the Life Esidimeni tragedy, illustrate the urgent need for culturally sensitive legal safeguards and accountability mechanisms that prioritise dignity, mental autonomy, and equitable access to care.

South Africa can draw critical lessons from both the EU and US regulatory approaches. The GDPR's treatment of brain and mental health data as a "special category," combined with its emphasis on explicit consent, data minimisation, and cognitive autonomy, provides a robust rights-based framework. Additionally, the EU's evolving discourse on neuro-rights offers a powerful model for embedding mental privacy within human dignity and self-determination. From the US, South Africa can learn how to address the regulatory challenges posed by direct-to-consumer neurotechnologies and cross-border data flows. However, it must consciously avoid replicating the US's fragmented, market-driven model that privileges corporate interests over individual rights. Instead, South Africa should develop a hybrid approach, one that combines international best practices with local ethical frameworks. This approach must include protections for vulnerable populations, formal recognition of traditional and communal healing systems, enhanced consent models tailored to relational autonomy, and robust data governance under POPIA that addresses both the cultural and socio-economic dimensions of mental privacy.

Legal frameworks must balance cultural practices with privacy and autonomy safeguards. Policymakers should develop culturally informed consent models, prevent exploitation, and address socio-economic inequities to ensure ethical, inclusive regulations that foster trust and equity in mental health care.

8.1 | Reconceptualising Mental Privacy Within South Africa's Plural Legal and Ethical Context

The discussion on mental privacy in South Africa must begin with an acknowledgment of the country's plural legal order and the enduring legacies of colonialism and apartheid that continue to shape notions of autonomy, personhood, and trust in biomedical systems. Whereas global neurorights frameworks, such as those proposed in the European Union and the United States, emphasise individualistic understandings of consent, autonomy, and cognitive liberty, South Africa's socio-legal context introduces layers of communal ethics and spiritual epistemologies that problematise these assumptions. Within many African worldviews, the self is relational, and cognitive experiences are embedded in communal and spiritual life. This relational ontology challenges the premise of mental privacy as an exclusively individual right, requiring instead a framework that reconciles collective belonging with individual protection.

South African legal norms, particularly those grounded in the Constitution's provisions on dignity, equality, and privacy, offer fertile ground for extending existing interpretations to include cognitive and mental dimensions. However, POPIA and related frameworks were not designed with brain data or neurotechnologies in mind. The result is a regulatory lacuna where brain data collected through neuroimaging, mental health apps, or AI-driven diagnostic tools remain ambiguously protected. Bridging this gap necessitates both interpretive expansion and legislative reform, recognising that brain data, while deeply personal, also carries collective cultural meanings in South Africa's hybrid health systems.

8.2 | Socio-Cultural Dimensions: Trust, Stigma, and Relational Personhood

In South Africa, understandings of mental health and illness remain shaped by both biomedical and traditional healing systems. Many communities interpret mental states through spiritual or ancestral frameworks, where disclosure, interpretation, and healing are collective processes rather than private acts. Consequently, Western-derived notions of "mental privacy" may appear alien or even counterproductive in contexts where collective deliberation or spiritual consultation is central to care. At the same time, the historical trauma of apartheid-era psychiatry and medical exploitation has entrenched deep mistrust toward institutions, particularly concerning the collection and use of mental health data. This dual reality, communal openness in some contexts and institutional suspicion in others, requires a nuanced, culturally responsive approach to policy and governance.

Mental privacy, therefore, cannot be reduced to a matter of individual consent, it must be framed as an ethical obligation to protect vulnerable populations from both technological and structural exploitation. Given the widening accessibility of digital mental health tools and neurotechnologies, particularly in underserved communities, safeguards against cognitive manipulation, stigmatisation, and data misuse are essential. The challenge lies in constructing a rights-based framework that acknowledges both relational autonomy and historical injustice.

8.3 | Ethical Imperatives: Beyond Consent to Cognitive Justice

Ethically, the debate on mental privacy intersects with broader notions of cognitive justice, the right of all individuals and communities to maintain epistemic agency over how their thoughts, emotions, and mental states are represented, interpreted, or manipulated. In South Africa, this requires moving beyond procedural informed consent toward participatory and reflexive models of engagement, where affected communities actively shape the terms of data collection and usage. Such an approach aligns with African communitarian ethics, which emphasise reciprocity, collective well-being, and moral responsibility over strict individualism.

Moreover, neurotechnological innovation should be guided by principles of beneficence, non-maleficence, and justice, ensuring that the deployment of technologies like brain-computer interfaces or affective computing systems does not deepen existing inequalities. Ethical governance frameworks must account for the asymmetries of power between developers, users, and data subjects, and explicitly safeguard against cognitive exploitation and behavioural manipulation.

In addition, economic injustice is reflected in structural poverty in South Africa. Digital inequality, inadequate access to mental

health services, and limited legal literacy significantly influences how mental privacy must be understood and protected. Access to neurotechnologies and mental health apps is unequally distributed, with wealthier populations benefiting from digital diagnostics and neurofeedback tools, while low-income individuals often rely on under-resourced public clinics or traditional healers. This results in unequal exposure to both the benefits and risks of mental data processing. Economic vulnerability also increases the likelihood of coercive data practices. The SAHRC determined in its 2017 report as one of the key findings that the effective implementation of a rights-based approach to mental health requires an emphasis on the social determinants of mental health and well-being [92]. This points to the need to engage with various stakeholders to consider ways in which effective participation and inclusion of people with psychosocial and intellectual disabilities can be realised, examining barriers to social, cultural and economic inclusion and considering ways in which these forms of exclusion impede human rights and negatively impact on mental health. It is unfortunate that persons in low-resource settings may be compelled to accept invasive data collection through free mental health apps in exchange for basic services or subjected to surveillance-based welfare programs that track cognitive states without adequate safeguards. Further compounding the problem, many South Africans lack digital literacy and access to technology, making it difficult to understand or meaningfully consent to how their mental data is collected, used, or commercialised. Additionally, disclosures made in traditional or spiritual healing contexts fall outside existing data protection laws, despite often involving highly sensitive and sacred information. These gaps leave vulnerable populations legally exposed. Finally, the commodification of mental health data poses serious risks. Without robust legal protections, the brain and emotional data of marginalised individuals may be sold, used for profiling, or exploited by commercial interests, reinforcing systemic inequality.

Together, these factors reveal that mental privacy in South Africa is not merely a neuroethical or digital rights issue, it is fundamentally a matter of social and economic justice. A future-oriented regulatory approach must therefore recognise that mental privacy is deeply intertwined with access to dignity, fair treatment, and equitable participation in society. Accordingly, legal frameworks must be extended and adapted to ensure that mental privacy is recognised and protected as a socio-economic right, grounded in the transformative values of the South African Constitution. future legislation and policy in South Africa must move beyond adopting international best practices and instead cultivate locally legitimate and ethically coherent frameworks for mental privacy. Protecting the mental lives of South Africans requires a commitment to dignity, spiritual agency, and cultural inclusion as much as it requires legal reform.

9 | Policy Recommendations

- To enhance protections for neural and mental health data, POPIA should be amended to explicitly classify this data as “special personal information”, imposing stricter processing requirements such as explicit consent, data minimisation, and enhanced security measures, especially for neurotechnologies and mental health apps.
- Require all entities deploying mental health apps or neurotechnologies to conduct and publish context-specific ethical impact assessments. These should evaluate the implications for mental privacy, autonomy, and vulnerability within socio-economically and culturally diverse populations.
- Current consent models presume individual autonomy rooted in Western liberal philosophy. In South Africa, consent often takes place in communal, spiritual, or family-based settings. Consent frameworks should integrate relational autonomy, allowing space for traditional decision-making, while preserving individual dignity and the right to mental privacy. Informed consent models should incorporate communal and spiritual decision-making while upholding individual autonomy. Consent processes should allow individuals to consult with trusted traditional or religious leaders without compromising personal choice. Additionally, culturally appropriate educational materials should be developed to explain mental privacy, data protection, and cognitive autonomy using accessible language, analogies, and local examples.
- To strengthen community engagement, partnerships with traditional healers, sangomas, inyangas, and religious leaders should be fostered to raise awareness about mental privacy. These leaders should receive training on what kinds of data neurotechnologies collect, and how this may affect spiritual, communal, or ancestral beliefs, data protection, ensuring sensitive information shared during rituals or consultations aligns with modern privacy standards. Finally, collaboration between traditional healers and biomedical practitioners should be encouraged through formal referral systems that maintain patient confidentiality while improving access to mental health care. This should include protocols for the protection of sacred disclosures made to spiritual or traditional practitioners, which may not align with Western data retention norms.
- Prohibit the commercialisation or sale of mental health and cognitive data to third parties without explicit, culturally contextualised consent. South Africa must avoid the US model where mental health apps commodify sensitive data with minimal user protection.

10 | Conclusion

South Africa's approach to mental privacy must transcend the transplantation of Euro-American neurorights frameworks. Instead, it should evolve through an iterative dialogue between constitutional values, cultural ethics, and global human rights norms. By situating mental privacy within the nation's complex socio-legal and historical landscape, policymakers can craft a framework that both protects individuals from digital and cognitive exploitation and affirms the collective dignity of its diverse communities.

By contextualising mental privacy within South Africa's socio-cultural and legal milieu, this paper advances a theme-specific understanding of how neurorights discourse must adapt to postcolonial, plural societies. The findings underscore that

mental privacy cannot be universally protected through biomedical or data-governance norms alone but must be reframed through culturally embedded and community-sensitive models of autonomy and confidentiality. In doing so, this work closes a critical gap in the current literature and provides a foundation for both localized policy reform and comparative global neuroethics scholarship.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are openly available in Scholar at https://scholar.google.com/.

Endnotes

[1] In Addition to DSM, the International Classification of Diseases 11th Revision (ICD-11) can be used which is the WHO global standard for diagnostic health information https://icd.who.int/en. These diagnostic manuals differ which makes it challenging to develop digital mental health tools that complies with sometimes conflicting criteria.

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