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WHO CONSULTS SANGOMAS IN KHAYELITSHA? AN EXPLORATORY QUANTITATIVE ANALYSIS

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Abstract

This paper employs quantitative analysis to explore which people in Khayelitsha (an urban African community in Cape Town) are likely to be clients of 'sangomas', that is, traditional healers who specialise in divining illnesses usually perceived to be caused by witchcraft. It shows that sangoma clients are older, disproportionately female, poorer and less well educated than other people and that they are less trusting of others and more likely to believe in the efficacy of witchcraft. Being a recipient of a disability grant is the most significant predictor of whether the respondent is a sangoma client or not. The paper also discusses different quantitative sources for the use of traditional healers in South Africa, showing that the way the question is posed is all important.

Introduction

This paper employs quantitative analysis to explore which people in an urban African community are likely to be clients of 'sangomas', that is, traditional healers who specialise in divining illnesses usually perceived to be caused by witchcraft. It uses data from a survey of residents of Khayelitsha, Cape Town's largest African township (home to over a third of the total African population in the metropolitan area).

The first houses in Khayelitsha were built in 1984. Since then, the township's informal and formal housing areas expanded rapidly and by 2001, the population had reached 327,000. Khayelitsha's residents include those who moved to the township from surrounding squatter camps and back-yard shacks when the first houses were built, and many people who migrated to the township (mainly from the Eastern Cape) over the past two decades. The population thus varies significantly in terms of the relative balance of exposure to rural and urban life. If the belief in witchcraft is more common in rural communities, this could affect the demand for sangoma services. However, as traditional healing paradigms have proved flexible in the face of urban living in other parts of Southern Africa (see, for example, LeBeau, 2003; Dillon-Malone, 1988: 1159-60), the degree of 'rurality' of social background may prove irrelevant. Indeed, if suspicion of witchcraft is a function of competition, insecurity and income inequality (Ashforth, 2001, 2005), then one would expect to find a significant portion of people in urban areas also manifesting witchcraft beliefs. Khayelitsha

is a good place to test this and other possible socio-economic determinants of who becomes a sangoma client.

The quantitative analysis draws on a 2004 representative survey of 570 people in Khayelitsha conducted by researchers from the Centre for Social Science Research. This was the second wave of a panel study in which respondents had first been interviewed in 2000 as part of a wider survey of labour-market behaviour.[1] Amongst other things, the Khayelitsha 2004 survey asked respondents if they had consulted a 'sangoma' the last time they were 'very sick'. This paper uses this data to probe the characteristics of people who responded positively to this question and thus can be regarded as 'sangoma clients'.

The Zulu word 'sangoma' (or isangoma) is conventionally used in African studies to describe traditional medical healers whose methods of diagnosis are linked to divination through communication with spiritual others, most notably ancestors (Henderson, 2005 – this volume; Wreford, 2005b, 2005c – this volume). Sangoma specialise in divining, healing and protecting against witchcraft (Good, 1987; Gelfand, 1967; Ashforth, 2005; Wreford 2005a). Sangomas appeal to their ancestors for help in diagnosing problems and prescribing remedies and routinely check to see if illnesses are caused by their clients having violated cultural norms and traditions. Connections have been drawn in this respect between sangoma practice and the central role of the collective unconscious in Jungian psychotherapy (Buhrmann, 1984; Wreford, 2005b). However, unlike psychotherapy which 'cures' by facilitating self-understanding, sangomas 'cure' through cleansing rituals and by prescribing herbal and other remedies (mostly purgatives).

Thirty-five respondents – that is, 6.1% of the total – in the Khayelitsha survey said that they had consulted a sangoma the last time they were 'very sick'. Of these sangoma clients, 19 (56%) said that they had visited more than one sangoma. The most common reported diagnosis by the sangoma was that the respondent had been bewitched or poisoned – often both. (Note that the word poisoning in this context is indicative of witchcraft because "a notion of 'poison' serves as a basic building block for interpreting the dangers arising from the domain of 'witchcraft'" (Ashforth, 2005: 144)). Of those who reported that the sangoma told them that they had been bewitched, one third reported that the sangoma had told them that they had been bewitched by their mother or a close family member. Just under a third of respondents reported that the sangoma had told them that they had angered their ancestors. In other words, the reported diagnosis by sangomas is consistent with what we know from the relevant anthropological literature about the witchcraft paradigm within which they function.

With regard to the treatment strategies of sangomas, these appear to have followed the typical sangoma prescription of cleansing through purging – that is, instigating vomiting or diarrhoea (sometimes both), with an emphasis on vomiting (88% of sangoma clients reported being given a substance to make them vomit). Eighty-five percent of sangoma clients said that they had been given medicine to stop them being bewitched – and of these, most (90%), were also given purgatives. In addition to purging, sangoma clients reported being given remedies to 'clean the blood' (68% of sangoma clients) and make them 'stronger' (90% of sangoma clients). Most sangoma clients reported that they were fairly satisfied (although not enthusiastically so) with the treatment offered by the sangoma (20% said it helped a lot and 63% reported that it helped 'a bit')

This paper investigates whether there are any statistical regularities which could help predict whether a respondent is likely to be a sangoma client or not. Although 35 respondents constitutes only a small cell of individuals, the statistical analysis reported below reveals some interesting statistically significant patterns.[2] Before doing so, however, it is worth placing this figure of 6.1% in a comparative context and exploring the limitations for the study that are posed by the way the question was asked.

Methodological Issues Posed in Measuring 'Sangoma Clients'

Any empirical investigation into who becomes a sangoma client is plagued by a number of methodological problems concerning both how the question is posed and understood.

Posing the Question

The first problem is one of definition of the sangoma. Whereas the term 'sangoma' strictly refers to a specific form of healing through ancestor-assisted divination, ritual and cleansing, it is often used as a synonym for 'traditional healer' in every-day discourse. As Ashforth notes in his study of Soweto, "most discussions of traditional healers generalize the Zulu usage of sangoma and inyanga to cover all traditional healers serving Africans in the region, regardless of ethnicity" (2005: 52).[3] Furthermore, depending on the individual, the broad catch-all phrase 'traditional healer' can either be understood narrowly, or more broadly to include traditional birth attendant, purveyors of herbal remedies and inyangas, those who specialise in removing witchcraft objects through surgery and umthandazi (spiritual healers). Questionnaires which use generic terms such as 'traditional healer' are thus likely to produce noisy data because of different understandings in the mind of respondents about what, exactly, is being asked.

The second problem is the time period. Do you ask about a specific reference period (for example, 'in the past month did you visit a sangoma') or about an illness incident ('the last time you were sick') – or do you ask whether the person has ever visited a sangoma? The data is likely to vary sharply in response to the time period. For example, the South African Demographic and Health Survey (1998) asked specifically if the respondent had visited a 'traditional healer or herbalist' in the past month. Only 1.4% of all respondents (and 1.8% of African respondents) said they had. This is significantly lower than the 6% of respondents in Khayelitsha who reported that they had visited a sangoma the last time they were very sick (that is, no time restriction such as 'in the past month', was imposed). Although differences between these two estimates of the percentage of sangoma clients are in large part a function of the scope of the two studies (the Demographic and Health Survey was a national survey and the Khayelitsha survey was a township-level survey), the way the question was designed no doubt also affected the number of positive responses.

The third problem is whether you ask about visits to sangomas at the individual or household level. Do you ask the respondent about their own experience, or do you ask the respondent about their experience *and* the experience of every other household members? The South African General Household Survey (2003), for example, opted to ask a single respondent about the health-seeking behaviours of all other household members. According to this national survey, only 0.4% of all people (and 0.5% of Africans) visited a traditional healer during the past month. This is significantly lower than the result obtained from the South African Demographic and Health Survey (reported above).

The trouble with household-level information is that although it allows for the collection of information about more people, it is subject to bias in that the respondent does not have full information about the activities and characteristics of all household members. An alternative is to take a non-specific approach and ask the respondent to talk about the last time 'they or any other household member' visited a sangoma/traditional healer (as was the case in the Katutura (Namibia) survey discussed below).

The most comprehensive Southern African survey of the use of traditional healers in an urban African township is that by Le Beau. She interviewed 362 people in Katutura (the African township in Windhoek, Namibia) about their health-seeking behaviour. She asked people about the last time they or a family member was seriously ill (2003: 164). Because the question encompassed all family members, more potential clients of traditional healers were likely to be captured in the Katutura study than the Khayelitsha study. The Katutura survey also probed whether the respondent (or family member) had sought help from more than one medical practitioner or healer.

Ten percent of respondents reported that a traditional healer had been consulted in the first instance, and 32% said that traditional healers were consulted subsequently. Of those who reported going to traditional healers, 18% indicated that they consulted a second traditional healer when the treatment proved unsuccessful (*ibid*: 211). In other words, 18% of the 32% (that is, 6/32) who visited traditional healers in the second instance were already clients of traditional healers (rather than people who had first tried a Western doctor or self-medication before opting to visit a traditional healer). A total of 36% (10%+32%-6%) thus reported that they or a family member was a client of (at least one) traditional healer. Given an average family size in Katutura of 5.1 (Pendleton, 1993: 132), dividing 36% by 5.1 results in a per person indicator of 7% for the number of sangoma clients. This is comparable to the 6.1% for the individual respondent from Khayelitsha.

Understanding the Question

The problem of how respondents interpret questions about sangomas or traditional healers has already been touched on with regard to the definition of such healers. However there is a much more fundamental problem with regard to how respondents understand the concept of 'illness'. The answer to the question 'did you visit a sangoma the last time you were very sick' also depends on how respondents understand illness. Not only are respondents going to have individual views on the matter, but they are also likely to have views about what sort of illnesses the fieldworker wants to hear about.

Following Beyerstein, a distinction may be drawn between biomedical understandings of disease as "a pathological state of the organism due to infection, tissue degeneration, trauma, toxic exposure, carcinogenesis, etc" and the more subjective notion of illness as "the feelings of malaise, pain, disorientation, dysfunctionality or other complaints that might accompany a disease" (1997: 2). Such feelings of malaise are "moulded by cultural and psychological factors" and may be physical or psychosomatic in origin (*loc. cit*). Asking someone about the last time they were "very sick" falls into a grey area between these two concepts: some respondents may understand the question strictly in biomedical terms, and others may interpret the notion of being 'sick' as 'feeling ill or unwell'.

To make matters more complex, respondents may differ in how they interpret which 'illnesses' are suitable for reporting to survey field-workers. Le Beau in her study of health-seeking behaviour in Katutura (2003), provides a compelling case that people distinguish between 'Western' or 'universally recognised illness symptoms' (for which their overwhelming preference is to seek Western medical attention) and specifically 'African' illnesses which they believe

Western medicine is incapable of treating. Ashforth argues that the same thing is true for South Africa:

> The foundational distinction in everyday understandings of health in Soweto, as in the rest of black South Africa, is between 'natural' illnesses… and 'man-made' or 'African' diseases… Sometimes a further distinction among natural ailments is made between diseases of 'whites' and other natural ones known to Africans of old. As an everyday rule of thumb, natural illnesses are thought susceptible to treatment by Western medicine, and man-made afflictions are immune to such treatment and require the intervention of healers deploying spiritual powers (2005: 44-5).

In her 1996 survey, Le Beau asked respondents what 'illnesses' they believed that Western doctors are unable to treat. Table 1 lists the percentage of respondents who volunteered (unprompted) illnesses that they believed were not typically viewed as appropriate illnesses for Western health practitioners to deal with. These are illnesses with a social/spiritual aetiology (origin) – that is, those that come from the patient's spiritual realm including breaking cultural taboos, contamination, witchcraft, misfortune and ancestor dissatisfaction (*ibid*: 3). They include problems such as tokoloshe[4] infestations (bad spirits in the house or body) and bad luck – that is, problems that push the boundaries of the term 'illness' way beyond its normal limits.

TABLE 1: Selected illnesses which respondents believe are not suitable for treatment by Western doctors (Representative Survey of Katutura, 1996)

	Percentage of respondents volunteering these illnesses (n=362, each respondent could list more than one illness)	Reason for visiting a traditional healer (as a percentage of all reasons for visiting a traditional healer)
Bad luck/misfortune	8.3%	2.5%
Jealousy	1.1%	5.3%
Traditional poisoning (witchcraft)	10.5%	8.5%
Bewitchment	13.0%	22.8%
Bad spirits in house or body	3.6%	11.0%
Swollen feet/gout	3.0%	4.5%
Sexual and reproductive problems	6.1%	10.6%
'Something that blocks the chest'	4.4%	1.2%
Mental illness	38.7%	7.7%
Epilepsy	24.0%	2.8%
Other	N/A	23.1%
Total	**N/A**	**100%**

<u>*Source*</u>: *Le Beau (2003: 218-9, 209-10).*

Although some illnesses (such as swollen feet, epilepsy and abdominal, sexual and reproductive problems) are closely associated with witchcraft, the boundaries between illnesses with a natural and a spiritual aetiology are far from exact. Any 'Western illness' could be attributed to witchcraft in the same way that misfortune can be. People may thus consult Western doctors to help cure the illness, and consult a sangoma to understand why they had the misfortune of contracting the illness in order to take appropriate steps to address the spiritual

causes. The case history of Nana discussed by Mills (2005 – in this volume) tells precisely this kind of story.

This interface between Western and traditional medicine is illustrated in Table 2 which reports – according to different typical illness manifestations – how people in Katutura say they use both systems. For each illness listed, the majority of respondents report a preference for Western medicine. However, a substantial minority report that they would seek the help of a traditional healer as a first or second resort with regard to intestinal problems, mental problems, epilepsy and infertility. This probably reflects the fact that these illnesses are typically associated with witchcraft and other spiritual aetiologies (as shown in Table 1). Such findings are consistent with another Southern African study from the early 1960s of patients in Harare hospital who had first sought the advice of a traditional healer. By far the greatest number of cases pertained to intestinal and abdominal problems (Gelfand, 1967: 87-100).

However, according to Leonard, the fact that people have different health-seeking strategies for different illnesses is consistent with the 'active patient' model which holds that each 'illness condition from which a patient might suffer should be seen has having a unique production function for healthiness' (Leonard, 2004: 2-3). The model predicts that people will consult traditional healers for conditions that are responsive to both medical and patient effort – such as chest pains, stomach aches and respiratory problems (*ibid*: 22-3). Such an explanation does not rest on witchcraft beliefs as the driving force behind which illnesses are taken to traditional healers – although it is consistent with it (as patients need to believe that the traditional healer is successful in addressing the witchcraft induced problem, and in this sense, the condition is responsive to effort on the part of the patient and the healer).

The fact that people utilise Western medicine for most illnesses, but often seek both Western and traditional health care services for specific problems, points to the dangers of posing either or questions to respondents about the use of traditional healing services. For example, in the 2005 South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, respondents were asked where they 'usually obtained health care' (Shisana *et al*, 2005: 127). Unsurprisingly, only 0.1% reported that they usually obtained health care from traditional healers. This figure is meaningful only in that it tells us what we already know – that people mainly use Western biomedicine – and tells us nothing useful about the demand for traditional healing services for specific conditions.

To return to the question posed in this section – how respondents in social surveys understand the concept of 'illness' – the preceding analysis suggests that a great deal of caution is in order. Whether a person records that they consulted a sangoma the last time they were 'very sick' depends on what illness episode is

being reported, on how the respondent conceptualises illness, on whether he or she believes that the ultimate cause of the particular illness episode was natural or spiritual in origin, and on his or her judgement as to what the interviewer considers an appropriate range of responses to be. For example, if respondents believe that the interviewer is asking specifically about 'Western' illnesses – that is, diseases with typically recognised symptoms (such as diarrhoea) – they are likely to report only visits to a sangoma for such illnesses. They may also have consulted a sangoma in regard to African illnesses (such as tokoloshe infestations and problems of infidelity) – but chose not to report this on the grounds that it probably did not fall within the bounds of the interviewer's notion of an 'illness'. If so, then the number of actual visits to sangomas would have been under-estimated by the survey.

TABLE 2: Health-Seeking Behaviour (first and second resort) by type of illness (Representative survey of Katutura, 1996)

	Western Medicine		Traditional Healer		Treat at Home	
	First resort	Second resort	First resort	Second resort	First resort	Second resort
Athsma	87.7	86.1	0.5	5.9	11.8	8.0
High Blood Pressure	88.8	89.6	1.9	4.0	9.3	6.4
Recurring Fever	41.6	72.8	1.3	3.7	57.1	23.5
Frequent Dizziness	74.7	76.3	6.2	14.2	19.1	9.4
Persistent Cough	40.0	69.3	1.3	4.5	58.7	26.1
Headaches	60.0	69.1	10.4	20.3	29.6	10.7
Impotency	86.3	83.3	8.5	13.5	5.2	3.2
Infertility	63.8	55.6	31.2	40.8	5.0	3.6
Intestinal Problems	43.0	48.1	39.8	46.5	17.1	5.3
Stomach problems	68.5	73.5	8.0	17.1	23.5	9.4
Liver problems	90.3	93.0	2.7	3.2	7.0	3.8
Mental illness	52.9	46.5	42.0	51.3	5.1	2.1
Menstruation problems	81.6	86.4	1.1	4.5	17.3	9.1
STDs	91.5	90.1	3.5	5.1	5.1	4.8
Tuberculosis	94.4	93.9	0.5	1.9	5.1	4.3
Malaria	91.2	96.0	0.5	1.6	8.3	2.4
Childbirth	74.3	88.3	8.7	4.1	17.1	7.6
Diarrhoea	33.8	82.7	1.9	4.3	64.4	13.0
Bleeding nose/mouth	53.2	61.6	19.7	31.5	27.1	6.9
Sore eyes/ears	78.9	86.3	1.6	8.6	19.5	5.1
Epilepsy	54.5	48.0	39.8	47.7	5.6	4.3
AIDS	93.4	90.1	2.1	5.4	4.5	4.5

Source: Le Beau (2003: 200-01).

Thus, rather than viewing the 35 respondents in the Khayelitsha survey as the only sangoma clients in the sample, it is safer to regard them as a sub-set of a wider group of possible sangoma clients.

One potential way around the problem of how respondents perceive the severity and nature of illness, is to examine the health-seeking behaviour of people who subsequently died of their illness. This was the methodology adopted by Case *et al* (2005). By examining the 'verbal autopsy' reports (that is, interviews with close family members of the deceased) collected by the Africa Centre Demographic Surveillance site in Northern KwaZulu Natal, they were able to put together a picture of the health-seeking behaviour by people with proven life-threatening conditions in the period (up to a year) of their terminal illness. Of the 1,282 cases they considered, 97% had had some contact with Western

medicine before they died (either a public clinic or a private doctor) and half had seen a traditional healer. In only four cases was it reported that the individual had consulted a traditional healer rather than a Western doctor. Case *et al* thus conclude that "services provided by traditional healers appear to be complements to, rather than substitutes for, those provided by public and private doctors" (2005: 6). This is in line with LeBeau's findings from Katutura. Case *et al* were, however, able to take the analysis one step further by distinguishing between the health-seeking behaviour of individuals who died after a short illness compared to those who died after an illness of more than six months duration. They found that those with low levels of education who died after a short illness were more likely to have visited a traditional healer than those with higher levels of education – but that these differences did not exist for those who died after longer periods of illness. Case *et al* observe that such results "are consistent with a model in which better educated people respond to illness initially by seeking out Western medicine, and less well educated persons by seeking out traditional healers" (2005: 15).

One of the interesting features of the Case *et al* study was that it distinguished between different kinds of traditional healer. They found that of those adults aged 20-60 who had consulted a traditional healer, 42% had consulted herbalists, 20% had visited faith healers and only 13% had visited sangomas (2005: 10). Note, however, that given the design of the study, such results apply to the health-seeking behaviour of terminally ill people – hence one cannot infer that the pattern of consultation between different kinds of traditional healer can be generalised to the broader population.

We now turn to an exploration of the socio-economic characteristics and perceived health of Khayelitsha residents who reported having visited a sangoma the last time they were very ill.

Characteristics of Sangoma Clients in Khayelitsha

Mean Differences

As noted in the introduction, the 570 Khayelitsha respondents in the 2004 survey had previously been interviewed in 2000. As the earlier questionnaire had probed the personal history of each respondent, there is an extensive data base to draw on when the information from both surveys is merged into one file. For example, if one agrees with Giddens that "modernity destroys tradition" (1994: 91), then one might hypothesise that people who visit sangomas come from more 'traditional' backgrounds than others – with growing up in a rural as opposed to an urban area standing as a possible proxy indicator for such

background. However, if one agrees with Ashforth (2001, 2005) that witchcraft beliefs stem from material and spiritual insecurity, then it is likely that many urban dwellers too may be concerned about witchcraft.

As it turns out, sangoma clients were marginally – but not significantly – more likely to have grown up in urban rather than rural areas (31% of sangoma clients were living in urban areas by the time they were 14 as opposed to 29% for the sample as a whole and 73% reported that they had received most of their education in rural areas as opposed to 69% for the sample as a whole). They were also no more or less likely to be recent migrants to Cape Town. In other words, rural background was an insignificant determinant of whether a respondent was a sangoma client or not. Anthropologists would, of course, not be surprised by this result given the substantive literature showing that the attribution of illness and misfortune to witchcraft is widespread in African cities (see, for example, Mayer and Mayer, 1961; Hammond-Tooke, 1970; Dillon-Malone, 1988; Slikkerveer 1982; Staugard, 1986; Hirst, 1990; Ashforth, 2001, 2005; Le Beau, 2003). Indeed, beliefs in witchcraft are now understood by some anthropologists as efforts by people to assert "a measure of control over worlds often perceived to be rapidly changing" (Comaroff and Comaroff, 1993, xiv) as they engage with the forces of urbanisation and modernisation (Moore and Sanders, 2001: 10-13).

Sangoma clients were, however, significantly less likely to report that they could speak or write good English than was the case for the sample as a whole (59% of sangoma clients reported that they could read or write in good English as opposed to 71% for the sample as a whole). This suggests that they are likely to be at a disadvantage in the 'modern' economy. Sangoma clients were also more likely to report that they agreed with the statement that finding a job is a matter of 'pure luck' than was the case for the sample as a whole (88% and 75% respectively). This perhaps suggests that sangoma clients recognise their marginal position – and that this in turn is understood in terms of a paradigm of good or bad fortune (which in turn is consistent with the illness and healing paradigm used by sangomas). In order to capture this aspect of their relationship with the modern economy, a variable was created which took the value of 1 if the respondent reports that they speak or write English poorly and/ or if they agree with the statement that it is 'pure luck whether you get a job or not'. Seventy-five percent of the sample and 91% of sangoma clients scored a 1 for this variable. A t-test of the difference between these sample means indicates that it is significant at the 5% level.

Table 3 reports the unconditional means (and other summary statistics) for other selected variables obtained from the 2004 survey. For example, it shows that more sangoma clients are women (69%) than is the case for the general sample (60%) – but that this is not a statistically significant difference. This is perhaps

surprising given that problems relating to fertility are one of the main reasons that people visit traditional healers (as shown in Table 2) – and women are almost certainly more likely to report such problems than men. A similar trend is evident for labour-market status. A greater proportion of sangoma clients were either unemployed or not participating in the labour market than was the case for the sample as a whole – but the mean differences were not statistically significant.

TABLE 3: Unconditional Mean Differences, Selected Variables

	Age	Years of education	Monthly personal income	Total household income	Recent migrant	Agree that traditional medicine can help fight AIDS	Female	Agree that some people got AIDS through bewitchment	Have a disability grant
Sample as a Whole (n=570)									
Mean	38.5	8.9	R888	R2,105	0.111	0.0895	0.597	0.1167	0.0804
Standard deviation	12.3	3.1	R1,444	R1,884	0.313	0.2856	0.491	0.3212	0.2721
Clients of Sangomas (n=35)									
Mean	43.2	7.9	R927	R1,387	0.114	0.2857	0.686	0.2571	0.2647
Standard deviation	11.4	3.3	R1,775	R1,311	0.321	0.4583	0.471	0.4434	0.4478
Mean differences between sample as a whole and sangoma clients									
Difference	-4.8**	1.0*	-R39	R719**	-0.004	-0.1***	-0.09	-0.14**	-0.18***
t-statistic	-2.20	1.74	-0.15	2.19	-0.07	-3.92	-1.1	-2.52	-3.67

	Working	Unemployed	Non labour force participant	Index of social support	Trust in people	Serious illness or injury in past four years	Belong to one or more community organisations		Attends religious meetings more than once a month
Sample as a Whole (n=570)									
Mean	0.456	0.367	0.4439	34.0	3.64	0.075	0.455		0.699
Standard deviation	0.499	0.482	0.4972	8.4	0.841	0.263	0.498		0.459
Clients of Sangomas (n=35)									
Mean	0.371	0.40	0.4571	32.6	3.38	0.129	0.576		0.677
Standard deviation	0.490	0.497	0.5054	10.0	0.888	0.341	0.502		0.475
Mean differences between sample as a whole and sangoma clients									
Difference	0.08	-0.33	-0.01	1.38	0.26*	-0.05	-0.12		0.02
t-statistic	0.97	-0.39	-0.15	0.86	1.73	-1.10	-1.35		0.25

*Notes: * indicates significance at the 10% level and ** at the 5% level. *** at the 1% level.*

With regard to statistically significant mean differences, Table 3 shows that clients of sangomas are more likely to be older, less educated, and come from poorer households than is the case for the sample as a whole. They are also significantly more likely to have a disability grant (that is, a government grant equal in value to the old age pension that is paid out to people who have been judged by a medical officer as being too sick to work). This may seem unsurprising given that a disability grant is a proxy for poor health, and one would expect people with poor health to make more use of medical services (traditional or otherwise) than those with better health. However, it is somewhat puzzling that a second possible proxy for poor health – that is, whether the respondent reports that they had a serious illness or injury in the past four years – did not show up as having a significant mean difference between sangoma clients and the sample as a whole. This issue is explored in more detail below.

Finally, one would expect people who visit sangomas to hold attitudes consistent with the witchcraft paradigm. Two questions from the 2004 survey relating to the cause and possible cure for AIDS can be used as possible proxies for such attitudes. As Ashforth notes, "Symptoms of illness associated with the onset of AIDS, such as persistent coughing, diarrhea, abdominal pains, and wasting, have long been associated in this part of the world with the malicious assaults of witches" (2005: 9). Probing attitudes about the aetiology of AIDS is thus potentially of value. The first question asked whether respondents agreed or disagreed with the statement that 'some people got AIDS through bewitchment' (26% of sangoma clients agreed with the statement as opposed to only 12% of the sample as a whole). The second question asked whether respondents agreed or disagreed with the statement that traditional African medicine can help fight AIDS (29% of sangoma clients agreed, whereas only 9% of the sample as a whole agreed).

Given that a significant number of sangoma clients agreed that a dread disease such as AIDS could be visited on people as a result of deliberate bewitchment by others, it is perhaps unsurprising that sangoma clients tend to be less trusting of people in general than was the case for the sample as a whole. Respondents were asked whether they agreed or disagreed (and how strongly) with the statement, "In general, most people can be trusted". Responses were scored from 1 (strongly disagree) to 5 (strongly agree). As can be seen in Table 3, the mean value of these responses was 3.64 for people who were not sangoma clients, and 3.38 for people who were. This difference is significant at the 10% level.

The relationship between witchcraft beliefs and trust in others is a close one. In his analysis of Soweto, Ashforth (2005) stresses the importance of material and spiritual insecurity as the source of jealousy and resentment – that is, the elemental motives of witchcraft. He argues that those living in a world with witches do so:

> in the light of a presumption of malice: one must assume that anyone with the motive to harm has access to the means and that people *will* cause harm because they can. If the supposition that harm *can* be caused by mysterious means must be taken seriously, then it is dangerous to assume that an instance of suffering might be accidental or a product of purely impersonal forces devoid of connection with human or spiritual agency (2005: 69).

This, of course, poses serious problems for social relationships. As Ashforth notes, "The possibility of extraordinary action by people who are otherwise experienced as utterly ordinary makes the smiles of the villainous neighbour masks of extraordinary complexity" (*ibid*: 13). When life is believed to be subject to secretive, occult attack, it is 'wise to presume malice… Such wisdom,

however, makes trust inordinately difficult" (*ibid*: 80). And, "when people begin to wonder whether witchcraft is affecting their fortunes, they have access to innumerable healers willing to endorse and inflame their suspicions." (*ibid*: 62). That those who were sangoma clients in the Khayelitsha survey were significantly less likely to trust other people than those who were not, is thus hardly surprising!

Ideally, one would wish to include a range of additional variables when predicting who is likely to be a sangoma client. These include whether the respondent had conducted a ritual for their ancestors recently, and whether he or she expects to be buried in ancestral lands.[5] It would also have been useful if the data set had contained more (and more subtle) questions about witchcraft, social capital and trust. However, as discussed below, even with a relatively limited set of variables, quantitative analysis is able to shed some light on the question of who visits sangomas.

Regression Analysis

It is useful to see whether these mean differences remain significant in a multivariate analysis. Table 4 displays the results of a set of probit regressions. Probits are regressions run on a binary dependent variable that in this case takes the value of 1 if a person is a sangoma client, and 0 if he or she is not. In selecting a set of possible explanatory variables, it is good practice to be guided by a set of hypotheses. These are as follows:

1) People are more likely to visit sangomas if they had a health problem in the past few years. There are two proxies for health problem, the first being reported health status in 2000, and the second being whether the respondent has a disability grant or not.

2) People are more likely to visit sangomas if they believe in the witchcraft paradigm, believe that luck plays a major role in finding a job, tend not to trust people, and have few urban skills (as proxied by an inability to speak good English). Such individuals are more likely to blame their problems on the malfeasance of others.

3) Income may play a role too – but the direction of that relationship is unlikely to be clear: individuals with access to income can afford to go to sangomas, but such individuals may also prefer to go to Western doctors instead.

Table 4 tests these propositions in a multivariate regression analysis. Model 1 includes two health-related variables: the respondent's self-reported health status in 2000 (a dummy variable taking the value of 1 if the respondent said that their health was poor, fair or good in 2000 and 0 if they said it was very good or excellent); and whether the respondent is in receipt of a government disability

grant. It also includes three attitudinal variables. The first combines the two AIDS-related variables 'traditional medicine can help combat AIDS' and 'people can get AIDS through bewitchment' into one dummy variable 'traditional healing paradigm – AIDS' which takes the value of 1 if the respondent scored a 1 for either or both of the former two variables. The second variable is also a composite variable taken from the 2000 wave of the panel that can serve as a rough indicator of being marginalised from the 'modern' industrial urban economy in 2000. This variable is constructed as follows: the respondent scores a 1 if they indicate that their ability to speak or write English is poor, and or if they agree with the statement that getting a job is a matter of 'pure luck'.

TABLE 4: DProbit Regressions on 'Sangoma Client'

Dependent Variable: Sangoma client	1	2	3
Age			
dF/dx			0.001
standard error			0.001
p>|z|			0.575
Female			
dF/dx			0.013
standard error			0.018
p>|z|			0.483
Education			
dF/dx			-0.001
standard error			-0.003
p>|z|			0.807
Disability grant recipient	***	***	**
dF/dx	0.131	0.177	0.100
standard error	0.060	0.072	0.063
p>|z|	0.002	0.000	0.021
Total personal income (logged)		***	**
dF/dx		-0.010	-0.008
standard error		0.003	0.003
p>|z|		0.005	0.012
Income of other household members (logged)		**	***
dF/dx		-0.008	-0.007
standard error		0.003	-2.37
p>|z|		0.013	0.007
Traditional healing paradigm - AIDS			
dF/dx	0.029	0.020	0.023
standard error	0.023	0.022	0.021
p>|z|	0.181	0.331	0.212
Poor health in 2000	*	*	
dF/dx	0.043	0.042	0.036
standard error	0.029	0.029	0.026
p>|z|	0.083	0.088	0.105
Trust in people	*	**	
dF/dx	-0.212	-0.023	-0.014
standard error	0.109	0.011	0.011
p>|z|	0.052	0.049	0.170
Marginalised in 2000	*		**
dF/dx	0.042	0.035	0.047
standard error	0.018	0.019	0.016
p>|z|	0.070	0.133	0.042
Number of observations	492	448	441
Pseudo R-squared	0.1046	0.1453	0.1700

*Notes: * indicates significance at the 10% level and ** at the 5% level. *** at the 1% level.*

Note that the regression output for the probit lists the marginal effect (dF/dx) of a unit change of each explanatory variable (holding all other explanatory variables constant at their mean values) on the probability of being a sangoma client. Thus, in model 1, controlling for the other variables, being 'marginalised'

increases the respondent's chances of being a sangoma client by 4 percentage points (but the variable is significant only at the 10% level). Being in receipt of a disability grant increases the probability of being a sangoma client by 13.1 percentage points (and this is significant at the 1% level). The variable measuring trust in other people has a negative sign (people who are less likely to trust others are more likely to visit sangomas) and the coefficient is significant at the 10% level.[6]

The result for the disability grant recipient is intriguing. Given that we controlled for poor health status, the statistically significant value for the coefficient of this variable suggests that this could be picking up an income effect: people with disability grants not only have an incentive to visit a sangoma (because the disability grant implies that they are disabled/ill in some way to begin with) but they also have the personal means.

Model 2 explores this in more detail by adding two further income variables: the (log of the) income of the individual and the income of other household members. Both coefficients are significant and negative – which suggests that controlling for other variables, people with higher incomes (or have access to higher incomes by living in households with income earners) are less likely to be clients of sangomas. More specifically, the model predicts that controlling for other variables, a 1 percent increase in income will result in a decrease of 1 percent in the probability of being a sangoma client. Intriguingly, the coefficient on the disability grant remains positive, significant and has a larger size impact. This suggests that the reason for the positive association between the disability grant and being a sangoma client is not related to income – but rather to the characteristics of people on disability grants.

Model 3 includes a set of additional socio-economic variables, namely age, gender and years of education. None of these variables proved to be statistically significant, but adding them improved the explanatory power of the regression model (as the Pseudo-R-squared statistic rose). Note that including these variables results in the 'trust on other people' becoming less statistically significant (there is now a 17% chance that the coefficient's true value is 0). The only statistically significant variables that remain are the income figures, whether the person has a disability grant or not, and the composite variable testing for whether the individual is marginalised from the modern economy or not.

Table 5 presents the predicted probability of respondents being a client of a sangoma (using model 3 in Table 4). In prediction 1, the predicted probability is calculated (as was the case for the models in Table 4) with the explanatory variables held constant at their means. Thus, in the case of the dummy variable 'female' that takes a value of either 1 or 0, the calculation sets the dummy variable at the proportion of females in the sample (i.e. 61%). In other words

the calculation is for a mythical individual who is 61% female. If instead, we were to request a predicted probability for a real person with specific characteristics, then it is necessary to set the calculation at specific values (rather than using the default option of a mean value). Predictions 2 and 3 in table 3 are examples of such calculations based on model 6 in Table 4.

Prediction 2 in Table 5 calculates the predicted probability of being a sangoma client in the case of a woman of mean age, education, personal income and income of other household members who also has a disability grant, who reported poor health in 2000 who does not trust people, could be regarded as 'marginalised' in 2000 and agrees with the traditional healing paradigm as far as AIDS is concerned. According to the model, such a respondent has a 59% chance of being a client of a sangoma.

Prediction 3 in Table 3 runs the same marginal effects calculation, but this time varying the characteristic of the respondent in one way – by assuming that she does not have a disability grant. The predicted probability of being a sangoma client drops by almost half to 31 percent. This is a stark illustration of the importance of having a disability grant – even after controlling for health and income – for being a client of a sangoma.

TABLE 5: Predicted Probabilities of being a Sangoma Client

	1		2		3	
Dependent Variable: Sangoma client	dy/dx	x	dy/dx	x	dy/dx	x
Age	-0.001	38.6	0.002	38.6	0.002	38.6
Female	0.0127	0.608	0.064	1	0.055	1
Education	-0.001	9.02	-0.004	9.02	-0.003	9.02
Disability grant recipient	0.100	0.088	0.284	1	0.284	0
Total personal income (log)	-0.008	4.858	-0.034	4.858	-0.035	4.858
Income of other household members	-0.007	5.000	-0.344	5.000	-0.031	5.000
Traditional healing paradigm – AIDS	0.023	0.342	0.105	1	0.087	1
Poor health in 2000	0.036	0.218	0.145	1	0.116	1
Trust in people	-0.014	3.624	-0.069	0	-0.063	0
Marginalised in 2000	0.047	0.769	0.314	1	0.216	1
Predicted probability	0.0370076		0.59360687		0.31010576	

Conclusion

The preceding multivariate analysis shows that the probability of a person being a sangoma client is affected by health-related, attitudinal and material factors. Whether a person was from a rural or an urban background had no effect on them becoming a sangoma client. Instead, the most significant predictor was whether the respondent was a recipient of a disability grant or not. However, it is important to bare in mind that this result is only as strong as the regression model – which in turn is limited by the available proxies for cultural beliefs and attitudes towards traditional medicine in general, and sangomas in particular. At best, the regression model could only 'explain' 17 percent of the variation in the variable sangoma client. There is a clear need for supplementary ethnographic information and for more focussed and probing survey questions.

Nevertheless, the Khayelitsha survey enables researchers to probe the possible determinants of who becomes a sangoma client in more thoughtful ways than is possible using the more conventional survey data sets such as the Demographic and Health Surveys in Southern Africa, and the General Household Survey in South Africa.

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Notes

[1]   See Magruder and Nattrass (2005) for a discussion of this panel study.

[2]   This analysis was conducted using Stata 8. The relevant do-file is called 'sangoma.do' (to be run on 'okpanelkmp0004' – that is, the panel data set comprising the 570 people from Khayelitsha who were interviewed in 2000 and 2004). The do-files and data set are available on request.

[3]   Ashforth does, however, note that if pushed, most respondents will recognise sangomas as a specific category of healers involved with drumming (2005: 52). This is consistent with Janzen (1992).

[4]   A tokoloshe is most often described as a small, hairy man-like being with a large penis, feet and ears who haunts houses and sexually assaults women at night. It was originally a South African concept, but fits neatly into the witchcraft ideology of other Southern African ethnic groups and is now widespread throughout Southern Africa (Le Beau, 2003: 5).

[5]   I am grateful to Mugsy Spiegel for these observations. We intend to collect data on these variables in future surveys of Khayelitsha.

[6]   As the trust variable is a five-point scale, it would have been preferable to include it in the form of dummy variables for four out of the five values. However, there are insufficient observations for this. Care must be taken not to put a cardinal interpretation on this variable, but rather to consider the sign and significance of it.