

THE SOCIAL DIAGNOSTICS OF STROKE-LIKE SYMPTOMS: HEALERS, DOCTORS AND PROPHETS IN AGINCOURT, LIMPOPO PROVINCE, SOUTH AFRICA

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Summary. This paper focuses on the clinical and social diagnostics of stroke-like symptoms in Limpopo Province, South Africa. The research questions addressed here are: what are the lay understandings of stroke-like symptoms and what are the health-seeking behaviours of Tsongan Mozambican refugees and South Africans in this area? The study site is ten villages in the Agincourt sub-district of Limpopo Province which are within the health surveillance area of the Agincourt Health and Population Unit (AHPU) of the University of Witwatersrand. The population are Tsongan who speak Shangaan and comprise self-settled Mozambican refugees who fled to this area during the 1980s across the nearby border and displaced South African citizens. The latter were forcibly displaced from their villages to make way for game reserves or agricultural development and moved to this area when it was the former 'homeland' of Gazankulu. The team collected data using rapid ethnographic assessment and household interviews as part of the Southern Africa Stroke Prevention Initiative (SASPI). The main findings are that stroke-like symptoms are considered to be both a physical and social condition, and in consequence plural healing using clinical and social diagnostics is sought to address both these dimensions. People with stroke-like symptoms maintain their physical, mental and social well-being and deal with this affliction and misfortune by visiting doctors, healers, prophets and churches.

Introduction

This paper focuses on the clinical and social diagnostics of stroke-like symptoms in Limpopo Province, South Africa. The data were gathered during 2002 as part of the Southern Africa Stroke Prevention Initiative, which is based in the Agincourt Health

& Population Unit of the University of Witwatersrand. This paper explains how stroke sufferers try to maintain their physical, mental and social well-being by visiting healers, prophets and doctors within a plural health care system. In order to understand the physical, mental and social well-being of stroke sufferers in this population of Mozambican refugees and internally displaced South Africans, it is necessary not only to present descriptive data but also to review the colonial and post-colonial discourse on healing.

This paper focuses not on the nature of belief but on affliction and misfortune in the form of stroke-like symptoms, their impact on individuals and their households, and their health seeking behaviours. The study is concerned with social diagnostics – beliefs and behaviour regarding why the illness occurred and how to deal with it – alongside the clinical diagnostics. It looks at how the villagers living in the north-eastern corner of rural South Africa promote and protect their mental and social well-being when faced with sudden stroke-like symptoms.

There are several theoretical approaches to understanding health and illness in Africa. Some studies such as Vaughan (1991) have looked at the social construction of medical discourse about Africa and Africans, and how the ideas of difference have been developed during the colonial period (Junod, 1939). There are studies that focus more on the patterns of plural healing and health seeking behaviour through therapy management groups, and pay attention to explanatory models of illness and forms of social suffering (Janzen, 1978; Kleinman *et al.*, 1978, 1997). Another framework is a political economy approach (Farmer, 2001), which links health seeking behaviour to the economic realities and constraints of poverty and the costs of health care. A fourth category draws on recent extensive work on the body, looking at the embodiment of affliction and misfortune both in peoples' lives and within the fabric of their society and the body politic (Turner, 1968).

Dealing with misfortune and affliction involves mental and social well-being, and this leads to the consideration of 'witchcraft'. Within social anthropology, the contextualized approach of Evans Pritchard (1937) focused on beliefs about good, evil, causation, divination and healing. Witchcraft offered the explanation of *why* misfortune occurred more than the *how*. Later the Manchester school of social anthropology looked at fission and fusion through the idiom of witchcraft accusations and put forward the argument that they resulted in social action and change and relieved social tensions. Increase in witchcraft was attributed by anthropologists to tensions from social change related to colonialism in Africa – wage labour, urbanization, Christianity – and was linked to 'new forms of consumption, production and social control' (Sanders & Moore, 2001, p. 9).

Recently the notion of modernity in relation to witchcraft has been explored. Comaroff & Comaroff (1993) have suggested that there are multiple modernities within which witchcraft practices may have different trajectories; and there has been some focus on how witchcraft beliefs or practices could be seen as a 'matter of social diagnostics rather than belief' (Moore & Sanders, 2001, p. 4). It has also been suggested that witchcraft can be used as a way for those without authority to exert power, to resist the State or legitimate the State. So the recent renaissance of interest in witchcraft in the post-colonial African state is seen as 'specifically tied to African forms of modernity' (Moore & Sanders, 2001, p. 6), as part of everyday local

knowledge, power and the interpretation of misfortune (Ashforth, 2001). The meanings and use of witchcraft are constantly transformed depending on the political and social context.

The authors of this paper take the approach that the term witchcraft is dispensable through using local terms, and remaining grounded in empirical data. Ngubane's book *Body and Mind in Zulu Medicine* (1977) is extraordinary in its clarity and precision of translation and terminology. Throughout the entire book, the words 'witchcraft' or 'witchdoctor' were not used but healers were referred to as diviners, doctors and Western-trained doctors. She argued that the diseases of African peoples are based on Zulu cosmology (in this case Shangaan/Tsonga) and this means their interpretation is bound up with African ways of viewing health and disease. Ngubane describes illnesses as being categorized as 'natural illnesses' that are somatic and beyond the control of the patient; 'mystical illnesses' that need symbolic medicines and treatment; or 'moral illnesses' that are associated with social situations and are manifested by misfortune with somatic symptoms or just misfortune. Her view is that:

In the interpretation of illness and its treatment, we see an elaborate and ordered system of ideas and practice. It is a coherent view that prevails even now in a society that has faced repeated and continued stresses. It probably has sustained the people and provided them with deep and satisfying answers to suffering brought by illness and misfortune. (Ngubane, 1977, p. 158)

Historically in this area of Southern Africa, beliefs about ancestors and misfortune have been contested by the development of local churches. Sundkler's study of Bantu Prophets in South Africa (1961) focused on the impact of apartheid on the separatist African churches and how they developed both as healing churches and as social movements. The churches have continued to the present day. Niehaus *et al.* (2001), in research undertaken in a village very close to those in this study, traces historically how the 'villagization' following the Bantu Authorities Act in the 1960s displaced people from their homeland. Migrant labour increased and so did 'Zionist' churches. Christianity characterized Satan, witches and alien spirits as evil or malevolent. The ancestral spirits were seen as less important and the power of the Holy Spirit as more so. However, Niehaus points out that although the churches had this position, people themselves often contested this and saw both ancestral spirits and healers as potentially benevolent. Witchcraft is therefore a power exercised by the less powerful and invoked when there are perplexing events. Niehaus has also written more recently about the changing official discourse concerning witchcraft within the New South Africa (Niehaus, 2001). It is being seen as a marker of African identity whereas under the British and during the apartheid era there were laws formulated to suppress both witchcraft accusations and attempts to practise it. In South Africa, whilst there was a Suppression of Witchcraft law (1957), it was not enforced by the chiefs within the 'native homelands' (Niehaus, 2001, p. 187).

A recent commission of inquiry into witchcraft, the Ralushai Commission, had a wide representation of South Africans, amongst them a social anthropologist, professor of law, pastor and magistrate, lawyer, chief, healer, theologian, police and an ANC representative. They interviewed people from 173 communities and 43 different organizations. They concluded that belief in witchcraft is omnipresent among Africans with the only doubters being leaders of European-controlled churches. They

do, however, condemn witch hunts and killings. They blame youths, the police and sometimes healers. They conclude that witchcraft beliefs and practices form part of the culture of Africans in South Africa and Africa as a whole, and that the Suppression of Witchcraft Act is unacceptable and should be replaced by a new Act of Witchcraft Control. They suggest that traditional healers should be regulated through a council (Ralushai *et al.*, 1996, cited in Niehaus, 2001).

This paper explores how these Mozambican and South African stroke sufferers understand their somatic afflictions and social misfortunes and how they utilize healers, prophets and doctors to promote their mental and social well-being at this time of crisis in their lives. It is possible to write about this topic without using the word witchcraft, as Ngubane (1977) has done. Linguistically the problem of translation from local languages to English is difficult. This paper will use the Shangaan terms as much as possible in order to build up a picture of local meanings.

Study site and population

The Southern Africa Stroke Prevention Initiative (SASPI) is a multidisciplinary study funded by the Wellcome Trust, UK, through the Health Consequences of Population Change Programme 2001–3. It received ethical permission from the Ethics Committees of the London School of Hygiene & Tropical Medicine and from the Medical School of the University of Witwatersrand. The study aims are to explore the growing problem of cardiovascular disease in rural Africa and how best to respond, by focusing on the prevalence of strokes, the identifiable risk factors, lay understandings of stroke and its causation, patterns of health seeking behaviour, and the burden of stroke on households.

The particular setting is 21 villages (population 69,000) in the Agincourt sub-district of Bushbuckridge that are part of a health and demographic surveillance site of the Agincourt Health & Population Unit, linked to the University of the Witwatersrand (Collinson *et al.*, 2002) in Limpopo Province (previously Northern Province).

This is an area that was part of the former homeland of Gazankulu during the apartheid era. Approximately 30% of the population in these villages are self-settled Mozambican refugees, who live in either separate unrecognized villages or in mixed villages. The villagers rely on subsistence agriculture on their smallholdings, which are too small to be viable, and supplement this with a variety of paid wage labour. They work as seasonal agricultural workers on local commercial farms, as migrant labourers in the copper and gold mines and in servicing tourists in the nearby Kruger National Park and private game parks. Men of working age are often away working, returning at the end of each month, or less frequently.

Unemployment is extremely high (up to 80% in 2002 in Acornhoek and Bushbuckridge, the main towns). Water, electricity and improved housing are beginning to be supplied to some of the villages as part of the rebuilding and redistribution of resources within South Africa. Although South African citizens have access to state benefits such as pensions, disability grants and child allowances, Mozambicans at the time of the study data collection did not. In March 2003, a court case judgement opened access to these benefits to non-citizens who were registered as

permanent residents with South African ID papers. These wider eligibility criteria will be of benefit to many Mozambican families in the area, providing they are not changed by a subsequent Court of Appeal decision. The benefits are of particular importance to households in the current situation of economic hardship.

There is a range of social and material deprivation and disadvantage: some have water, electricity and employment, others do not. Fortunes of households fluctuate: some are citizens, others are not. The advent of sudden stroke-like symptoms is a catastrophic event both for the individual and their household.

Methods

Verbal autopsy data from the DSS in Agincourt revealed that stroke was the most common cause of death in people aged over 50 years (Kahn *et al.*, 1999). Almost no data were available on incidence, prevalence, or burden of disability of stroke in rural Africa. The study had clinical, epidemiological and anthropological aims. Clinically, it aimed to describe the nature of strokes of survivors admitted to hospital. Epidemiologically, it aimed to estimate the prevalence of stroke survivors and the prevalence of conventional risk factors for stroke. Anthropologically, it aimed to understand lay beliefs about stroke and other conditions, health seeking behaviour, and the burden to the community of disability arising from stroke. The team brought together the disciplines of neurology, public health, anthropology, occupational therapy, epidemiology, statistics and demography. This paper explores only the lay beliefs about stroke and health seeking behaviour in promoting the physical, social and mental well-being of stroke sufferers.

A local field team with previous experience of structured interviewing as part of the annual census update (RM, PR) were trained by the authors to carry out rapid ethnographic assessment (REA) using a range of qualitative methods (observation, semi-structured individual and group interviews) and participatory techniques (health walks, ranking and mapping). They were trained in requesting informed consent at the village, group and individual level and did so in line with recommended international best practice (Nuffield, 2002). They were also trained in the recording of detailed field notes, and a range of computer skills. There were repeated follow-up training visits (GLH, MS) and in addition they were supervised on site (BN).

Rapid ethnographic assessment was completed in six villages: two Mozambican, two South African and two mixed. Altogether, 125 interviews were carried out and these included group or individual interviews with healers, prophets, shopkeepers, church members, burial societies, gardening groups, market women, soccer teams and members of public committees, as well as individual householders and members of their families.

Subsequently, 35 semi-structured household interviews with stroke sufferers were completed. These people were identified as follows. Two additional questions were added to the annual household census carried out by AHPU in the summer of 2001. These were 'Have you experienced weakness down one side?' and 'Have you been told you have had a stroke?'. A total of 980 people answered one or both of these questions affirmatively and were subsequently visited by a physician with an interpreter who gave them a clinical neurological examination. One hundred and three

people were identified as having had a stroke, and of these 35 were visited and interviewed at home with other household members in order to understand the impact of the condition on the family, health seeking behaviour patterns and ways of coping. This was a stratified sub-sample selected according to gender, receipt of disability benefits or pensions and whether they had experienced a mild, moderate or severe stroke.

All interviews were taped and then translated from Shangaan during transcription, and typed up in Word. They were then analysed both manually and using QSR NVivo software (QSR International Pty Ltd; Bazeley & Richards, 2000). Certain transcripts were coded independently by two of the authors (MS, GLH) to check the reliability of the descriptive coding categories.

Findings and discussion

The rapid ethnographic assessment revealed that villagers did not think stroke was one of their main health problems. They considered that the main health problems were the scarcity of water, poverty and high unemployment. When listing illnesses, stroke did not appear. The findings have yielded a detailed glossary of illness terms in Shangaan. Additionally there are data on ideas about illness and health seeking behaviour both within the households as well as when visiting staff in clinics and hospitals, prophets in churches and healers in their homes.

Illnesses are understood as being African (*xintu*) or Western (*xilungu*) and alongside this they are referred to as social (caused by humans) or natural (physical). Stroke-like symptoms such as numbness down one side are understood to be both derived from a social condition called *xifulana* and a natural condition called *xistroku*. *Xistroku* is the Shangaan term derived from the English medical term 'stroke' and is used to describe weakness down one side, or paralysis:

Xifulana is similar to stroke because it affects the body parts and they both stop blood from flowing in other parts of the body. But the difference is that *xistroku* is not a human caused illness whereas *xifulana* is. (Male healer)

I think there are similarities between *xistroku* and *xifulana*. By this, I mean a person not being able to use one part of his body. Stroke is also when one part of your body is weak. (Young man)

Weakness or dryness on one side is a natural illness. *Xifulana* is caused by human beings. They both cause dryness, are painful and there is little use of the affected part. (Woman)

Respondents often described *xifulana* as being caused by jealousy, and poverty was often mentioned. Someone may be jealous of another for being able to pay school fees for their children or being able to choose when to eat breakfast, lunch or dinner. It is believed to be transmitted by stepping on a 'trap', an object which is laid in your path with 'your name on it' in order to hurt you.

I have never suffered from *xifulana* but what I can say is that *xifulana* is caused by people who are jealous of others. Someone might be jealous of you because you are working and he or she is without work. (Middle-aged woman, church member)

The following were comments made by three women from a burial society during a group discussion:

Xifulana is caused by hatred and jealousy. Like the fact that you are educated and my children are not. I might become jealous of that.

People just set a trap; you step on it and *xifulana* attacks.

For example, I see this house is well decorated and in my house I don't even have a tin to decorate. I may be tempted to do it. Or if your child drives a car and mine does not own a car.

Treatment

Whereas the physical symptoms of dryness can be treated at a clinic or hospital, it is believed that this will not be effective without addressing the underlying social causes of the condition if it is suspected or believed to be *xifulana*. There is a belief that injections are harmful and perhaps fatal to people suffering from *xifulana*. Plural healing or 'double treatment' is used by people visiting healers, prophets, clinics and hospitals at different stages and in different sequences to treat and manage the condition of 'dry limbs' and paralysis.

Your hands and legs would be dry and might lead to one being crippled and you may have a swollen stomach. Others might experience headaches. Normally the clinic can cure headaches. If after the treatment, you see no change, then you start to suspect it is *xifulana* and then you consult traditional healers....clinics are for natural illness but there are illnesses that are caused by human beings that a clinic cannot treat successfully. (Woman)

When people suffer from *xifulana*, they go to the traditional healers for treatment. I am not sure about what kind of treatment they receive from them. (Young man)

You can go to the healers and then to the doctors. When the healers treat you they use a razor to cut your skin so that they can put *muti* (medicinal herbs) in your skin. On the other hand the doctors may give you some tablets and medicine to drink. (Woman)

Plural health seeking behaviour

An analysis of the household interviews with stroke sufferers and members of their families has revealed the health seeking behaviour of these stroke sufferers, offering further understanding of specific ideas about this affliction. There is clearly a pattern of plural healing that is often called 'double treatment' and is explained in a variety of ways. The pills may deal with the physiological condition, but the prophets, healers (*inyangas*) and churches deal with the spiritual and social afflictions. There are clinics, hospitals and private doctors. The government clinics are free for women and children and run by nurses. They are reported to have erratic drug supplies although the main health centre of the area generally is well stocked. The nurses refer patients to the hospitals and distribute drugs. There are three district hospitals in the area. There is a standing charge for admittance to the hospital of R35 but drugs are free. There are also private doctors in the towns and villages in the area.

Of the 35 stroke sufferers, six reported using only allopathic sources of health care: the clinics, hospitals or private doctors. There were an additional five who used allopathic care and attended a healing church. Twenty-two of the stroke sufferers used allopathic care combined with visiting healers and/or prophets. There were only two people who visited *inyangas* or prophets exclusively. Therefore 33/35 (94%) used allopathic care either on its own or in combination with other kinds of help. In terms

Table 1. Hierarchies of resort of 35 stroke sufferers in Limpopo Province

Order of help	Clinic	Doctor	Hospital	<i>Inyangas</i>	Prophet	Church
1st	10	8	7	7	1	2
2nd	5	7	8	7	3	1
3rd	6	9	3	6	3	2

of hierarchies of resort, in 25 cases the first points of help sought were allopathic, in seven cases they were healers (*inyangas*) and in three cases they were prophets or churches. The health seeking behaviour patterns met the physical mental and social needs of the sufferers and their families through their plurality.

Healers (*inyangas*) do a variety of things. Some of them are diviners who, by throwing bones and communicating with ancestral spirits, can protect people from misfortune, rectify its effects and identify people who are perpetrating *xifulana*. Some of them are healers who prepare herbal medicines and often insert it through cutting skin with a razor. The healers may also suggest enemas and emetics to cleanse and rid the body of impurities.

There are prophets who are attached to African Apostolic churches, such as the Zion Christian Church (ZCC). They also prepare herbal medicine but pray to God, Jesus and the Holy Spirit rather than the ancestors. They have a different cosmology. They may be hostile to witchcraft and witches. In addition there is treatment through inhaling steam of substances poured on heated stones. They may also administer enemas using, generally, 'sunlight soap' (a local brand of soap) and pray with the sufferer. There are churches that practise healing through the power of prayer and herbal teas. These are mainly the ZCC and the International Pentecostal Church (IPC). People may attend the services regularly and several stroke sufferers reported spending three days of the weekend at church. The following is an account of visiting a church and doctor for help.

I consulted at the Faith Assemblies Church for help. I did not consult either prophets or *inyangas* for treatment. This is because I do not believe in them. I believe in Jesus Christ, and through prayer I am able to defeat challenges I come across. At the Faith Assemblies Church they just prayed for me. They did not give me any medication. I felt better after consulting at the church. In January, I consulted Dr X. Before the doctor could check me he said 'I do not know why you were attacked by stroke, because according to me stroke normally attacks older people'. I did not ask him why he said that stroke normally attacks older people. I paid R100 for the consultation. The doctor checked me and told me that my blood pressure is high. He offered me an injection, and gave me pills for pains and high blood. I used the treatment for two weeks. I do not think that the treatment helped me because after that I felt worse. I went back to the church for help. They prayed for me, and as time went by I felt better. The pastor advised me to also pray hard myself so that I can get better. (Young Woman, mild stroke 2 years previously)

The onset of stroke-like symptoms is sudden and dramatic and seemingly unexplainable. Help is sought from many sources as the following account of a woman in her 60s visiting a prophet, *inyanga*, doctor and church indicates:

It was in 1992, I was ploughing in the field I felt dizzy. I went to sit over there (pointing outside). Whilst I was sitting there, *ahey*, I felt I was not strong. I asked myself why am I weak, why am

I hungry, is it because I did not eat anything? I gave money to the children and said 'Rush to the shop and buy bread and cold drink for me'. They ran and brought food for me and I ate. When I tried to get up, I felt drowsy so I sat down... I was unable to speak and they took me to a certain prophet. I stayed at the prophet's place, I was unable to do anything with my hands, I was unable to sit up by myself. I stayed, I stayed and stayed until I said to myself this man (prophet) will kill me, his healing process is not clear to me, so I left and came home... My husband saw that I was still ill, so he took me to a certain healer (*inyanga*). I stayed and stayed and I said to myself this one is playing with me; let me go to hospital so I went to M. I stayed and stayed until a certain old doctor there said to me 'Do you know that you will be crippled like this for the rest of your life? You will never change'. I said *ahey* (really?) and he said *ahey* (yes). I said he is wasting my time... So I went to a ZCC prophet where I also stayed and stayed and I said '*aahh*, this one is playing with me too'. I came home, to the children and my husband. They said we will not leave you like this and we will get tired, we are taking you to the *inyanga*. There they tried to treat me but I got tired of residing in people's households so I came home... I stayed here at home for a while, others said to me there is a church that helps, go there. My husband took me there and I felt better. I am like this today because of this church. My improvement is slow because I do not have money to go to church, I do receive a pension but it is used to support the entire family and the children who are at school.

People talk about why they think they had strokes and describe its occurrence. Here are some examples of how people explained the events that they felt precipitated their stroke-like symptoms. They had various types of social explanations for why they had suddenly experienced the physical symptoms of numbness down one side. Two examples follow:

I used to work as stone blaster at the mine. Even though I used a mask to protect myself, I think the dust went through the mask because after work, my mucus had dust in it. Even when I sneezed dust came out. Another reason might be that my wife once heard rumours that I was living with another wife at my work place. My wife visited me without notifying me beforehand, and she found me with the other lady. The lady at work arranged for both of us to sleep on the floor. When I slept with her, I suspected that there was something wrong. The next day I decided to follow her when she was about to bathe in the changing room. I found a small bottle with a liquid substance in her bra. The bottle had medicine (*muti*) in it. When I asked her, she claimed it was a lotion for her face. I took the bottle and hid it for I suspected that it was *muti*. I suspected she used this *muti* because I was no longer coming back home, and I was living with another wife. Her friends told her that if she did not use the *muti* to bring me back to her, the other lady was going to inherit all my property when I die. (Man in his 40s, onset of stroke 3 years ago)

Because after my sons died part of me died too. I am unable to laugh and feel happy. Each and everyday I wake up feeling unhappy and tired, I do not sleep at night, I cannot believe my children are dead. The doctor who said I think and worry too much was right. I became ill because I am in pain when I think about my two sons. (Woman)

The economic burden of seeking care from so many sources is considerable. Although drugs are free in clinics and hospitals, the latter have a standard entrance charge (R30–35) and private doctors charge for consultations (R60–100). Healers may levy a small charge initially and only request further payment when there is an improvement in the condition, and prophets and churches do not charge. There are transport costs involved in accessing this care. In addition, the economic and social impact of caring may be considerable, especially if there is a loss of income involved by the sufferer or the carers. This is only partially compensated for by state benefits such as the Disability Allowance or a pension if the stroke sufferer is eligible and has claimed.

It is clear that the stroke-like symptoms are understood both as a physical, social and mental affliction and misfortune. Numbness down one side changes the lives of the sufferers and their families and the affliction and misfortune are embodied. The care and support of allopathic practitioners, prophets, healers and churches contains and addresses the physical, mental and social suffering. People view the symptoms of numbness as both *xistroku* (natural, physical) and *xifulana* (social, moral). Almost all of them visit allopathic practitioners and in addition the majority are using either healers, healers and prophets, or healers and churches.

These people in Limpopo Province are requesting both clinical and social diagnostics of their stroke-like symptoms and are actively seeking their containment in order to maintain their physical, mental and social well-being. Their sustained and focused efforts to do this in a harsh economic, physical and social environment undergoing radical political change is remarkable. Ideas and actions about numbness down one side can be seen as the social diagnostics of *xifulana*, which occur alongside the clinical diagnostics of *xistroku*, and are part of dealing with the uncertainties and ambiguities which occur existentially for all human beings. Here in Limpopo Province in the villages around Agincourt, there are opportunities but also real threats to the body politic, social and physical at this specific point in time of multiple modernities in post-colonial Africa in general, and in the new South Africa in particular.

The findings of this study are being disseminated to the villages, health care providers and policymakers in a variety of ways during 2003/4. It is planned to develop and implement a further programme of community based interventions to address both the clinical and social suffering of experiencing stroke-like symptoms.

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