

# Poverty and Traditional Religious Belief in Limpopo and South Africa

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*Although traditional beliefs are important to many South Africans, the area is understudied. We compare our poverty measure to those developed and used by Statistics South Africa and the World Bank, to determine that the traditionally religious are poorer than average, both in South Africa as a whole, and in Limpopo Province (where we undertook additional fieldwork). While traditional religious beliefs can be held by individuals who at the same time also hold more main-line religious affiliation, no structured survey instruments to date have explored the poverty status of those holding dual beliefs--an important area for future research.*

*Keywords: poverty measurement and analysis, traditional religious belief, poverty, Africa, health behavior, religion*

## **POVERTY IN SOUTH AFRICA**

South Africa is one of the poorest and most unequal countries in the world. The country struggles with what has been named its “Triple Challenge” of poverty, inequality and unemployment (Zuma, 2012). In 2015, approximately 40 percent of South Africans were living below the national poverty line (Stats SA, 2017b). The same year, the World Bank calculated the Gini coefficient to be 0.63, the highest in the world (World Bank, 2018c). The unemployment rate in 2017 was 26.7 percent (Stats SA, 2018).

Both the World Bank and Statistics South Africa (Stats SA), the government's statistical agency, produce comprehensive reports on the state and trends of poverty in South Africa. For the past twenty years, poverty in South Africa has been steadily trending downwards, signaling progress in the government's battle against poverty (World Bank, 2018, Figure 7). By one measure, Stats SA reported that the number of South Africans living below the national poverty line dropped from 51 percent of the population in 2006 to 36.4 percent in 2011, highlighting significant gains in national social welfare since the end of apartheid (Stats SA, 2017b). Data from the World Bank also supports this finding. According to the World Bank, the poverty rate of the country was at 53.2 percent in 2010, down from 66.6 percent in 2005 at the standard \$1.90 per person per day international poverty line (World Bank, 2018b).

However, the most recent reports from the two organizations have revived concerns for the trajectory of national social welfare. The positive trends of the previous two decades reversed their paths, and poverty rates started increasing again. According to Stats SA, the poverty rate halted its downward course in 2015 and increased to 40 percent of the population, up from 36 percent in 2011 (Stats SA, 2017b). The

World Bank also estimated a similar trend in the South African poverty rate. As in the Stats SA report (2017b), the downward trend reversed and the World Bank reported a slightly increased poverty rate at 55.5 percent in 2014, up from 53.2 percent in 2010 (World Bank, 2018b).

The World Bank also identified important characteristics of the poor in South Africa that demonstrate how this trend reversal threatens the most vulnerable populations in the nation. In South Africa, poverty levels are consistently highest among black, female-headed households, which are 10 percent more likely to fall into poverty than their male-headed counterparts. Additionally, poverty status is deeply connected to lower education, unemployment, and family size, further emphasizing the perilous position of vulnerable households World Bank (2018a). Moreover, South African poverty is intimately related to geography, and poverty is significantly higher in rural than in urban locales. For example, the Limpopo province, located in the north-west of the country, is consistently the poorest region in South Africa. In 2009, approximately 72 percent of its inhabitants lived below the national poverty line (World Bank, 2018a). Not only is the poverty rate in Limpopo drastically higher than those of urban areas, but poverty is deeper and more unequal World Bank (2018a).

## **TRADITIONAL HEALING IN SOUTH AFRICA**

In addition to widespread poverty and inequality, another important characteristic of South African society is the presence and relevance of traditional healers. The term “traditional healer” refers to the broad domain of non-Western trained private health practitioners, who operate as herbalists, diviners, faith healers or a combination of the three categories (Flint, 2015). Traditional healers also serve as counselors, mediators, spiritual protectors, and teachers of traditional African religion, customs, and culture (Zuma et al., 2016; Mathibela et al., 2015). The prevalence and cultural significance of South Africa's traditional healers draws patients.

Significant barriers to health care access, among other factors, contribute to South Africans' reliance on traditional healers for treatment. Maimela et al. (2015) analyzed the efficacy of Western health centers in rural South Africa and found that Western public health clinics had a shortage of nurses and supplies, which led to long wait times for chronic disease treatment (Maimela et al., 2015). Nurses also had inadequate training to properly administer treatment for patients with chronic diseases. Patients often lack financial resources to access more expensive private health care and supplement the treatment they receive from public health services by visiting traditional healers. Structural barriers impede access to health care, and patients resort to cultural alternatives.

Rural communities also tend to rely on traditional healers due to inaccessibility of Western health clinics. A study of a rural population in Zambia found that traditional healers were, on average, located closer to rural villagers, had faster response times, and installed flexible payment structures, such as “no cure, no pay” or payment in commodities, like livestock and crops (Stekelenburg et al., 2005). Because many rural households in South Africa rely on subsistence agriculture, these communities have low cash holdings, offering another explanation behind the attractiveness of traditional healers over Western health clinics.

South Africans generally express high levels of trust and satisfaction with their treatments from traditional healers. Researchers found that South African men trusted traditional healers more than biomedical practitioners and public state councilors to confidentially safeguard stigmatized and sensitive information, such as their HIV/AIDS status (Mambanga, Sirwali and Tshitangano, 2016). Many South Africans also self-report increased levels of happiness and reduced symptoms of depression and anxiety after visiting a traditional healer (Nortje et al., 2016) (Sato and Costa-Font, 2014). Cultural considerations, such as local conceptions of illness and religious beliefs, also contribute to preferences for traditional healers. A study of Cameroonian traditional healing found that rural residents would travel long distances to receive treatment from traditional healers, regardless of whether a Western health facility was closer (Labhardt et al., 2010). Additionally, Muslim women in Ghana relied on traditional healers because of providers' perceived insensitivity toward religious and cultural practices (Ganle, 2015).

South Africa's serious health care challenges have overstretched the biomedical sector and bolstered the role of traditional healers, particularly in rural areas. For example, nearly one in five South Africans live with HIV/AIDS, with nearly 340,000 new infections and 200,000 AIDS-related deaths in 2013 alone (UN AIDS, 2014). South Africa has 7.2 million people living with HIV/AIDS - the highest number in the world (Avert, 2017). Furthermore, HIV/AIDS disproportionately affects rural communities; in the rural KwaZulu-Natal province, HIV/AIDS prevalence is almost 40 percent (Republic of South Africa, 2012).

Traditional healers fill the gap left by biomedical centers in rural areas in HIV/AIDS treatment (Semenya and Potgieter, 2014). In a study comparing Native American and South African traditional healing, Native American traditional healers were found to have reduced HIV/AIDS infection rates by limiting high-risk behaviors such as substance abuse (Flint, 2015). Flint (2015) also posits that traditional healers could reduce HIV/AIDS infection rates in South Africa by supplementing biomedical HIV/AIDS treatment with educational materials on sexual health.

In addition to HIV/AIDS-related health education, traditional healers can contribute to rural health care through early detection of diseases and referral of patients to biomedical health care providers. In Nigeria, many traditional healers lacked adequate knowledge of the causes and treatments of malaria but were highly effective in its diagnosis (Okeke, Okafor and Uzochukwu, 2006). Encouraging traditional healers to refer patients to biomedical providers could improve early detection and chronic disease management among rural communities (Maimela et al., 2015).

Currently, mutual mistrust precludes traditional healers and biomedical practitioners from working together (Campbell-Hall et al., 2010). In South Africa, only 58 percent of Western health practitioners believe that traditional healing is a good primary health care system, and only 53 percent believe that it is safe (Mokgobi, 2014). Conversely, a majority of traditional healer view collaboration between traditional practitioners and Western biomedical health practitioners as vital (Summerton, 2006). Traditional healers reported a desire to increase cooperation between the two entities, however they felt that Western health care providers did not give them appropriate reciprocation and respect (Campbell-Hall et al., 2010; Sorsdahl et al., 2009).

Western biomedical centers' incorporation of traditional healers into South Africa's health care system does have its limitations. Das et al. (2016) conducted an analysis of the effects of training rural traditional healers in India on health care provisions. Das et al. (2016) found that training did not decrease traditional healers' use of unnecessary medicines or raise the level of health care to that of formal health care providers (Das et al., 2016). While perhaps not a long-term solution, a targeted strategy to build upon the positive aspects of traditional medicine practices may improve health care, especially in poor, rural areas that lack adequate health resources (Lambert et al., 2011).

Both health systems are not mutually exclusive and many people consult both Western health clinics and traditional healers. While difficult to parse out, estimates of traditional healing usage vary significantly. Surveys from 1995 and 1998 found that an estimated 3.6 to 12.7 percent of the South African population used traditional healers (Peltzer, 2009). More recent sources suggest much lower traditional healing usage. Surveys from 2005 to 2007 suggest that traditional healing use is closer to 1 percent or less (Peltzer, 2009).

Indeed, in the GHS, only 491 households out of 92,445 in 2014 and 320 out of 74,449 in 2015 reported that if they had a medical need that they would go first to a traditional healer. Of course, this question was worded in such a way that we cannot ascertain whether a respondent might have gone to a traditional healer after she or he saw a biomedical health care provider. We found a higher prevalence - about five percent - reported traditional religious belief in both South Africa as a whole, and in Limpopo Province specifically, in our analysis of the General Household Survey (GHS) in 2014 and 2015 when a question was asked about religious belief (Table 1).

However, the GHS question was a mutually exclusive query - respondents could only specify one choice in religious belief. We know that many people have dualistic or even more complex religious beliefs in South Africa, Africa, and the world generally, where people can identify with a main-line religion yet hold other religious beliefs (Gottlieb, 2006) (Mbiti, 1991). Since we do not yet have a survey instrument which queried dual belief, we use the 5 percent of GHS 2014 and 2015 respondents who

reported that their religious affiliation was traditional African religions. We then compare their poverty status to the remainder of the GHS sample, after constructing a poverty measure.

## **POVERTY MEASUREMENT METHODOLOGY**

There are a variety of ways to measure poverty; there is the World Bank's purchasing power parity (PPP) international poverty line of \$1.90 per person per day as well as national poverty lines with upper, lower and food-price bounds. Furthermore, poverty can be calculated through income or consumption, and can also be divided into headcount ratios, poverty gaps, and severity of poverty measures. Stats SA administers two national surveys for poverty measurement - the Income and Expenditure Survey (IES) and the Living Conditions Survey (LCS). In the IES and LCS questionnaires, Stats SA uses a combination of diary and recall methods to collect data and estimate a household's expenditures for the past year. Furthermore, Stats SA utilizes a cost of basic needs approach to produce three national poverty lines: the food poverty line (FPL), the lower-bound poverty line (LBPL) and the upper-bound poverty line (UBPL). The FPL is the Rand value of the bare minimum of food required to maintain an adequate level of health for an individual on a per capita per day basis. It serves as the base for the LBPL and UBPL, which include non-food components. Generally, the LBPL is the preferred metric of Stats SA, as it is commonly used for the country's poverty reduction targets.

The World Bank uses a slightly different approach to calculate their headcount poverty rates, which explains the differences between the Stats SA poverty headcounts and the World Bank's. The World Bank uses the international PPP \$1.90 per day poverty threshold, which is considerably lower than the Stats SA lower-bound poverty line. Accordingly, poverty will be higher when measured at the national line compared to the international line.

We compiled a range of poverty measures from different sources to create a general composite of poverty levels and trends in South Africa. We took our base measures of South African poverty from the World Bank's Poverty and Equity Data Portal, their March 2018 Overcoming Poverty and Inequality report, and from the 2017 Stats SA Poverty Trends report. As previously mentioned, the World Bank and Stats SA both used the Stats SA-administered Living Conditions Survey (LCS) and the Income and Expenditure Survey (IES) to construct the national and international poverty headcount ratios. However, Stats SA conducts a third national household survey questionnaire, the General Household Survey (GHS). Stats SA administers the GHS to broadly cover six main areas: education, health and social development, housing, household access to services and facilities, food security, and agriculture (Stats SA, 2017a).

We chose to construct our own measure of poverty using the GHS, because the GHS data set allows us to generate poverty cross-tabulations and significance tests to distinguish between traditionally religious and non-traditionally religious populations. Unfortunately, there are serious limitations with the GHS survey in that it does not collect a full consumption module or detailed income data like the LCS or IES. Instead, consumption is collected by a sole question indicating ranges of household consumption. Income is similarly inadequately captured in the GHS. There is only one question about income of the household. We return to these inadequacies below.

We calculated our GHS poverty measures using a consumption-derived headcount ratio at the \$1.90 per person per day Purchasing Power Parity (PPP) poverty line. For our analysis, we adjusted the GHS per capita expenditure by the Organisation for Economic Co-operation and Development (OECD) PPP exchange rates. We then constructed poverty indicator variables for South Africa, the Limpopo region, traditionally religious individuals and traditionally religious in Limpopo. We were only able to construct the traditionally religious dummy variables in 2014 and 2015, because those were the only two years in which the GHS asked the question about religious beliefs. Finally, we individually tabulated the weighted number of poor South Africans with each of the poverty dummies to construct poverty cross-tabulations.

We repeated this process with the Stats SA Lower-Bound Poverty Line (LBPL) instead of the World Bank's \$1.90 threshold, enabling comparisons with the Stats SA-provided poverty rates. We also estimated an income-derived poverty rate. We were only able to estimate our income-derived poverty rates for the years of 2009-2016, as the GHS first began recording total household income in 2009. We do

not present our GHS-derived estimates of poverty as strictly comparable to Stats SA or the World Bank in terms of adequacy for national poverty policy. They most certainly are not. We calculate them so that we can determine whether the traditionally religious are in fact poorer. Indeed, as can be seen at a glance (Tables 3 and 4) that our consumption-based poverty estimates differ from the reliable ones of Stats SA and the World Bank, although the trend is similar. These differences are not because we used different poverty lines, but because the GHS welfare aggregates are insufficiently captured by only one question each for consumption and income.

In comparison to the World Bank's measures, our point estimates are off. For example, we estimate that in 2011 about 37.2 percent of the South African population is poor, whereas the World Bank estimate is nearly half that at 16.5 percent using the same \$1.90 per person poverty line. However, we are much closer in 2014, where the World Bank estimate is 18.9 percent and we estimate 26.5 percent. The gap is likely due to differences in calculation of household expenditure. The World Bank uses both the IES and LCS and a combination of reporting methods to construct their household expenditures for the past year. The GHS only asks respondents to recall their household expenditures for the past month. Typically, households will underreport when they are prompted to recall their expenditures, as recall diminishes over time (Scott and Amenuvegbe, 1990). Recording expenditures in a diary will result in a higher, and more accurate, documentation of expenditure patterns than the recall method.

This conclusion is further supported in the comparisons between our GHS-calculated and the Stats SA national poverty line headcount ratios. Stats SA, which uses the IES to calculate a headcount ratio at a national poverty line, shows that in 2015 average household consumption expenditure was 103,293 Rand, whereas in the GHS average household consumption expenditure in 2015 was merely 54,681 Rand. The significantly higher expenditure in the Stats SA report provides further evidence that the recall method present in the GHS causes underreporting of household consumption. Another potential reason behind the differences in point estimates is that the GHS uses ranges and top-codes its expenditure data. Accordingly, to calculate our poverty rates, we applied the mid-points of these ranges to the poverty line to determine poverty status, which will not produce the most accurate results. The IES avoids this issue by providing exact household expenditure data. These important differences between the GHS and the IES/LCS can provide some insight into why our poverty ratios are considerably higher than the World Bank's estimates. Our measures of household welfare when using our consumption aggregate are too low, making our poverty headcounts are too high in comparison to the World Bank's \$1.90 per person line. Additionally, we make no adjustment for economies of scale in consumption so we are further off from the Stats SA figures (Lanjouw and Ravallion, 1995).

Our GHS income-based poverty estimate is much closer to the World Bank's \$1.90 per person poverty line in 2014, but still significantly different from Stats SA in 2015 despite these level differences. The trends that we found in our data match those present in the World Bank and Stats SA findings. Generally, between 2005 and 2011 poverty in South Africa decreased significantly, however this progress stagnated after 2011 and the over the next five years South Africans experienced a slight uptick in poverty.

## **DISCUSSION OF DATA SETS AND POVERTY TABLES**

Despite the various methods and poverty lines present in our tables, a few common themes emerge. Namely, the traditionally religious are considerably more likely to be poor, compared to national averages. Additionally, the traditionally religious in the Limpopo province have even higher poverty rates compared to the non-traditionally religious in Limpopo and the traditionally religious throughout the nation. Accordingly, both of our variables for Limpopo and traditionally religious are associated with significant increases in poverty. Our national poverty rate for all South Africans, calculated at the \$1.90 daily threshold, was 27 percent for 2015. In the same year we estimated that approximately 50 percent of Limpopo residents lived in poverty ( $p < 0.01$ ).

Notably, we found that respondents who indicated belief in traditional religions had a 53 percent poverty rate ( $p < 0.01$ ), and those who were traditionally religious and lived in Limpopo had a very high

poverty rate of 67 percent ( $p < 0.01$ ). These general conclusions were confirmed by our poverty estimates in both years with both poverty lines. However, the disparities are even more striking when measuring with the national poverty lines. For example, we estimated that around 50.5 percent of South Africans nationally were living below the Stats SA LBPL. When we calculated an estimate for the poverty rate of the traditionally religious living in Limpopo, our results were stark. Approximately, 88.06 percent of that specific population was living below the national poverty line ( $p < 0.01$ ).

## **FIELDWORD**

This paper is part of an ongoing research collaboration on traditional healing and social welfare between the University of Venda (Univen) and the University of Virginia (UVA). In August 2017, researchers from UVA's Batten School of Public Policy collaborated with researchers from Univen in Thohoyandou, South Africa, to interview local traditional healers and to produce a mixed-methods analysis of the social welfare of traditional healers. A total of twenty-seven individual interviews of traditional healers were conducted in Elim, South Africa, and the study found that traditional healers' monthly incomes spanned the income distribution significantly. Further analysis, however, confirmed that a majority of healers still lived below the \$1.90 per person per day international poverty line despite the income spread. While the study did not explore the quality of primary care offered by traditional healers, it did indicate that traditional healers are available and affordable for people in Limpopo, South Africa.

In 2018, the UVA research team extended the collaborative research project with Univen and conducted another trip to Thohoyandou in the summer. In this iteration of the project, the team sought to further examine the socio-economic status of the traditionally religious and the nature of their religious beliefs and health-seeking behaviors. The researchers visited nine sites throughout the Limpopo region, and interviewed 112 individuals with the help of translators. The project sought to provide insight into the question of whether or not the poor are more likely to use the services of traditional healers.

According to the data collected, there was no clear and discernible relationship between monthly income and likelihood to visit traditional healers or Western health clinics. This might be due to a variety of confounding factors. For example, many respondents reported that if they did not have enough money then they would go to a Western health clinic first – as the clinics were free to use, reducing the income effect for traditional healers. Additionally, the questionnaire attempted to account for a duality of beliefs, as the GHS forces respondents to indicate a single religious category, when many South Africans often ascribe to more than one religion. However, religious beliefs were fairly fluid, and our questionnaire did not consider the widespread prevalence of faith healing, which combined elements of traditional African religions and Christianity. This non-binary characteristic also blends into health care choice. Of those that indicated using the services of both traditional healers and clinics, many stated that they would initially visit their preferred health practitioner (either Western or traditional) and only go to the other if they did not feel cured.

## **CONCLUSION**

Our conclusion in this paper – that the traditionally religious, especially the traditionally religious in Limpopo, are on average more likely to be poor – has important implications for policy and additional research, and builds upon prior research conducted. However, the complexities and intricacies of traditional healing that were exposed in the 2018 research trip also underscore the continuing relevance and need for additional research into the intersection of traditional healing, traditional religious belief, and poverty, and social welfare.

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APPENDIX

**TABLE 1**  
**PERCENT REPORTING TRADITIONAL BELIEFS**

<b>Year</b>	<b>In Africa</b>	<b>South In Limpopo</b>
2014	4.84	6.44
2015	5.27	4.42

Source: Author Calculations from GHS.

**TABLE 2**  
**WORLD BANK & STATS SA HEADCOUNT POVERTY IN SOUTH AFRICA**

<b>YEAR</b>	<b>P0 at Nat'l Z (WB)</b>	<b>P0 at Int'l Z (WB)</b>	<b>P0 at LBPL (StatsSA)</b>	<b>P0 at LBPL in Limpopo (StatsSA)</b>
2005	66.60	25.00	-	-
2006	-	-	51.00	67.10
2007	-	-	-	-
2008	62.10	16.90	-	-
2009	-	-	47.60	71.50
2010	53.20	16.50	-	-
2011	-	-	36.40	52.70
2012	-	-	-	-
2013	-	-	-	-
2014	55.50	18.90	-	-
2015	-	-	40.00	57.00
2016	-	-	-	-

Source: As reported by World Bank and Stats SA.

**TABLE 3**  
**GHS-DERIVED HEADCOUNT POVERTY IN SOUTH AFRICA**

<b>Year</b>	<b>P0 at Int'l Z</b>	<b>P0 at Int'l Z in Limpopo</b>	<b>P0 of Traditionally Religious at Int'l Z</b>	<b>P0 of Traditionally Religious at Int'l Z in Limpopo</b>
2005	55.93	65.17	-	-
2006	51.86	72.23	-	-
2007	47.66	65.63	-	-
2008	44.24	63.65	-	-
2009	37.52	60.64	-	-
2010	40.91	63.22	-	-
2011	37.2	62.08	-	-
2012	25.43	44.09	-	-
2013	23.8	41.99	-	-
2014	26.53	48.89	56.4	65.74
2015	26.85	49.76	53.15	66.78
2016	25.04	47.33	-	-

Source: Author Calculations from GHS.

**TABLE 4**  
**POVERTY ESTIMATES USING GHS CONSUMPTION**

<b>Year</b>	<b>P0 at Nat'l Z</b>	<b>P0 at Nat'l Z in Limpopo</b>	<b>P0 of Traditionally Religious at Nat'l Z</b>	<b>P0 of Traditionally Religious at Nat'l Z in Limpopo</b>
2005	67.11	70.24	-	-
2006	67.84	84.86	-	-
2007	65.67	81.7	-	-
2008	63.33	82.31	-	-
2009	57.29	77.14	-	-
2010	61.17	82.57	-	-
2011	60.42	84.2	-	-
2012	50.2	72.2	-	-
2013	49.73	72.1	-	-
2014	50.48	74.06	83.33	88.06
2015	49.25	73.94	82.7	86.4
2016	53.01	76.8	-	-

Source: Author calculations from GHS.

**TABLE 5**  
**POVERTY ESTIMATES USING GHS INCOME**

<b>Year</b>	<b>P0 using Income at Int'l Z (GHS)</b>	<b>P0 using Income at Nat'l Z (GHS)</b>
2005	-	-
2006	-	-
2007	-	-
2008	-	-
2009	16.43	37.61
2010	21.26	42.78
2011	20.97	43.36
2012	16.68	39.16
2013	14.48	37.75
2014	13.45	37.5
2015	18.7	43.23
2016	17.12	42.14

Source: Author calculations from GHS.