

**The role of traditional healers in oral health care in Kwa-Zulu  
Natal**

**By**



**Dr R Puranwasi**  
WESTERN CAPE

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**Supervisor: Professor Sudeshni Naidoo**

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## **KEYWORDS**

Traditional healers, oral health, Kwa -Zulu Natal, HIV/AIDS



## **ABSTRACT**

A qualitative study was carried out to assess the role of traditional healers in oral health care in Kwa-Zulu Natal province, South Africa. The aim and objectives of the study were to assess the oral care knowledge and practices among traditional healers, to determine the extent to which traditional healers can diagnose oral conditions and how they could be used in the provision of primary health care and prevention of the spread of HIV infection. Another objective was to use the information collected to serve as a guide for collaborative oral disease prevention programme development.

Three categories of traditional healers were identified in the sample: Isangomas, Nyangas and Umthandezelis. The average age of the sample was 45 years and the majority was female. Most healers were in training for between eight months and ten years. All traditional healers reported seeing patients with oral diseases and 93% reported that they referred patients elsewhere for additional help. All healers treated their patients with natural remedies. Seventy three per cent of the sample reported that they treated patients with HIV/AIDS. Less than 30% of the sample knew that AIDS was caused by a virus and 47% reported being 'told' by the ancestors whether an oral disease was HIV/AIDS.

In this study traditional healers were shown a series of ten photographs of common oral diseases and oral HIV lesions and asked to identify as many lesions as possible. Following basic training and education about the causes and diagnostic features of the lesions, 100% of traditional healers were then able to identify aphthous ulcers, 80% Kaposi's sarcoma and 73% could recognize cancer of the tongue. These results showed

that given proper education, traditional healers could play an important role in early detection of not only the common oral diseases but also the oral manifestations of HIV/AIDS. In addition, most traditional healers are skilled in interpersonal relations and if provided with the correct information they could be very effective as AIDS councilors. The traditional healers demonstrated good knowledge of the transmission, risk groups and prevention strategies for HIV/AIDS and they could serve as an important resource of information and should be incorporated in community based AIDS prevention and other programmes.



## DECLARATION

I declare that the thesis entitled “The role of traditional healers in oral health care in Kwa-Zulu Natal” is my own work, that it has not been submitted for any degree or examination at any other University, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Full name:



Signed:

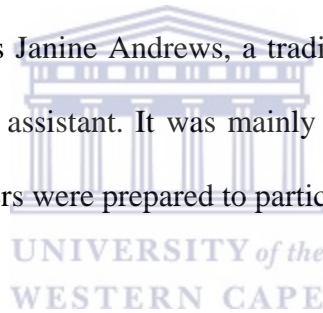
Date:

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# **THE ROLE OF TRADITIONAL HEALERS IN ORAL HEALTH CARE IN KWA-ZULU NATAL**

## **CHAPTER 1: INTRODUCTION**

A traditional healer is a person who has no formal medical training, but is recognized by the community in which he/she lives as being competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on social, cultural and religious background as well as the knowledge, attitudes and beliefs that are prevalent in the community regarding physical, mental and social well-being and the causation of the disease and disability (WHO/ UNICEF, 1978). Traditional healers were banned in South Africa by the Health Act of 1974 (Kale, 1995), but there is a process currently underway to register them with the Health Professions Council of South Africa. However, they existed in South Africa before its colonization from modern medicine. Traditional healers are accessible and culturally accepted health care providers by the community. There are about 200,000 traditional healers practicing in South Africa, compared with the 25 000 doctors of modern medicine. Eighty percent of the black population utilizes the services of traditional healers (Abdool-Karim, Ziqubu-Page, Arendse, 1994).

Essentially, traditional healers can be divided into three main categories: Isangomas, Inyangas and Umthandazelis. The most senior of traditional healers are the Isangomas. They are diviners and are highly respected in the community for their leadership and mystical powers. A person cannot choose to become a diviner. Only a person “called” by

the ancestors can become one. Isangomas determine the cause of illness by using ancestral spirits. They may or may not have knowledge of medicinal herbs. Ninety percent of Isangomas are female, although the calling is open to people of either gender, any age group or status. The duration of training for an Isangoma varies from a few weeks up to ten years and depends upon the ability of the apprentice. The fee for training is not fixed.

Following the Isangomas are the Inyangas. Ninety percent of Inyangas are men who have an intense and highly skilled knowledge of indigenous plants and their medicinal properties. Unlike the Isangomas, the Inyanga does not receive a “calling” and can choose his profession. The Inyanga spends a few years as an apprentice and does not profess to have divine powers. They specialize in the use of herbal medicine because they possess an extensive knowledge of curative herbs, natural treatments and medicinal mixtures of animal origin (Sokhela et al, 1985).

The third category of traditional healers is the Umthandazeli. These are Christian faith healer's that offer their services by means of prayer normally using holy water, herbs, ashes of burnt crosses or by hand touch (Sokhela et al,1985). They believe that their healing power comes directly from God, through ecstatic states and trance contacts with spirits, or sometimes a combination of both ancestral spirit and Christian Holy Spirit possession. A period of training as a healer in this case may not be necessary. There are three different categories of traditional healers, each having their own distinctive features.

Within each category there are different grades ranging from novices to specialists/consultants as depicted in the Table 1.

**Table 1: Traditional healing agencies (adapted from Abdool Karim, Ziqubu-Page and Arendse, 1994)**

Agent	Skills	Method of service	Nature of service	Accessibility
Isangoma (high grade)	1.Lower and middle grade qualifications a prerequisite 2."Call" by spirits 3.Apprenticed to an expert 4.Medical skills acquired as an inyanga	1.Essentially diagnostic 2.Contact with patient not needed for diagnosis 3. History, symptoms and nature of problem not revealed by patients	1.Conflict resolution 2.Revelation of misfortune & illness 3.Recommends solutions 4.Provides expertise and leadership	Relatively few
Isangoma (middle grade)	1.Lower grade qualification a prerequisite 2, 3 and 4 as above	1. As above 2.Throwsandreads"bones" 3. as above	1,2,3 and4 as above	Relatively accessible compared with above
Isangoma (lower grade)	1.First entry point to divination 2, 3 and 4 as above	1.As above 2.Divination through trance 3.As above 4.Co-operation of client sought	Confirms patient's belief	Much more accessible
Inyanga	1.Individual choice to become one 2.Apprenticed to an expert	1.Knowledge of symptoms and patients history necessary 2.Contact with patient necessary	Comprehensive, curative, prophylactic, ritualistic and symbolic	Freely accessible
Specialist	Usual family prerogative	Essentially curative	Consultant, special skills	Fewer in number
Spiritual healer	Trances and contact with spirits	Essentially diagnostic	Lays on hands, prays, provides holy water and other symbols	Freely accessible

At present, all health services in South Africa are under severe economic constraints and available manpower resources are insufficient to meet the health care needs of the population. This is especially so in the rural areas that is grossly underserved. Under these circumstances, it can be expected that traditional healers be considered by the

population as an alternative to the modern, often inaccessible and expensive health care systems, especially for the relief of acute pain.

A wide range of opportunistic infections (bacterial, fungal and viral), many of which manifest orally, are characteristic complications of HIV infections. It is well established that HIV-positive persons present with oral lesions at various stages of the disease. Studies have shown that oral lesions present in 40-70% of HIV-infected persons. Certain lesions are used as important markers of disease stage and state. These lesions include oral candidiasis, oral leukoplakia and Kaposi's sarcoma (Feigal, Katz and Greenspan, 1991). Candidiasis increases in prevalence with HIV titre (Patton et al, 1999) and, consequently occurs during both the acute phase of HIV infection (Khan and Walker, 1998; Kinloch-de Loes, Hirschel and Hoen, 1995) and in advanced- stage disease (Begg et al, 1997; Katz, Greenspan and Westenhouse, 1992). Treatment of opportunistic infections is one the important factors for management of HIV-AIDS patients. However, constraints include the high cost of antifungal drugs and resistance to conventional drugs. Traditional healers have an important role in the early detection of HIV/AIDS and should be encouraged to refer clients early to a clinic or hospital for counseling and treatment.

Despite much research in recent times for health (medical) sector collaboration with traditional healers, there is a paucity of literature with regard to the role of traditional healers in the provision of oral health care and in the diagnosis and management of the oral manifestations of HIV/AIDS. Given the shrinking health budgets, economic constraints and the diminishing capacity for oral health personnel to handle the burden of

oral health throughout much of Sub-Saharan Africa, it would seem logical to develop and enhance co-operation and collaboration between the formal oral health services and traditional healers to bring all available resources in the health sector to serve the population for better oral health and HIV/AIDS prevention. It has to be emphasized that no HIV/AIDS prevention programme in Africa can succeed without the help and co-operation of traditional healers. Traditional healers are considered to be effective agents of change as they command authority in their communities, function as psychologists, marriage and family councilors, physicians and legal and political advisors. They are also the legitimate interpreters of customary rules of conduct, morality and values. Hence, they have the authority to change or create new rules and to influence their people in matters relating to sexual conduct. Traditional healers provide client-centered, personalized health care that is culturally appropriate and tailored to meet the needs and expectations of the client. This is especially important in the case of STDs and HIV/AIDS. Since the beginning of the AIDS epidemic there have been many collaborative studies with traditional healers, to assess their knowledge and perceptions of STDs and HIV/AIDS, in the hope of finding new and more effective ways of combating the disease. With these results, programmes were created that trained traditional healers as educators and counselors to disseminate information and prevention practices about HIV/AIDS amongst their peers and communities. After training, it was realized that most traditional healers could play a significant role in health education, promotion and distribution of condoms, treatment of opportunistic infections, early referral and participation in research projects on HIV/AIDS. Most healers are capable of identifying oral candidiasis, which is the most prevalent oral manifestation of HIV/AIDS.

## **CHAPTER 2: Literature review**

A search of all the electronic databases for the period 1965 to 2005 was carried out and only a few relevant articles were found. Ideally, only peer-reviewed publications detailing the findings on the role of traditional healers in oral health care should have been used in this review, but due to the paucity of such studies in South Africa, scientific papers, reports, abstracts and conference proceedings of similar studies carried out in other countries, have been consulted for this report.

Traditional healing has always been a component of health care in South Africa but the actual contribution of traditional healers to health care in the province of Kwa Zulu Natal or South Africa is not known. A study by Puckree et al. (2002) was carried out to determine the role of traditional healers in Durban, Kwa Zulu Natal. They also investigated the number of patients that consulted traditional healers, the types of conditions treated and the frequency of consultations. Their results showed that 70% of patients consulted a traditional healer as a first choice, an Isangoma being the most popular type of healer. A significantly large number of patients consulted traditional healers for potentially life-threatening conditions. They concluded that since traditional healing was an integral component of health care in South Africa, health care professionals needed to be proactive in integrating traditional healing with Westernized practices in order to promote health for all.

A study carried out by Lewis et al. (2004) reported on the oral health care knowledge and practices of African traditional healers from two communities: Zonkizizwe and Dube in the Gauteng Province, South Africa. They carried out a cross-sectional descriptive study using a purposive sampling method. Their measuring instrument was a questionnaire and clinical photographs of common oral conditions. According to their findings, more than 90% of traditional healers from both areas correctly identified photographs of gingival inflammation, dental caries and oral candidiasis. Over 50% of healers from both areas had patients who presented with mouth problems such as toothache, swollen gums and oral candidiasis. Eighty four percent of healers from Zonkizizwe gave oral health advice to their patients, including specific advice on how to brush their teeth. Eighty two percent of healers from Zonkizizwe referred their patients with oral problems compared to 44% of healers from Dube. The high referral rate suggested a belief on the part of the healers that there was value in their patients attending a clinic for oral problems. It also acknowledged their limitations in treating patients for oral diseases.

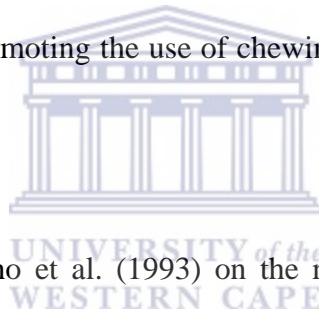
Considering that oral candidiasis has been reported as the most prevalent oral manifestation of HIV/AIDS and the fact that almost all traditional healers can recognize oral candidiasis suggests that traditional healers could play an important role in the efforts to address HIV/AIDS in South Africa.

A study carried out in Nigeria by Ongunbodede (1991) found that traditional healers were providing dental care, but their work was not integrated with that of a dentist. Ongunbodede (1991) also found that the traditional healers were open to the prospect of



collaborating with the dental profession, whereas the reverse was not true. If one considers the fact that traditional healers are more numerous than dental and medical practitioners and the fact that they are widely accepted by a large proportion of the population, it is only logical that their work be integrated with that of the dental and medical practitioners.

In Africa and some parts of Asia chewing sticks are used for plaque removal (Akapta et al. 1977; Enwonwu et al. 1985). Most plants used as chewing sticks contain fluoride and/or have antimicrobial, anti-cariogenic or anti-inflammatory properties (Enwonwu et al. 1985; Sote, 1987). This is a good example of how traditional healers can be used to promote oral health care by promoting the use of chewing sticks in remote or rural areas of the country.



A study carried out by Ngilisho et al. (1993) on the role of traditional healers in the treatment of toothache in Tanga region, Tanzania found that sixty per cent of the villagers that suffered from toothache sought treatment from traditional healers. They were all treated with local herbs and forty per cent of the villagers who sought this service obtained relief of pain for more than six months. The authors concluded that the presence of modern health facilities did not influence the villagers' use of traditional healers. Hence, it could be expected that traditional healers be considered as an alternative to modern health systems by the population, especially for the relief of acute pain, in underserved rural areas.

However, one needs to be wary of certain ‘damaging’ traditional practices e.g. the practice of extracting tooth buds and of rubbing herbs on to the gingivae of children by traditional healers in order to treat fevers and diarrhea, has been documented in countries such as Tanzania and Uganda (Kikwilu and Hiza, 1997). By extracting tooth buds based on this belief, children become victims of the practice because it denies or delays its prescription of scientifically proven treatments for diarrhea and fevers. The fact that belief in the efficacy of some traditional treatments, despite their damaging consequences still exists, shows that there is a dire need for health education programmes as well (Kukilwa and Hiza, 1997). Discouraging the adoption of deeply rooted traditional practices that are potentially hazardous to health and oral health, need to be made a public health priority. This could be achieved by educating not only the general public, but also the traditional healers and community leaders that convey the knowledge to their people. In Sudan, Baba and Kay (1989) recommended a major educational campaign aimed at encouraging the population to consult competent authorities when they encounter health problems.

Therapeutic methods used by African traditional healers include psychosocial counseling, simple surgical procedures, rituals and symbolism. The types of medications used by traditional healers can be classified as follows:

*Preventive and prophylactic medications*

Among the Zulus, medications for self-fortification are called amaKubalo. It is sprinkled around and about their home to ward off lightening or to cause the evildoer discomfort in his impious endeavors.

### *Treatment for ailments*

According to Bryant (1970) and Gumede (1991) these are prepared in different forms such as cold and hot infusions, decoctions, powders, poultices and lotions, and a variety of earthy ointments that comprise animal fat, clay and sometimes ashes. These formulations are made into different medicinal mixtures, known as umuthi, from secret recipes that are a part of the knowledge that the traditional healer passes onto his/her apprentice. The mixtures can be drunk, smoked, inhaled used for washing or steaming or smeared on the body. Pouring the required amount of cold water on chopped herbs, bark or root makes cold infusions. If hot infusions are simmered or boiled for some time they are made into decoctions that can be used orally, as rectal enemas or for inhaling.

### *Medications used to destroy the power in others*

These target specific individuals like witches. A concoction is placed in the enemy's path so that when the enemy crosses the path, he/she will contract a fatal disease.

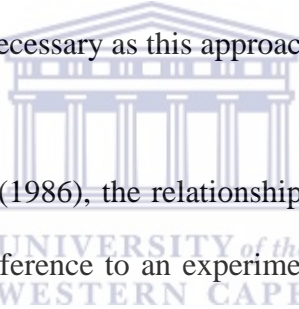
The need to identify and recognize the beneficial effects of traditionally used plants and medicaments has been recognised and many groups have now taken up the issue (Hamza et al. 2005; Tapsoba and Deschamps, 2005; El-Hilaly, Hmammouchi and Lyoussi, 2003; Kambizi and Afolayan, 2001; Gessler et al, 1995). An investigation into the treatment of oral diseases with medicinal plants in the Kadiogo Province, Burkina Faso reported that although the region is mainly urban, it appears that traditional healers who live there, and the general population, continue to rely on plant products when dealing with a broad range of oral health concerns (Tapsoba and Deschamps, 2005).

Hamza et al. (2005) investigated the antifungal activity of traditionally used Tanzanian plants and found good correlation between traditional therapeutic use and the *in vitro* antifungal activity and corroborated the importance of ethno botanical surveys for screening plants as a potential source for bioactive components that may have preventive, prophylactic or treatment properties for oral and other diseases.

Some of the most common surgical procedures performed by African traditional healers are scarification, bloodletting and cupping. A number of rituals such as the induction of vomiting, enemas, bloodletting, whistling or animal sacrifices are performed if the illness is perceived to be bewitchment. The aim of these rituals is to restore balance and harmony, reduce patient's anxiety and serves to relieve feelings of guilt.

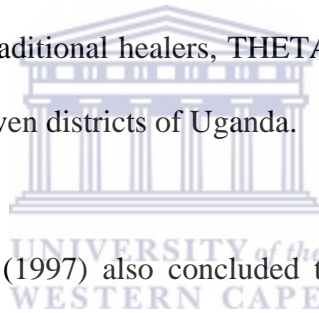
Sarita and Tuominen (1993) undertook a study to investigate the pattern of utilization of medical and dental health care services in rural Tanzania. They reported that nearly all the subjects interviewed made use of modern dental and medical health care services and that home remedy was the only indigenous method of treatment used for dental problems while for medical problems a traditional healer was the most commonly used indigenous alternative. Adults probably did not use traditional healers for dental problems because they cannot alleviate the acute episodic dental pain. Sarita and Tuominen (1993) concluded that the pattern of utilization of health care services differed for medical and dental problems and that this should be taken into account when planning comprehensive health care services for rural African societies.

The literature review revealed that there have been many instances where traditional healers have collaborated with various modern health sectors. Wilkinson et al. (1999) carried out a study in Hlabisa, South Africa to determine precedent and potential for traditional healers to act as tuberculosis (TB) treatment supervisors. Although only four per cent of the study population believed that traditional healers could cure TB, 84% stated that they would consider choosing a healer as a treatment supervisor. Eighty eight per cent of healers in the study population reported having referred patients with possible TB to hospitals for treatment and all the healers were keen to negotiate collaboration with health services. Nearly all (92%) were also willing to act as treatment supervisors. Wilkinson et al. (1999) concluded that the potential for collaboration was high in Hlabisa and that further evaluation was necessary as this approach was scaled up.



In an earlier report by Edwards (1986), the relationship between traditional and modern medicine was described, with reference to an experimental research study conducted in South Africa, which focused on interviews with traditional Zulu healers and modern clinical psychologists with the same group of psychiatric patients. His results indicated that while traditional and modern practitioners worked from different theoretical orientations, they were in significant agreement as to both diagnosis and treatment of patients when faced with the same limited choice of options. The patients in his study also perceived both the traditional and modern practitioners as being more or less equally helpful.

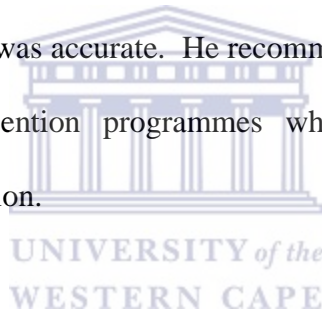
In Uganda, THETA (Traditional and modern health practitioners together against AIDS and other diseases), is promoting collaboration between traditional and biomedical health workers in the prevention and care of sexually transmitted infections (STIs) including HIV/AIDS. The projects involve collaboration in clinical trials to study the effectiveness of herbal treatments for opportunistic infections and to empower traditional medicine practitioners to offer counseling and education on STIs/AIDS. After receiving training some traditional healers became involved in community education, others in counseling and HIV-support groups. This resulted in an overall increase in the community education, counseling and understanding about HIV. It also resulted in behavior change in the public, including an increase in condom use. Hence, by respecting the knowledge, experience and beliefs of the traditional healers, THETA was able to expand the project to cover some 250 healers in seven districts of Uganda.



A study by Homsy and King (1997) also concluded that traditional healers could be trained as counselors and educators to disseminate HIV/AIDS information and prevention practices between their peers and communities. Case studies indicate that traditional healers are capable of performing at least as well as their biomedical counterparts as AIDS educators and counselors. Of concern to King and Homsy (1997) was the failure of many projects to provide systematic follow-up to healers after their initial training. Such follow-up is essential to support healers in dealing with unfamiliar issues such as condom use and death and dying.

Masauso Nzima et al. (1996) carried out a similar study in four Copperbelt towns in Zambia. A program was established whereby traditional healers received AIDS training and learns to counsel clients on safe sex behaviors. Follow-up meetings are held monthly between health professionals and traditional healers. The project has been highly successful and traditional healers now sell condoms to their clients through a social marketing program.

A qualitative investigation by Abdool Karim (1998) exploring potential preventative health roles that traditional healers could play with regard to the AIDS epidemic found that the Isangoma's knowledge of the transmission mechanism, risk groups and prevention strategies for AIDS was accurate. He recommended that traditional healers be incorporated into AIDS prevention programmes where they can play a role in community-based AIDS education.



According to Green (1999) there is increasing recognition on the role of traditional healers in preventing and controlling HIV/AIDS and other sexually transmitted infections (STIs). A number of these HIV prevention programmes have involved traditional healers and has helped them to improve their skills in diagnosing, treating and counseling clients with HIV/AIDS and STIs.

Green (1999) made some important recommendations for one to consider when planning collaborative work with traditional healers:

- Be fair and democratic in selecting healers for training
- Try to identify and train motivated healers who are respected in their communities
- Do not make membership of a traditional healer association a requirement for participation in HIV/AIDS training
- Encourage healers to promote sexual abstinence among youth, and fidelity within marriage among adults.

The World Health Organization (WHO) and other official groups acknowledge the potential effectiveness of traditional healers as primary takeovers and the potential efficacy of their treatments in the fight against HIV and AIDS, sexually transmitted disease, and other infectious diseases (Hewson, 1998). The WHO also supports the integration of Western medicine and traditional healing and encourages referrals between the two. In South Africa, traditional healers have their own organization (Board of traditional healers) that is recognized by the Department of health and by the Ministry of Health respectively. Among the Zulu population, traditional healers serve many functions in the community, such as the role of a minister of religion, legal advisor, healer, custodian of history and tradition and community organizer (Gumede, 1991; Mkhize, 1981; Ngubane, 1977 and Chonco, 1972). By virtue of their stature, traditional healers can bring about change in the behaviour of individuals, families, neighbourhoods and communities.



The aim of this study was to assess the knowledge and practices of traditional healers and determine the extent to which traditional healers can diagnose oral conditions and how they can be incorporated into the service provision of primary health care and prevention and spread of HIV infection.

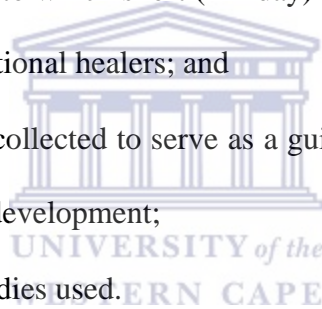


## CHAPTER 3: AIMS AND OBJECTIVES

The aim of the present study was to assess the oral care knowledge, practices and procedures amongst traditional healers.

The objectives of this study were:

- To determine the traditional healers knowledge about oral health;
- To describe the traditional healers and the oral health care services they provide;
- To determine the extent to which short (1-2 day) training courses will have on the diagnostic skills of traditional healers; and
- To use the information collected to serve as a guide for collaborative oral disease prevention programme development;
- To describe herbal remedies used.



## **CHAPTER 4: RESEARCH DESIGN AND METHODOLOGY**

### **Introduction**

African traditional healers are highly respected and are consulted by at least eighty percent of South Africans before they visit a professional nurse or allopathic doctor. The Health Professions Council of South Africa (HPCSA) acknowledges that traditional healers have a role to play in the health sector and have begun registering traditional healers.

In order to set up the study, meetings were held with the uMngeni municipal manager, local chiefs and professional nursing and medical staff in the uMngeni Municipality, located in the Kwa Zulu Natal Midlands. Initially, respected elder community health workers liaised with local traditional healers before a meeting could be set up. Traditional healers are generally very secretive; hence interviews were only conducted after they were granted permission from the ancestors to participate in the study.

This chapter describes the study design, sample, survey method, how the questionnaire was piloted, data entry and method of analysis.

### **Choice of Research Method**

The choice of a research method relates to the aims of a study and consequently will depend upon the nature of the enquiry and the type of information required. There are a variety of research methods available none of which are necessarily superior to another but are used for different purposes. In this chapter reasons will be put forward for the use of qualitative methodology in this study.

## **Qualitative research**

Qualitative research has a number of characteristics, which differ from the quantitative style of research. The most fundamental one being its express commitment to viewing actions, events, norms, values, etc. from the perspective of the population being studied. This type of approach clearly involves a willingness to empathize with those being studied, and also a capacity to penetrate the frames of meaning in which they operate. Consequently, this results in data, which is largely textual in character but also based in the language and experiences of the informants. Qualitative research aims to achieve this by means of deliberate interaction between researcher and those being researched.

One of the main purposes of qualitative research is to provide a detailed description of the social settings of those being investigated. An important contribution of descriptive detail for the researcher is to produce analyses and explanations, which do justice to the context in which his or her observations and interviews are conducted. Qualitative researchers tend to favor a research strategy, which is relatively open and unstructured rather than one, which has decided in advance precisely what ought to be investigated and how it should be done. In this way, it is argued that this open research strategy enhances the opportunity of encountering entirely unexpected issues, which may be of interest to the researcher.

### **Qualitative research methods are characterized by:**

- Small numbers of subjects chosen purposively but not necessarily representative of the population.
- Open ended and dynamic processes where the interviewer plays a crucial role in the data collection process
- Concerned with in depth exploring and uncovering data rather than counting it. The data has been considered soft and impressionistic but can explore areas in more depth and subtlety than quantitative methods.
- Can use a wide variety of techniques to collect data including depth interviews, group interviews, participant observation and projective techniques.
- Is led by the respondent's priorities and therefore is more representative of their views
- Is concerned more with what things exist and why rather than how many.



### **Non sampling errors**

Qualitative research may be affected by inexperienced interviewers, respondents wishing to give socially desirable responses particularly in group interviews and also by attributive error, that is, the researchers prejudices may influence the analysis. These can be lessened by checking for consistency of responses, using one trained interviewer and by using a triangulation method whereby another person reviews ten per cent of the data to check for bias.

## **Sampling errors**

Qualitative research can be affected if care is not taken in the choice of the participants particularly if matching is attempted.

## **RESEARCH METHOD CHOSEN**

In this study, there were many factors that influenced the choice of research method used.

These were:

- The aims of the study
- The review of the literature
- The advantages of a qualitative methodology
- Acceptability of the research method to the participants.

As this study was concerned with the role of traditional healers in oral health, it was felt that an administered questionnaire with open and closed ended questions, as well as identification of common oral lesions, would be the most appropriate way to elicit the information required.

## **Administered questionnaires as a survey method**

This was the method chosen for collecting data in this study. The purpose of a questionnaire is to collect factual and/or attitudinal data for measurement. It needs to be well designed to obtain accurate and valid responses.

## **Design rules**

The same rules of design apply to all types of questionnaire:

- It must suit the aim of the study
- It must suit the nature of the respondent
- It should be clear, simple, unambiguous
- The design should minimize potential errors from respondents and coders
- The subject of the questionnaire should interest the respondent, encourage their co-operation and elicit truthful answers
- Well worded questions are essential, and pitfalls must be avoided, for example, 'double-barreled questions' that is, when two questions are included in one- the questions will have to be separated so that the respondent and the researcher can distinguish between the two.
- The wording of the questions should not lead the respondent to feel obliged to answer in a particular way, which may not be truthful
- Questions must not alienate either the respondent or the researcher
- Efficient and meaningful analysis of the acquired data should be possible.

## **Instrument used**

A questionnaire (Appendix 2) with open and closed ended questions was the instrument used to collect the data in this study. The other measuring instrument was a series of ten colour photographs of common oral conditions and oral HIV lesions. The questionnaire

for this study was designed to ensure that it was suited to the aim and objectives of the study. We endeavored to ensure that it was simple, clearly understood and unambiguous.

### **The development of the study questionnaire**

Planning of the questionnaire began in January 2003. It was developed following a number of group discussions with traditional healers and other professionals working in the field. After a thorough review of the literature, the questions were formulated. It took about a year to generate the questionnaire, as there were no existing questionnaires to extrapolate from. The data was grouped into the following categories:

#### *Demographics*

The demographic information was further subdivided into groups that included the age and gender of the TH, their literacy level; length of training period; duration of practice as a TH and the distance of their practice from the nearest health care facility.

#### *Oral health knowledge, understanding and practices*

The traditional healer was asked to identify certain oral conditions and they were questioned regarding its cause, complications and possible treatment.

#### *Education and counseling*

Traditional healers were questioned about their oral health knowledge and their willingness to screen and educate their clients about oral health care.



### **Piloting the questionnaire**

In March 2004 the completed questionnaire and photographs were tested on six traditional healers. The pilot study was done to:

- Test the suitability of the method of collecting the data
- Check the adequacy of the questionnaire
- Check that all questions were clear and unambiguous
- Remove any items that did not yield usable data.

### **Preparation for the final draft**

After the pilot study, irrelevant and ambiguous questions were identified and either reformulated or deleted. This resulted in a general improvement of the questionnaire and an increase in the efficiency of the enquiry. The improved and redesigned questionnaire was then translated into isiZulu. The final draft of the questionnaire (Appendix) with 24 questions was then printed and copied for the larger study. The design and construction of the instrument took fifteen months to complete.

### **Preparation and conduct of the interviews**

#### **Establishing contacts**

All researchers are dependant upon the goodwill and availability of their subjects. During the initial meeting co-operation of local leaders and the relevant health authorities were obtained. Community health nurses were recruited to gain access to a number of traditional healers both in terms of geographic accessibility and acceptance of the project by the traditional healer.

Fifteen traditional healers were invited to the initial meeting at a central venue. The researcher was introduced to the group of healers. He thanked them for responding to the invitation and explained the aims and objectives of the study, what participating in the study would involve and how long the interviews would take. At the outset a cleansing ceremony was performed and the most senior Isangoma asked the ancestors for permission to participate in the study. Once permission was granted, all the traditional healers readily signed the consent forms to participate in the study.

### **Interview approach**

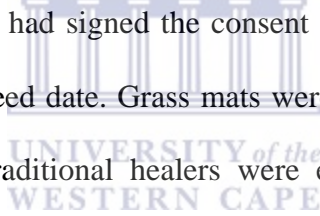
Six of the most influential traditional healers were then selected for the pilot study. I considered a traditional healer to be influential if he was a chief or headman in his area or was educated and was training other traditional healers. Those selected had status and were well respected by the community. Further, they catered to the physiological needs of their people and also act in an advisory capacity on various day-to-day issues that affect individuals and their communities. Group discussions were held regarding oral health conditions and their diagnosis. A questionnaire with open and closed ended questions and clinical photographs of easily recognizable common oral conditions plus oral lesions associated with HIV infection, were used to obtain information.

### **Data collection**

The assistance of a traditional healer (Isangoma) with a practice nearby was enlisted. She was fluent in English, Afrikaans, and isiZulu, and proved to be an excellent research assistant/translator. Attempting to get a group of 10-15 traditional healers together, at a

central location proved to be a logistical nightmare. I was invited to one of the local Traditional Healer Association meetings where I was able to address the gathering for a few minutes. The purpose of the study was explained to them and permission was requested to attend the next scheduled meeting in order to conduct interviews with those who consented to be interviewed.

The next meeting was arranged for three months later and the use of my dental consulting rooms was offered. The venue was perfect as it was centrally located, near a taxi rank and provided a suitable meeting room. I also agreed to provide their lunch and teas for the day.



Fifteen traditional healers, who had signed the consent form to participate in the study, arrived at the venue on the agreed date. Grass mats were placed on the floor and all the healers sat in a circle. The traditional healers were encouraged to bring along any materials or items used in the practice of traditional healing (drums, whisks, bones, herbs, scarification instruments, etc.) in order to make them feel at home during the workshop.

The first half of the morning session mainly consisted of ceremonial activities as the venue had to be cleansed (by burning incense and herbs and sprinkling of holy water) and the 'sacred space' protected (by placing salts and powdered roots in the corners of the room). Candles were lit and placed in the centre of the circle and certain herbs were burnt to create copious amounts of smoke. The traditional healers were then encouraged to consult with their spirits through prayer or dreams before the workshop proper commenced.

Our aim was to make the traditional healers aware that the programme accepted their belief system and the reality of their spirits. As facilitators, it was important for us to demonstrate an acceptance of the spirits and a willingness and desire that they be a part of the process. Hence, by honoring their customs, information was shared by all three types of participants at the workshop.

The facilitator then invited the local spiritual leader to open the way for the participants to learn. This involved invoking the spirits through drumming and chanting traditional songs. The facilitators then introduced themselves and then asked the traditional healers to introduce themselves by giving their names, which district they came from and their totem. The facilitator then initiated a discussion by asking the traditional healers to tell us about any dreams/ visions/ messages they have had about the workshop, including the purpose of the workshop and the effects it was likely to have. Each participant was then given an opportunity to voice his or her opinion.

This provided the facilitators with a good indication of what the participants (and their ancestral spirits) believed the workshop to be about and what they expected to get out of it. The facilitator then gave a brief background about the research project, the purpose of the workshop, roles and expectations of the facilitators and the format for the remainder of the workshop.

The self-administered questionnaires and pens were then handed out to each participant and they were asked to answer all questions. The principal investigator, together with the

translator then interviewed each participant in a separate room away from the rest of the group. Following the semi-structured interview, the traditional healers were shown ten photographs of some common oral diseases and oral HIV lesions and asked to identify as many as they could. Their answers were recorded in a table. The participants then adjourned for lunch.

Following the lunch break, the principal investigator described each of the oral diseases and lesions in the photographs in detail and informed the participants of the names of the lesions, their cause, how to identify them and possible remedies for them. The participants were encouraged to ask questions if they were unsure about any of the lesions described.

Following the tea break later that afternoon, each participant was then shown the same photographs again and asked to identify the lesions. Post-test results were then recorded in a table. The remainder of the day consisted of large and small group discussions.

The fact that the facilitator was also a traditional healer (Isangoma and Inyanga) ensured the trust and co-operation of the rest of the group. The traditional healer facilitator provided an intimate knowledge of the language, culture and practice of traditional healing. She was also able to identify with the needs and aspirations of the participants. A key factor in the success of the workshop was the establishment of a successful relationship between the facilitators and the participants.

### **Validity and reliability**

The principal investigator and translator (fluent in English and isiZulu) were the only investigators involved in conducting interviews, keeping records, gathering and interpretation of data, thereby assuring confidentiality and the standardized recording of information. Furthermore to ensure validity, the triangulation method was used, whereby another person reviewed ten per cent of the data to check for bias.

### **Coding for analysis and Data entry**

Data was entered into Microsoft Excel and the SPSS package was used to analyze the data. The chi-squared test was used to compare qualitative data. Data was firstly captured from the questionnaires. A binary format was chosen for the closed ended questions, where a 'yes' answer yielded a value of one and 'no' was assigned to zero. For open-ended questions, where similar responses were possible, alphabets, at my discretion, was assigned to answers. Having values/alphabets made the use of the *count-if*, *average*, *if-then*, *maximum* and *minimum* functions available on Microsoft Excel possible. Where the assignment of alphabets or values were not possible, the small number of questionnaires made it simple to physically analyse such data.

Hypothesis testing was used to determine relationships between data, while the chart drawing functions available on Microsoft Excel was used for figures and graphs.

## Summary

Fifteen traditional healers were interviewed for the study. The instrument developed to collect the data is described in this chapter. The instrument chosen was a questionnaire with open and closed ended questions. The other measuring instrument used was a set of ten photographs of common oral conditions and HIV lesions. The principal investigator carried out all the interviews, hence there was a hundred percent response rate.



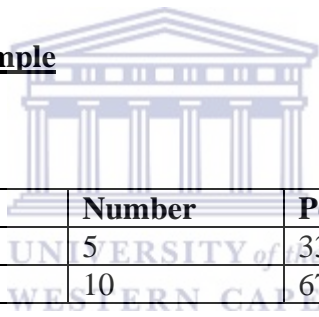
## **CHAPTER 5: RESULTS**

An analysis of the questionnaire and identification of the photographs forms the basis of the results. The in-depth qualitative interviews with traditional healers provided more detailed information about their knowledge, attitudes and beliefs

### **Demography of the sample**

Fifteen traditional healers took part in the study. There were 5 (33%) males and 10 (67%) females in the study (Table 2). All traditional healers in the study had attended school and 12 (80%) could read and write. Three (20%) of the traditional healers had obtained a university degree or diploma.

**TABLE 2: Demography of sample**

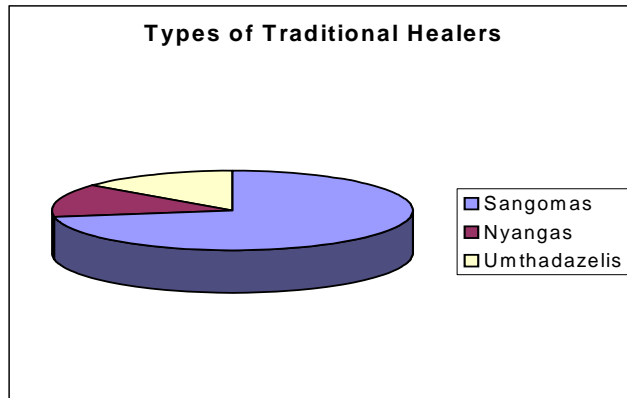


<b>Gender</b>	<b>Number</b>	<b>Percent</b>
<b>Male</b>	5	33
<b>Female</b>	10	67

There are three types of traditional healers, and their division of the sample population is depicted in Figure 1.



**Figure 1: Types of traditional healers**



There were 12 (80%) Isangomas, 4 (26.7%) Nyangas and 5 (33.3%) Umthandazelis, in the study population (Figure 1) Note that a traditional healer can belong to more than one category. Eleven (74%) were female Isangomas and 2 (14%) were male Isangomas. There were an equal number 2 (14%) of male and female Nyangas and only 5 (33%) female Umthandazelis in the study population. The average and standard deviations of the age, training and practice periods of all traditional healers are shown in Table 3.

**TABLE 3: Age, years in training and practice**

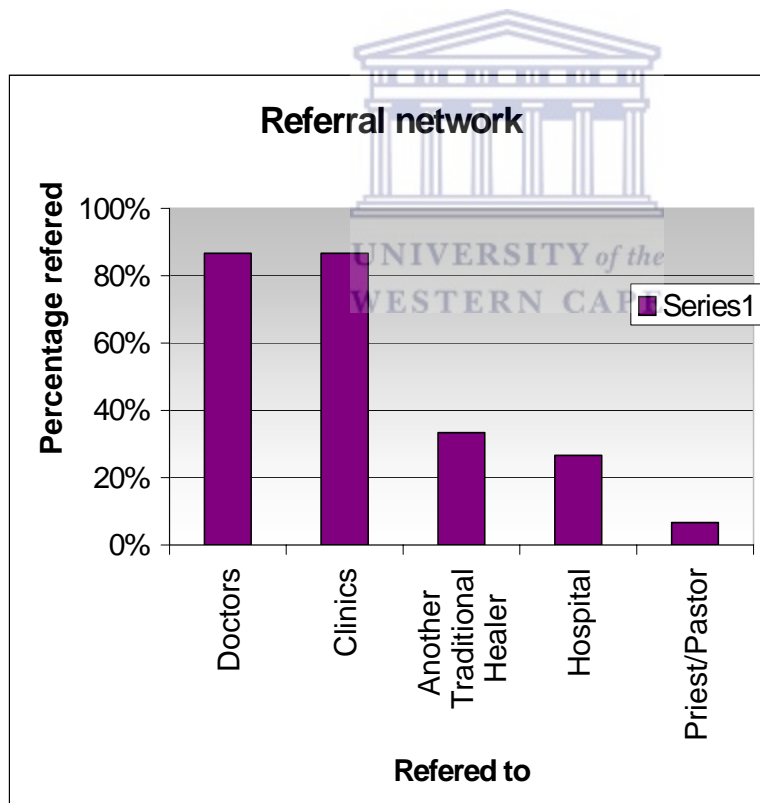
	<b>Average (years)</b>	<b>Standard Deviation</b>
<b>Years in training</b>	3.5	2.1
<b>Years in practice</b>	15.9	13.0
<b>Age</b>	45.5	11.9

Most of the traditional healers in the sample were in training for between eight months and ten years. The average training period being 3.5 years with a standard deviation of 2.1. The number of years the traditional healers was in practice ranged between 1 and 40 years. The average number of years in practice for the sample was 15.9 years.

Their ages ranged from 30 to 63 years. The mean age of the sample was 45.5 years

93% of traditional healers stated that they referred their clients elsewhere for additional help. Their referrals rates can be shown in Figure 2.

**Figure 2: Referral network**



A high percentage of traditional healers in the sample (86.7%) referred their clients to doctors or the nearest public clinic. Another 26.7% referred their clients to a hospital whereas 33% of the sample referred their client to another Isangoma.

All traditional healers (100%) reported seeing patients with mouth problems and they listed common mouth problems to be (in order of frequency):

- Thrush/Candida
- Gum disease
- Cold sores
- Tooth decay/cavities
- Gum boils/dental abscess
- Halitosis
- Swollen Glands
- Oral cancer

In addition, they recognized mouth problems by the following symptoms:

- Swollen and bleeding gums
- Halitosis
- White spots on the tongue and cheeks of the patient
- Swollen glands on the neck and throat
- Loose teeth
- Ulcers in the mouth

Sixty per cent of the healers in the sample know what causes mouth problems. The most commonly listed causes were:

- Plaque
- Tartar build up
- Lack of dental care or knowledge thereof
- Grinding of teeth
- Lack of calcium in the patients diet

All the traditional healers interviewed in the sample treated their patients with natural remedies for mouth problems. Some of the remedies used by traditional healers and their purposes are listed in the Table 3:

**TABLE 3: Types of remedies used**

<b>Name of Remedy</b>	<b>Purpose</b>
Sage leave; Salt water	Disinfectant
Vitamin C pills; Lemon; Thyme	Treats infections
Disprin; Cloves	Pain relief
Glycerine	Promotes healing
Carpobrotus Edulis (Sour fig)- leaves crushed for juice	Treats thrush; mouth and throat infection; Toothache
Bicarbonate of Soda	Eradicates ulcers
Brushing with Charcoal	Strengthens teeth
Gum from Acacia Karroo (Umunga)	Treat thrush
Bark of Berula Erecta	Treat toothache
Cotyledon Orbiculata (pigs ear)-juice	Treat toothache
Qodenaea Angustifolia- Bark	Treat thrush; Sore throat
Tetradenia Riparia (Iboza/ginger bush)- leaf infusions	Sore throat; Mouth ulcers
Zanthoxylum Capense: (small knobwood)-roots	Sore throat; Mouth ulcers; Numbing sensation
Asteraceae (African wormwood)-leaves, stems and roots	Sore throat; gum infection; Toothache
Amaryllidaceae (iNcwadi/Tumbleweed)-outer bulb scales	Dress wounds, boils, Abscesses, skin diseases
Hypoxidaceae (iLabatheka/ African potato)-weak infusions of the bulb	Treat headaches, cancers, inflammations and HIV
Asphodelaceae (iBhucu/Bulbine)-leaves are crushed or the gel from the leaves	Treat cracked lips, rashes, boils, wounds, venereal disease and stops bleeding

Thirty three per cent (33%) of patients go back to the traditional healers with the same problem (i.e. they are not cured). Seventy three per cent (73%) of traditional healers in the sample stated that they treated patients with HIV/AIDS while only less than 30% knew what caused the virus. Forty seven per cent of healers say that they are 'told' whether an oral disease is HIV/AIDS related by their ancestors, while the rest are unable to distinguish whether or not these diseases are caused by HIV/AIDS.

All traditional healers (100%) stated that they would like to know more about oral lesions associated with HIV/AIDS. Almost all traditional healers reported educating and counseling their clients about HIV/AIDS. They currently advise their patients with AIDS/HIV infection to:

- Practice abstinence
- Use a condom
- Remain faithful to one partner
- Exercise regularly
- Follow a healthy diet



**TABLE 4: Type of advice or counseling given to patients with HIV/AIDS**

<b>Advice /counseling</b>	<b>No. of citations</b>
Promote abstinence, fidelity, partner reduction	15
Advised condom use	15
Advice on partner testing, treatment	8
Advice on maintaining health, diet, exercise and nutrition	12
Promoted positive attitude, acceptance of condition	10
Spiritual counseling	15
Biomedical referral	12

All (100 %) of the traditional healers in the study reported that they would be willing to screen their patient for:

- Tooth decay
- Gum disease
- Oral Cancer
- Oral manifestations of HIV/AIDS related infections



**Figure 3: Referral Rates for HIV/AIDS related oral infections**

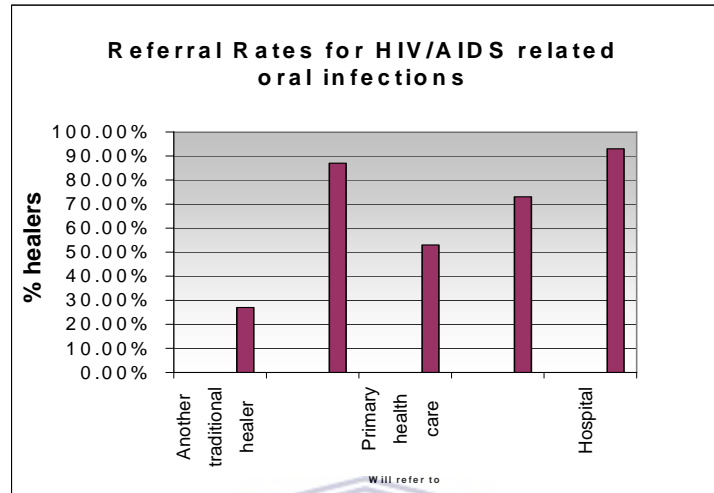


Figure three depicts graphically the rate of referral and to where traditional healers will be willing to refer their patients with HIV/AIDS. An impressive 93% referred patients to a hospital while 87% referred their patient to a doctor. 73% referred patients for counseling and treatment while 53% sent patients to a primary health care center. A further 27% sent patients to another traditional healer.

**Can you recognize any of the following oral diseases?**





A



F



B



G



C



H



D



I



E

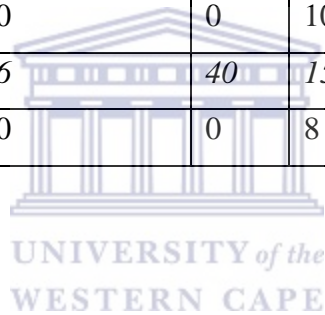


J

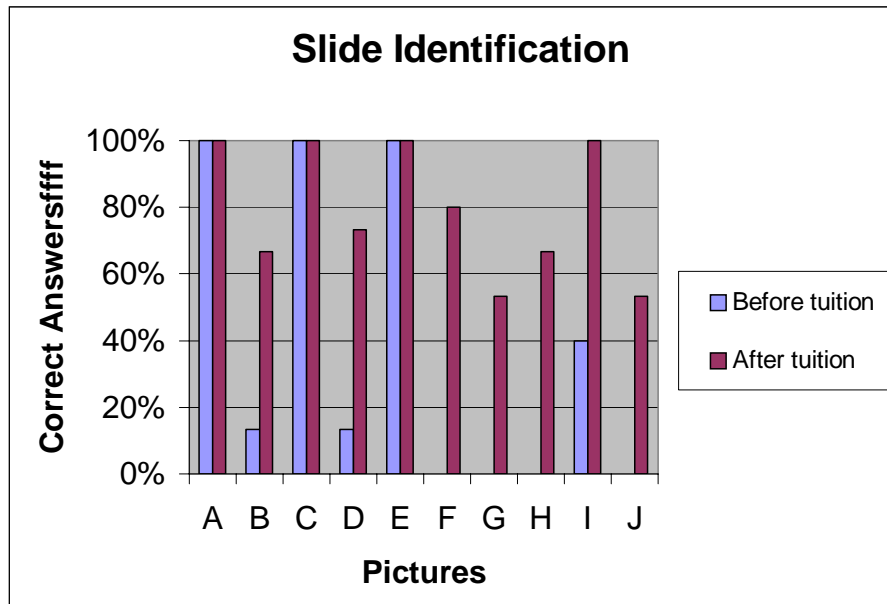


**TABLE 5: Pre and post test results to questionnaire**

<b>Letter</b>	<b>Name of Lesion or Disease</b>	<b>Pre-Test (correct)</b>	<b>%</b>	<b>Post-test (correct)</b>	<b>%</b>
<b>A</b>	<i>Dental Caries</i>	15	100	15	100
<b>B</b>	Gingival Caries	2	13.3	10	66.7
<b>C</b>	<i>Gum disease</i>	15	100	15	100
<b>D</b>	Cancer of tongue	2	13.3	11	73.3
<b>E</b>	<i>Candidiasis</i>	15	100	15	100
<b>F</b>	Kaposi sarcoma	0	0	12	80
<b>G</b>	Human Papilloma Virus	0	0	8	53.3
<b>H</b>	Angular cheilitis	0	0	10	66.7
<b>I</b>	<i>Aphthous ulcer</i>	6	40	15	100
<b>J</b>	Oral leukoplakia	0	0	8	53.3



**Figure 4: Photograph Identification**



During the workshop all traditional healers were shown a series of ten photographs to identify common oral diseases and HIV lesions. All of the traditional healers (100%) were able to identify photographs of dental caries, gum/periodontal disease and candidiasis. 40% of the healers were able to identify photographs of aphthous ulcers and a further 13% recognized pictures of gingival caries and cancer of the tongue. The facilitators then identified each photograph and described the identifying features of each disease/ lesion. The traditional healers in the study group were then shown the same set of ten photographs and asked to identify as many diseases/ lesions as possible. Post-tests 100% of traditional healers were able to identify dental caries, candidiasis, periodontal/gum disease and aphthous ulcers. An impressive 80% of healers were now able to identify Kaposi's sarcoma and 73.3% were able to recognize cancer of the tongue. A further 66.7% of healers were now able to identify gingival caries and angular cheilitis while 53.3% could identify oral leukoplakia and human papilloma virus (Figure 4).

## **CHAPTER 6: DISCUSSION**

### ***Introduction***

The aim of this study was to assess the oral care knowledge, practices and procedures amongst traditional healers in Kwa-Zulu Natal, South Africa. Such a study has not been conducted in the province before and the results of the study have proved to be very enlightening. In this final chapter, an overview of the main themes arising from this study will be presented. It will include a discussion on the methodology used in the study and important issues from the literature review will be compared with the findings from this study.

### ***Methodology***

In this study, an administered questionnaire was the method chosen for collecting data. The use of both open and closed-ended questions provided valuable information on the attitude; oral care knowledge, practices and procedures amongst traditional healers. Closed-ended questions offer a choice of responses to the respondents and they are asked to choose one. They are easy to answer, quick, require no writing and the analysis is straightforward but they may introduce bias when the respondent may be forced to make choices. Open-ended questions are not followed by a specific choice and the answers are recorded in full. It encourages a rapport between the interviewer and respondent, is more flexible and avoids misunderstanding. They are usually more difficult to answer and to analyse. The open-ended questions were used to ascertain the knowledge, general attitudes and reasons for attitudes of African traditional healers whereas the closed-ended questions measured their specific practices and attitudes.

This study also made use of in depth personal interviews, group interviews and participant observations in order to generate more in depth private accounts and to provide more interesting data. The personal interview allowed for flexibility, control, an improved response rate (100% in this study) and the collection of supplementary information. It also allowed for a greater understanding of African culture, traditions, practices and beliefs. However it is also an expensive and time consuming research design, that also lacks in anonymity and may be prone to interviewer bias.

### ***Results***

In this study three types of traditional healers were identified, that is, Isangomas, Nyangas and Umthandazelis. The majority of the traditional healers were Isangomas (80%) and they were mainly female (73%). A plurality of these women are in their mid forties. According to Green et al. (1995) Isangoma membership tends to be overwhelmingly female in Southern Africa, perhaps as much as 90%. These results are similar to those obtained by Kale (1995) and Salim et al. (1994). Isangomas tend to be ranked higher than Nyangas and Umthandazelis. Hammond-Tooke (1989) implied that Isangomas were less likely than Nyangas to engage in anti-social activities, which might suggest that Isangomas are more appropriate candidates for collaborative programmes.

The training of African traditional healers is not standardized. The aspirant traditional healer usually undergoes a period of initiation or apprenticeship that varies in standard, duration and format from one country to another. According to Dunlop (1975) learning and training is based on hands-on experience.

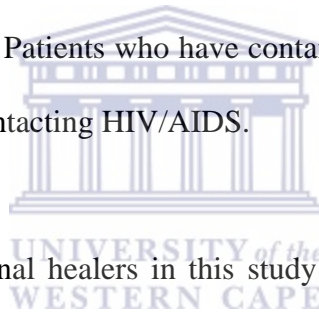
Farrand (1980) found that the length of traditional healer training varied from a few months to about a decade, depending on how fast the apprentice learnt the traditions, use of herbs and in the case of an Isangoma, the rituals to propitiate the ancestors when divining. She also noted that the trend in the suburbs of Johannesburg was towards shorter and more condensed training compared with the rural areas. According to the characteristics of our sample, 80% of the traditional healers were literate. The average training period being 3.5 years and the average number of years in practice for the sample was 16 years. Three healers reported having no formal education whatsoever whereas another three reported having a university degree/diploma.

In spite of the respect accorded to African traditional healers, studies indicate a general reluctance on the part of biomedical personnel to form a working relationship with them (Abdol-Karim et al, 1993). In the present study, nearly ninety per cent of traditional healers referred their clients to a doctor or state clinic and 26.7% referred clients to a hospital. These figures indicate that traditional healers have shown a greater degree of willingness to co-operate with biomedical practitioners. Green and Makhubu (1984) reported a similar favourable response, with 98% of traditional healers favouring co-operation with biomedical practitioners and 91% specifically expressing enthusiasm for some form of training in biomedicine. However, in South Africa, it is highly unlikely that biomedical personnel would refer patients to a traditional healer as they are still viewed with bias and suspicion. Many would view collaboration with or integration of traditional healers as a backward step because they have witnessed apparently harmful treatments administered by traditional healers.

In some countries (China, India and S. America), however, great strides have been taken towards collaboration, resulting in mutual trust and cross referral of patients (Abdool Karrim et al, 1993). The 30<sup>th</sup> World Health Assembly in 1977 adopted a resolution to promote traditional medicine worldwide. A year later at Alma Ata it was declared that African Traditional healers should be part of the primary health care team (Bannerman et al, 1983). In South Africa, traditional healers are now being recognized and registered with their own Board of Traditional Healers and efforts are being made to incorporate them into primary health care programmes. Findings from existing collaborative programmes suggest that traditional healers can play a positive role in community-based prevention. Traditional healers have been successful as supervisors of tuberculosis treatment projects (Wilkinson et al, 1999), in nutritional disorders (Friedman, 1998) and HIV/AIDS prevention (Arendorf et al, 1998 and King et al, 1997). In a study carried out by Lewis et al, 2004 more than 90% of healers recognized oral candidiasis, (whereas results from the current study was 100%). Since oral candidiasis has been reported as the most prevalent oral manifestation of HIV/AIDS, Lewis et al. (2004) concluded that traditional healers could play an important role in the early detection of oral HIV/AIDS in the effort to address HIV/AIDS in South Africa.

All traditional healers in the current study had heard of HIV/AIDS but less than 30% knew that a virus caused it. Of greater concern was the fact that 73% of traditional healers in the sample stated that they treated patients with HIV/AIDS. During the interviews it was learnt that none of the traditional healers practiced any form of infection control. None of the healers in the sample used gloves or sterilized their scarification

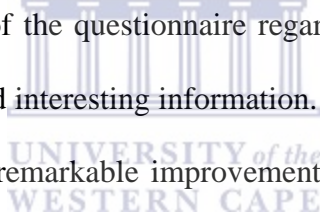
instruments. Many reported using a single blade or needle on as many as twenty clients before discarding it. Scarification is a technique used by traditional healers primarily as a means of getting medicine into the patient's body. When a patient visits a traditional healer complaining of pain, the healer makes a small incision in the patient's skin above the area that is painful, with a razor blade/needle and rubs medicine into the cut with his or her fingers or a soft tipped instrument. Patients are at risk of contracting AIDS if the razor blade/needle was used previously on patients with HIV, and was not sterilized. The healer is also at risk because his or her fingers come into direct contact with the patient's blood. If the traditional healer dips his or her finger or instrument into the container containing the medication, after it has come into contact with the patients blood the entire contents become contaminated. Patients who have contaminated contents applied to their cuts or wounds are at risk of contacting HIV/AIDS.



An impressive 80% of traditional healers in this study gave correct answers regarding symptoms of AIDS and all healers (100% of the sample) gave correct answers about the mode of transmission of HIV. In a similar study by Green et al (1995) eighty six percent of healers gave fully correct answers regarding the symptoms of AIDS and 93% of healers gave correct answers about the mode of HIV transmission. All healers expressed a desire to learn even more about HIV/AIDS despite the fact that they currently advise their patients about HIV/AIDS and its prevention. All the healers reported providing spiritual counseling and advised their clients to practice abstinence, to remain faithful to one partner and to always use condoms.



Eighty per cent of the sample advocated regular exercise, a healthy diet and provided information on nutrition whereas 67% of healers advised their patients to have a positive attitude and to accept their condition. Eighty per cent reported making biomedical referrals for patients with HIV related oral infections. Nearly all (93%) referred patients to a hospital, 87% sent patients to an allopathic doctor and 53% referred patients to a clinic or primary health care facility for further treatment of oral infections. A further 73% stated that they sent patients for counseling and treatment. These extremely high referral rates for oral HIV/AIDS lesions suggest that traditional healers are already collaborating with the dental profession. The referrals itself also acknowledged the limitations of traditional healers in treating patients for oral diseases.



The pre- and post-test results of the questionnaire regarding common oral diseases and oral HIV/AIDS lesions provided interesting information. Following basic education, after the initial testing, there was a remarkable improvement in recognition of common oral diseases and HIV lesions by the traditional healers. Initially all (100%) healers were able to identify dental caries, gum/periodontal disease and candidiasis, 40% could recognize aphthous ulcers and a further 13% could identify gingival caries and cancer of the tongue. After being provided with basic education, an impressive 80% of healers could recognize Kaposi's sarcoma, 67% could identify angular cheilitis and a further 53% could identify leukoplakia and human papilloma virus even though none of the healers were aware of these lesions pre-test. These results have shown how much can be achieved if regular workshops were held to educate and re-evaluate traditional healer's knowledge.

All traditional healers in the current study reported seeing patients with mouth problems and reported treating them with natural remedies. One of the plants used is the African wormwood. Fresh and dry leaves and young stems are drunk as a tea or boiled mixture. The roots are also sometimes used to treat fever, coughs and sore throats. A painful tooth is packed with fresh leaves to relieve the pain and decoctions may be held in the mouth to relieve pain from gum disease. The leaves of Bulbine are crushed to form a gel and are used directly to treat skin complaints, rashes, boils, cracked lips, venereal diseases and blood disorders. The bulb of Climbing Lily is used to treat a wide variety of medical complaints and for cleansing of the blood and to reduce swelling of tissue caused by accumulation of fluid. Either the whole plant or the rhizome of Clivia is used as it contains cardiovascular and pain-killing alkaloids. The tuber of Cortisone Plant is used as a sedative and to treat sores and wounds. The tuber of Forest Elephant's Foot contains toxins and cortisone. It is used to make a drink to treat rheumatism, cuts, wounds and sores. The bulb of Satin Squill is used for pain relief, feverish colds and as an expectorant. Decoctions of the bulb of Pineapple Flower are used as an enema to assist in the healing of bone fractures and to treat syphilis. The entire plant of Variegated Aloe is used to treat pain, either by applying the sap to the affected area or as an enema.

The tuberous rootstock of African Potato (*Sutherlandia*) is used for treatment of headaches, cancers inflammation and more recently HIV. Weak infusions of the bulb are used as a convalescent and strengthening tonic. Presently it is being used in numerous rural clinics in the treatment of AIDS and TB patients. *Sutherlandia*, improves their appetite resulting in significant weight gain, as well as enhancing their exercise tolerance,

sleep patterns and mood. Improvement in CD4 counts and decreases in the viral load in AIDS patients taking *Sutherlandia* have also been reported by clinicians.

The roots of White's Ginger are chewed or used as an emetic to treat indigestion and loss of appetite. The bulbs of Blue Squill are popular as an emetic for cleaning out and rejuvenating the body. It is also widely used to treat boils, sores and wounds. The leaves and roots of Wild Scabious are used to treat venereal sores. The rhizomes of Wild Garlic are used for treatment of fever and asthma. The leaves are used in cooking and are taken for oesophageal cancer.

The bark, stems and leaves of Paperbark Tree are used as a tonic for coughs, influenza and as a natural antibiotic. It is also used in the treatment of venereal disease, cancer and applied topically to cuts. The leaves of Sour Fig are crushed to obtain the juice, which is used to treat thrush, mouth and throat infections and toothache. The trunk of Acacia Karoo tree is milked to obtain the gum. This gum is applied to infected areas to treat candida. Another plant used in the treatment of candida is the bark of *Qodenaea Angustifolia*. African Cucumber is also used for oral and oesophageal thrush, sore throat and to control temperature. African traditional healers have been aware of many of the conditions treated by allopathic doctors for centuries and have the knowledge of what treatment to prescribe. There is a strong case for collaborative efforts between traditional healers and scientists to form a single multi-disciplinary and committed team to harness the synergies between indigenous knowledge systems, scientific research and biodiversity conservation for the benefit of human and environmental health.

All the healers reported a willingness to screen their patients for tooth decay, gum disease, oral cancer and oral manifestations of HIV/AIDS provided that they were given the necessary information and training.



## CHAPTER 7: CONCLUDING REMARKS

African traditional healers are extensively utilized in South Africa probably because they are available in areas where biomedical health services are lacking. Traditional healers share their patient's culture, beliefs and values and understand their expectations of health care hence they are generally more accessible and acceptable as health care providers. Their methods of treatment are effective in certain illnesses, as is their use of local herbs and medicinal plants for therapeutic purposes.

The main purpose of this study was to investigate the current role traditional healers play in oral health care delivery and to make recommendations in respect of their potential role in the Kwa-Zulu health care system. The majority of traditional healers in the study favored co-operation with biomedical practitioners and all expressed enthusiasm for some form of training in oral diseases and HIV lesion identification. They were even prepared to consider changing to safer practices and to possibly eliminate those traditional remedies and practices that proved harmful to patients.

HIV/AIDS education and prevention programmes are mainly based on Western principles and no attempt has been made to understand or integrate the diverse cultural and belief systems of Africa into such programmes, which is probably one of the reasons why many HIV/AIDS prevention programmes have failed so dismally. One of the aims of these programmes should be to convince traditional healers to promote the use of condoms and safer sex practices and to counsel their clients on the prevention of sexually transmitted diseases as well as HIV/AIDS. This can be very easily achieved considering

that traditional healers are highly skilled in interpersonal relations and are already widely accepted and respected by the general public. Traditional healers should also be encouraged to sterilize their instruments whenever they come into contact with bodily fluids in order to protect themselves and to protect future clients from the risk of contracting HIV infection. They should also be encouraged to refer AIDS patients to a clinic or hospital, without delay for further testing, counseling and treatment.



**APPENDIX 1**

**UNIVERSITY OF THE WESTERN CAPE  
FACULTY OF DENTISTRY  
INFORMED CONSENT FOR INTERVIEW**

Dear .....

I am from the Department of Community Dentistry from the Faculty of dentistry, University of the Western Cape. I/We would like to ask you a few questions about yourself and what you do. I/We are doing this to see if there are ways in which we can prevent oral diseases or assist you in recognizing oral problems.

The interview will take between 10 and 15 minutes. All the information obtained and all information that you give us about yourself will be strictly confidential.

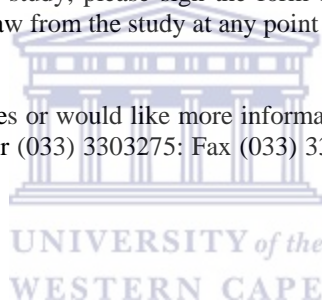
You are completely free to take part or not to take part in this study. If you decide that you do not want to be part of this study, this will not be held against you.

If you would like to take part in this study, please sign the form below to allow us to proceed with the interview. If you would like to withdraw from the study at any point or for any reason, please feel free to do so and no question will be asked.

If you do have any questions or queries or would like more information about the study, please contact Dr R. Puranwasi on the telephone number (033) 3303275; Fax (033) 3307707; e-mail [randhir@exact-net.com](mailto:randhir@exact-net.com) or after hours on (033) 3306765.

Thank you for your cooperation

Yours Faithfully



Dr Randhir Puranwasi

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**I AGREE/DISAGREE TO PARTICIPATE IN YOUR STUDY**

**NAME (BLOCK LETTERS):** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**APPENDIX 2**

**The role of traditional healers in oral health**  
**UNIVERSITY OF WESTERN CAPE**

Date/Usuku: \_\_\_\_\_ Rec. no: \_\_\_\_\_

Name/Igama: \_\_\_\_\_ AgeUbudala: \_\_\_\_\_

Gender/Ubulili: Male/Owesilisa  Female/Owesifazane

Please tick where applicable/Uyacelwa ukuba ugcalise okoyikona:

1. Are you a/ungubani: Sangoma   
Nyanga   
Umthandazi

2. Where were you trained/Ukufundele kuphi?  
\_\_\_\_\_

3. How long were you in training/Kwathatha isikhathi esingakanani?  
\_\_\_\_\_

4. Where do you practice/Usebenzela kuphi?  
\_\_\_\_\_

5. How long have you been in practice/Usunesikhathi esingakanani?  
\_\_\_\_\_

6. How close is the nearest health care facility from your practice/Sikude kangakanani isikhungo sezempilo?  
\_\_\_\_\_

7. Do you ever refer clients/Uyadlulisela : Yes  No

8. To whom do you refer clients/Udlulisela kuphi: Doctor   
Clinics/Emtholampilo   
Another Sangoma

Other/Abanye \_\_\_\_\_

9. Do you see patients with mouth problems/Ayababona abanekinga emlonyeni?  
\_\_\_\_\_  
\_\_\_\_\_



10. Can you name some of the mouth problems/Ungazisho ezinye?

---

---

11. How do you recognize the different mouth problems/Uzihlukanisa kanjani?

---

---

12. Do you know what causes the different mouth problems/Uyazi ukuthi zibangwa yini?

Yes/Yebo  No/Cha

13. If yes please explain/Uma kunjalo chaza

---

---

---

14. How do you treat the mouth problem/Uzelapha kanjani?

---

---

15. Do the patients come back with the same problem/Bayabuya nazo lezo nkinga?

Yes/Yebo  No/Cha

16. Do you treat patients with HIV/AIDS/Uyabalapha abanengculazi?

Yes/Yebo  No/Cha

17. Do you know what causes HIV/AIDS/Uyazi ukuthi ingculazi ibangwa yini?

---

18. Do people with HIV/AIDS have mouth problems/Abantu abanengculazi banoyo yini inkinga yezifo zomlomo? Yes /Yebo  No/Cha

19. Can you recognize oral disease caused by HIV/AIDS/uyakwazi ukubo izinkinga zomlomo ezibangwa ingculazi? Yes /Yebo  No/Cha

20 yes please explain/Uma kunjalo chaza

---

---

21. Would you like to know more about oral problems associated with AIDS/HIV/Ungathanda ukwazi kabanzi ngezinkinga zomlomo ezihambelana nengculazi?

---

---

22. Do you educate and counsel your patients about AIDS/Ubafundisa ubaluleke abantu ngengculazi?

---

---

23. Would you be willing to screen patients for oral diseases like Ungathanda ukuhlola abantu abenkinga yezifo zomlomo:

Tooth decay/ukubola kwamazinyo	<input type="checkbox"/>
Gum disease/Isifo zezinsini	<input type="checkbox"/>
Oral cancer/ikhensa yomlomo	<input type="checkbox"/>
Oral manifestations of HIV/AIDS infection Izinkinga zomlom ezibangwa ingculazi	<input type="checkbox"/>

24. Will you refer patients with oral manifestations of HIV to/Ungabadlulisela abanalezi nkinga?

Another traditional healer/Komunye umlaphi wendabuko	<input type="checkbox"/>
Medical doctor/Udokotela	<input type="checkbox"/>
Primary health care centre/Isikhungo sezempilo	<input type="checkbox"/>
Hospital/Isibhedlela	<input type="checkbox"/>
For counseling and treatment/Ukuyolulekwa nokulashwa	<input type="checkbox"/>

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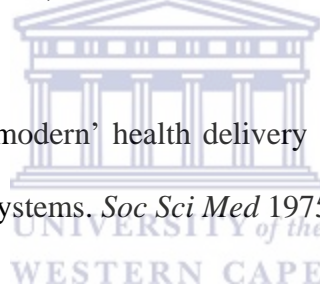
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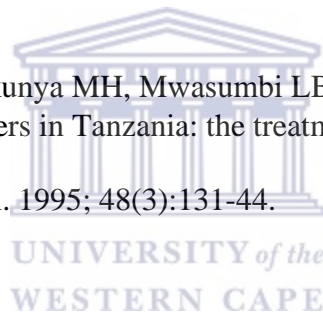
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