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HIV/AIDS/STI/TB knowledge, beliefs and practices of traditional healers in KwaZulu-Natal, South Africa

K. PELTZER[1], N. MNGQUNDANISO[2], & G. PETROS[2]

[1]*Human Sciences Research Council & University of Limpopo, and* [2]*Human Sciences Research Council*

Abstract

The aim of this study was investigate the HIV/AIDS/STI and TB knowledge, beliefs and practices of traditional healers in South Africa. In a cross-sectional study 233 traditional healers were interviewed in three selected communities in KwaZulu-Natal. Results indicate that the most common conditions seen were STIs, a variety of chronic conditions, HIV/AIDS (20%) and tuberculosis (29%). Although most healers had a correct knowledge of the major HIV transmission routes, prevention methods and ARV treatment, their knowledge was poorer on other HIV transmission routes, and 21% believed that there is a cure for AIDS. A minority reported unsafe practices in terms of reuse of razor blades on more than one patients and the reuse of enema equipment without sterilization, and two-thirds used gloves when carrying out scarifications. Randomized control trials are called for to test the effectiveness of traditional healing for HIV/AIDS, STI and TB prevention and care.

Introduction

Sexually transmitted infections (STIs) are one of the most common reasons for people to visit traditional healers in (South) Africa (e.g. Ndulo, 2001; Peltzer, 1998, 2000a, 2003; Wilkinson & Wilkinson, 1998; Zachariah et al., 2002). Most commonly treated conditions among urban healers (Peltzer, 2001) and rural traditional healers (Peltzer, 1998) in Limpopo Province, South Africa, were after children's diseases sexually transmitted diseases like *Tshofela/droop* (Gonorrhoea), *Lekhutlo* (ailment of a male who had intercourse with an 'impure women'), *Thosola* (Syphilis), and assumed AIDS cases (Peltzer, 2001). In a community survey Peltzer (2003) found among rural adult South Africans that from those who reported to have had a STI in the past 12 month that 36% had consulted traditional healers for treatment. Wilkinson & Wilkinson (1998) found among 360 patients presenting with STDs in a primary care clinic in KwaZulu-Natal that 14.6% had sought care for the previous illness from the traditional healer.

Peltzer (2000b) investigated the perceived efficacy of western and traditional health care in an urban community sample in the Limpopo Province, and found there were no significant differences in perceived efficacy for sexually transmitted diseases and AIDS between the two systems. This is surprising since western medical therapy provides effective treatments for STDs and there is currently no cure for AIDS. This finding compares with that of other studies (Green, 1992).

A number of researchers have identified HIV risk practices among traditional healers. Chipfakacha (1997) conducted a study in Botswana and found that some healers use the mouth for sucking blood (blood-letting); Somsé et al. (1998) found among healers in the Central African Republic that a large majority (75%) of those who reported using enemas as a treatment method had reused enema equipment without sterilization, in Zimbabwe traditional healers commonly 'bite out' an 'object' (taking the patient's blood into her or his mouth) that has been induced into the patient's body by witchcraft (Willms et al., 2001), and Peters et al. (2004) reported from Nigerian patients who had visited traditional healers that 77% got incisions made with unsterilized blades. Herbal preparations were then rubbed into these actively bleeding skin cuts, using unprotected fingers, which were in direct contact with the patient's blood. In Ghana, Neequaye et al. (1991) found that 39% of rural traditional healers did skin piercing, including scarification, by an unsterile instrument. Schmutzhard (1987) notes that African traditional healers use only razorblades or similar cutting devices for scarifications, never needles or other hollow instruments where blood might stay infective for longer, which limits the transmission of HIV unless scarifications are done

Correspondence: Prof Karl Peltzer, SAHA/SAHARA, Human Sciences Research Council, Private Bag X41, Pretoria 0001, South Africa. Fax: +27 12 302 2001. E-mail: KPeltzer@hsrc.ac.za

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on several people one after another, which is a rare practice.

Therefore the aim of this study was to investigate the HIV/AIDS/STI and TB knowledge, beliefs and practices of traditional healers in KwaZulu-Natal, South Africa.

Methods

Design

A cross-sectional design was used. Traditional healers were interviewed in three selected communities in KwaZulu-Natal, South Africa.

Sample and procedure

In all 233 traditional healers were included in the study, one had refused to participate. Two-thirds (150, 64.4%) of the traditional healers who participated were from rural areas (Swayimane and Ulundi) and 83 (35.6%) from an urban area (Mbali) in KwaZulu-Natal. Most (75.2%) were female and 57 (24.8%) were male. All participants were African, while almost all were Zulu (96.6%) and a few were Xhosa (2.1%) and Asian (1.3%). The majority (59.7%) was more than 45 years old, including 12 (5.5%) who were more than 65 years old at the time of the interview. A quarter (22.5%) did not have any formal schooling, 25.1% had up to Grade 5, 51.6% between Grade 6 to 11, and 10.8% had matric and more regarding formal education. Most traditional healers belonged to charismatic churches (Zion Christian Churches, Apostolic and Pentecostal Churches) (53.2%), followed by main stream churches (Roman Catholic, Anglican, Lutheran, Methodist Churches, and other Christian churches) (36.2%), African religion (7%) and no religion (4%).

Purposeful sampling was used to include all traditional healers from three selected communities after access was established through the Traditional Healers Council in KwaZulu-Natal and respective branches in the province. Traditional healers were contacted through existing lists in the branch offices and community meetings, and were then invited to contact points for an interview. Transport was reimbursed.

The study was approved by the Human Sciences Research Council Ethics Committee (Clearance no REC 2/12/11/02), the provincial Health Department in KwaZulu-Natal and the traditional Healer's Council in KwaZulu-Natal. Informed consent was obtained from all participants. Questionnaires were interview-administered in Zulu by two of the researchers (NM, GP), one traditional healer and one professional nurse trained in interview administration of this interview schedule.

Measure

A semi-structured questionnaire was developed from the literature (Chipfakacha, 1997; Green, 1994; King & Homsy, 1997; Peltzer, 1998; Somsé et al., 1998; UNAIDS, 2002) and key informant interviews (five traditional healers who did not form part of the final sample) including the following components: socio-demographic data (8 items), practice characteristics (7 items), conditions treated (2 items), STI/HIV/AIDS and TB knowledge (23 items, rated as true, false or do not know; 3 open-ended questions on known STIs, HIV symptoms and causes), HIV risk perception (2 items, rated from 1 = great risk to 3 = not at risk) and cultural attitudes (5 items), HIV and STI management (12 items), HIV risk practices (7 items), attitudes towards biomedical health practitioners and referral pattern (17 items)(response options for all questions, if not stated differently, were 'yes' or 'no').

Data analysis

Descriptive statistics were used to obtain frequency distributions using SPSS version 12.0.

Results

Results are divided into: (1) characteristics of traditional healers; (2) commonly treated conditions by healers; (3) STI/HIV/AIDS and TB knowledge; (4) HIV risk perception and cultural attitudes; (5) HIV and STI management; (6) HIV risk practices; and (7) attitudes towards biomedical practitioners and referral pattern.

(1) Characteristics of traditional healers

From the 233 traditional healers about half (52%) can be classified as diviners, 19% as herbalists, 16% diviner and herbalist, 12% as faith healers, and 10% were in addition to being a herbalist and/or diviner a traditional birth attendant. Traditional healers started practicing at different ages, a quarter were less than 26 years old, a quarter were between 26 to 35 years, a quarter between 36 to 45 years and a quarter at 46 years and above. Most traditional healers (55.4%) indicated that their training had lasted for more than a year, while 44.2% had less than one year training. One in five of the healers had had a training on HIV/AIDS lasting one day and more (see Table I).

Almost half of the traditional healers (44.4%) were members of a healers association and similarly

Table I. Traditional healer's characteristics.

Type of healer#	N = 233	%
Herbalist	45	19.3
Diviner-medium	122	52.4
Diviner and herbalist	37	15.9
Traditional birth attendant	23	9.9
Faith healer	28	12.0
Age at which practice started		
15–25 years	42	20.7
26–35 yrs	57	28.1
36–45 yrs	47	23.2
46 and more	56	27.0
Length of training undergone		
0–6 months	25	11.3
7–12 months	73	32.9
13–18 months	16	7.2
>18 months	107	48.2
Did you receive training on HIV/AIDS (one day and more)	43	18.9

Note: #multiple responses possible.

43.5% were registered with the traditional health practitioner's council.

The majority of the traditional healers (80%) indicated that they are working full-time as healers, 51.1% saw less than 11 patients in a months, while 36.4% saw 11 to 40 patients and 13.6% saw more than 40 patients in a month. A third (36%) of the traditional healers also admit patients for treatment.

(2) Commonly treated conditions by traditional healers

Traditional healers were asked about the five most common conditions they treat. By far the most commonly treated condition was sexually transmitted infections, followed by arthritis or rheumatism, stroke, headache, sores, children's problems, ancestral problems, sharp pains, spirit illness, and stomach problems; only a few (6%) mentioned HIV/AIDS (see Table II).

Further, traditional healers were asked if they had ever treated a patient with STIs, TB, AIDS and family planning. Two-thirds of the healers (138, 62%) indicated that they had treated *Ukubhajwa (this is a condition whereby one has difficulty in walking due to genital sores)*, 135 (60%) *Ilumbo* (any man made disease is referred to *ilumbo* (there can be many different kinds of this; in some cases the man will prepare *ilumbo* for his wife, in this case when the wife has sex with someone else other than the husband the other man will get the disease), 117 52% *Gcunsula* (Syphilis), 104 47% *Ispatsholo* (Gonorrhea), 64 (29%) tuberculosis, 43 (20%) AIDS, and 38 (18%) said that they had offered family planning (prevention of pregnancy).

(3) STI/HIV/AIDS and TB knowledge

Traditional healers were asked to name five sexually transmitted infections (STIs). Most frequently

Table II. Most common conditions treated by traditional healers.

English	Zulu	N	% of cases
1. Sexually transmitted infections	Izifo zocansi	159	71.6
2. Arthritis	Isifo samathambo	94	42.3
3. Stroke	Unhlangothi	70	35.5
4. Headache	Ikhanda elibuhlungu	69	31.1
5. Sores/shingles	Izilonda/ibhande	66	29.7
6. Children's problems	Izigulo zezingane	53	23.9
7. Ancestral problems	Amandiki	50	22.5
8. Sharp pains	Izibhobo/amahlaba	48	21.6
9. Spirit illness	Ukuthwasisa	47	21.2
10. Stomach problems	Isisu	46	20.7
11. Reverse bad luck	Ukulahla isilwane/ Ukubethela	41	18.5
12. Chest problems	Isifuba	31	14.0
13. Magic poisoning by stepping over something	Umeqo	28	12.6
14. Mental problems	Ukugula Ngengqonda	20	9.0
15. Being poisoned by food purposely	Idliso	20	2.1
16. Bad luck	Isichitho	15	6.8
17. High blood pressure/heart problems	Isifo senhliziyo	13	5.9
18. HIV/AIDS	Isandulela ngculazi/ingculazi	14	6.3
19. Infertility	Inzalo/isihlambezo	14	6.3
20. Epilepsy	Isifo sokuwa	9	4.1
21. Diabetes Mellitus	Isifo sikashukela	8	3.6
22. Cancer	Isifo somdlavuza	5	2.3
23. Other	Okunye	28	11.7

Note: #Multiple responses.

mentioned was syphilis (94.4%), followed by *Ilumbo* (88.4%), gonorrhea (70%), and HIV/AIDS (53.4%).

Further, traditional healers were asked in an open-ended question to list HIV/AIDS symptoms and to list causes of HIV. The five most frequently mentioned HIV/AIDS symptoms included diarrhea (60.9%), loss of weight (57.5%), chest problems (54.9%), sores/shingles (34.8%) and tiredness (33.9%). The most frequently mentioned causes of HIV transmission were through sexual intercourse (100%), blood contact (91.8%) and contaminated instruments (razors, needles) (71.2%), while mother-to-child transmission was only mentioned by 5% of the healers.

Further, HIV/AIDS and TB knowledge were assessed with 14 items on HIV/AIDS and five items on TB. Although most healers had a correct knowledge of the major HIV transmission routes (multiple sexual partners: 88%; blood contact: 91%; needles or razors: 95%), prevention methods (condom use: 90%), and ARV treatment (has to be taken for life time: 89%), their knowledge was poorer on other HIV transmission routes (breast feeding: 76%; oral sex: 73%; dry sex: 64%; and 'biting' out of foreign objects: 39%), HIV/AIDS myth (having sex with a virgin: 82%; getting HIV by using a cup or plate that has been used by a person with HIV/AIDS: 69%) and the nature of HIV/AIDS (being infected with HIV and still look healthy: 58%; there is no cure for HIV/AIDS: 79%). Regarding knowledge about tuberculosis 95% of the healers agreed that TB is curable and 93% correctly said that the treatment takes 6 to 8 months. Although 81% knew the transmission route that is breathing the air around a person who is sick with TB, many had misconceptions about TB transmission such as 85% believed it is possible get TB from smoking, and 65% from mosquito or other insect bites.

(4) HIV risk perception and cultural attitudes

The majority of traditional healers (72%) felt that they were at great risk of getting HIV at work when treating patients, while 37% felt at great risk of getting HIV in their personal life.

Most traditional healers (93%) approved of distributing condoms to clients, 82% acknowledged that condoms were an obstacle to reproductive sex and only one-third of the healers had ever used condoms themselves.

The majority of the healers (71%) agreed that dry sex should be discouraged, while only one in four (24%) felt that ritual cleansing such as widow inheritance should be discouraged.

(5) HIV/STI management

The majority of the traditional healers (74%) knew and 26% did not know where to obtain VCT. More than half of the healers (56%) indicated that they had referred a patient for HIV testing in the past three months. Two-thirds (66%) conducted an HIV/STI risk behaviour assessment (e.g. ask about risky sex) in the past three months, 61% integrated partner referral in their STD management, and 82% conducted HIV/STI risk reduction counselling (e.g. advise on condom use, abstinence, fidelity and partner reduction) in the past three months. However, only 27% of the healers had distributed condoms to their patients in the past three months, and only 19% reported that they had a container with condoms in stock. Many healers (58%) are involved in home-based care of patients, 36% conduct community HIV/STI education, and 24% had been keeping record of their patients in the past three months.

(6) HIV risk practices

Most traditional healers (73%) indicated that they had performed incisions or scarifications and 47% used an enema on their patients in the past three months. Ten (4%) said that they had reused the razor blade on more than one patient to perform scarifications, 20 (9%) reused the enema equipment without sterilization, 39% boiled water for reusable instruments, 54% indicated that they have a container where they keep used blades after completing a procedure, 63% used gloves when carrying out incisions or scarifications, and 10% reused gloves in the past three months, and 43% had a supply of gloves to protect them against infection.

Discussion

This study found that among the 233 traditional healers investigated that 72% treat STIs, 29% tuberculosis, 20% HIV/AIDS, and 18% family planning, which compares with other studies (e.g. Green, 1994).

Traditional healers in this study had adequate knowledge about HIV symptoms and causes of HIV. Although most healers had a correct knowledge of the major HIV transmission routes, prevention methods and ARV treatment, their knowledge was poorer on other HIV transmission routes (breast feeding, oral sex, dry sex, 'biting' out of foreign objects, HIV/AIDS myth (sex with a virgin, use of cups or plates), and 21% believed that there is a cure for AIDS. Knowledge on curability, treatment course and major transmission routes of TB were adequate but there were other great misconceptions

about TB transmission (smoking, insects). Misconceptions about HIV/AIDS were also found among traditional healers in other studies, e.g. in Zambia 44% believed mosquitoes could transmit HIV, 51% believed there is a cure for HIV (Burnett et al., 1999).

More than half of the traditional healers in this study was regularly involved in HIV/STI management in terms of assessment, referral for HIV testing, STD partner referral, HIV/STI risk reduction counselling, and home visits/care. However, only 27% had distributed condoms to their patients in the past three months. Traditional healers have implemented the recommendation to use condoms in Botswana (UNAIDS, 2002) and Malawi (Key & DeNoon, 1995), the delay of sexual debut among youth (Green, 2000), fidelity in monogamy (Green, 2000), and counselling of AIDS patients and their families such as in Malawi (Key & DeNoon, 1995). In Uganda traditional healers were also found to do home visits and provide care and support for PLWHA (UNAIDS, 2002). Munk (1998) describes 'traditional hospitals' in KwaZulu-Natal which also provide care and support for PLWHA. In KwaZulu-Natal traditional healers have also been successfully used for TB DOT supporters (Colvin et al., 2003).

Traditional healers in this study had a high risk perception of contracting HIV through treating patients. Most were involved in performing incisions or scarifications and the use of enema for the treatment of their patients. A minority reported unsafe practices in terms of reuse of razor blades on more than one patients and the reuse of enema equipment without sterilization, and two-thirds used gloves when carrying out scarifications. Among Zambian healers 77% were conscious of the potential risks of patients sharing razors for scarification (Burnett et al., 1999). If scarification and surgical tools are subsequently reused with another patient, it could have the risk of HIV transmission. The 'biting out' of foreign objects could result in HIV transmission. Preferably disposable tools such as razor blades or knifes should be used or else sufficiently sterilized.

The operational plan for comprehensive HIV and AIDS care, management and treatment for South Africa recognizes the role and function of traditional healers in the continuum of care, compliance, adherence, adverse event reporting, referral system and ensuring safe traditional health practices (Department of Health, 2004). Homsy et al. (2004) suggest that communities, traditional healer clients and practitioners (including traditional healers and biomedical practitioners) should be trained/empowered in the following minimum aspects of HIV prevention and care: (1) cultural beliefs and practices; (2) basic and updated information on prevention and care for sexually transmitted diseases (STDs), HIV/AIDS, and tuberculosis; (3) infection control; (4) identification of danger signs to enable traditional healers to make referrals; and (5) integration of biomedical and traditional counselling approaches on STDs, HIV/AIDS, and TB, including client counselling, support, and referral.

Randomized control trials are called for to test the effectiveness of traditional healing for HIV/AIDS, STI and TB prevention and care.

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