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Oral Health from the Perspective of Venezuelan Amazon's Guahibo People*

Salud bucal desde la perspectiva del pueblo Guahibo del Amazonas venezolano

Saúde bucal na perspectiva do povo Guahibo da Amazônia venezuelana

Glevi Montilla [a]
Universidad de los Andes. Mérida, Venezuela.
glevim9@gmail.com
https://orcid.org/0000-0002-0485-8675

Zamira Calderón [a]
Universidad de los Andes. Mérida, Venezuela.
zamiracalderon12@gmail.com
https://orcid.org/0000-0002-3096-8480

Fernando Rincón [a]
Universidad de los Andes. Mérida, Venezuela.
fernandorz14@gmail.com
https://orcid.org/0000-0002-5845-3825

María de los Ángeles León [a]
Práctica independiente. Quito, Ecuador.
maggy_angel11@hotmail.com
https://orcid.org/0000-0001-8036-555X

Óscar Alberto Morales [a]
Universidad de Los Hemisferios. Quito, Ecuador.
geode.ula@gmail.com
https://orcid.org/0000-0002-0879-6555

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Abstract

Background: The health-disease-care process is a universal event, which each society and culture develops in its own way. The specialized literature suggests that more studies and preventive actions are needed to improve the oral health of indigenous peoples, respecting their cultures. The Guahibo people are originally from the Venezuelan and Colombian plains, they are a heterogeneous population that is scattered both in the national territory and in eastern Colombia. Until now, no studies on the oral health from the Guahibo perspective have been found. **Purpose:** This research aimed to describe oral health from the perspective of members of the Guahibo community in Amazonas state, Venezuela. **Methods:** A qualitative, descriptive, and phenomenological study using ethnographic data collection techniques (open interviews, observation, and field notes) was carried out. Triangulation was used as the data analysis technique. **Results:** It was found that the Guahibo people merge western practices with the ancestral practices of their ethnic group in the prevention and treatment of oral diseases. Among the indigenous practices are religious rites, use of medicinal plants and mineral products. **Conclusions:** The presence of disease for Guahibo people is determined by the painful symptoms. The most widely used treatments are those that include plants and religious rites.

Keywords: dental anthropology; ethnodentistry; Guahibo people; Guajibo people; indigenous people; oral health; perception; Venezuelan Amazonas

Authors' Note: [a] **Correspondence:** glevim9@gmail.com; zamiracalderon12@gmail.com; fernandorz14@gmail.com; maggy_angel11@hotmail.com; geode.ula@gmail.com

Resumen

Antecedentes: El proceso salud-enfermedad-atención es un hecho universal, pero se desarrolla de forma particular en cada sociedad y cultura. La literatura sugiere que hacen falta más estudios y acciones preventivas tendientes a mejorar la salud bucal de los pueblos indígenas, respetando sus culturas. El pueblo Guahibo es originario de los llanos venezolanos y colombianos, es una población heterogénea que se encuentra diseminada tanto en el territorio nacional como en el este de Colombia. Hasta ahora, no se encontraron estudios sobre la salud bucal desde la perspectiva de los Guahibo. **Objetivo:** El objetivo de esta investigación fue describir la salud bucal desde la perspectiva de los miembros de la comunidad Guahibo estado Amazonas. **Métodos:** Se realizó un estudio cualitativo, descriptivo, de diseño técnicas etnográficas de recolección de datos (entrevistas abiertas, observación, notas de campo). Para el análisis de los datos, se empleó el método de triangulación. **Resultados**: Se encontró que el pueblo Guahibo fusiona las prácticas occidentales con las prácticas ancestrales propias de su etnia en la prevención y tratamiento de enfermedades bucales utilizando entre las prácticas autóctonas, los ritos religiosos, uso de plantas medicinales y productos minerales. **Conclusiones:** La presencia de enfermedad para el pueblo Guahibo es determinada por la sintomatología dolorosa. Los tratamientos más comúnmente utilizados son los que incluyen plantas y ritos religiosos.
Palabras clave: Amazonas venezolano; antropología bucal; etnoodontología; percepción; población indígena; pueblo Guahibo; pueblo Guajibo; salud bucal.

Resumo

Antecedentes: O processo de cuidados de saúde-doença é um facto universal, mas desenvolve-se de uma forma particular em cada sociedade e cultura. A literatura sugere que são necessários mais estudos e ações preventivas para melhorar a saúde oral dos povos indígenas, respeitando as suas culturas. O povo Guahibo é nativo das planícies venezuelana e colombiana, uma população heterogénea que se encontra dispersa tanto no território nacional como no leste da Colômbia. Até agora, não foram encontrados estudos sobre saúde oral na perspectiva do Guahibo. **Objetivo**: esta investigação visava descrever a saúde oral na perspectiva dos membros da comunidade Guahibo no estado do Amazonas. **Métodos:** Foi realizado um estudo qualitativo, descritivo, utilizando técnicas de recolha de dados etnográficos (entrevistas abertas, observação, notas de campo). Para a análise dos dados, foi utilizado o método de triangulação. **Resultados:** Constatou-se que o povo Guahibo funde práticas ocidentais com práticas ancestrais da sua própria etnia na prevenção e tratamento de doenças orais utilizando. Entre as práticas indígenas estão os ritos religiosos, o uso de plantas medicinais e produtos minerais. **Conclusões:** A presença da doença no povo Guahibo é determinada pelos sintomas dolorosos. Os tratamentos mais usados são aqueles que incluem plantas e rituais religiosos.
Palavras-chave: Amazónia venezuelana; antropologia dentária; etnoodontologia; percepção; população indígena; povo Guahibo; povo Guajibo; saúde oral

INTRODUCTION

The concept "people" refers to the set of features that characterize a human group in terms of their territory, history, culture, and ethnicity from which they builds a sense of identity (1-6). Indigenous peoples of Latin America are recognized as the direct descendants of the inhabitants of this region before the arrival of Europeans in the 15th century. These peoples have their own culture, language, and customs that differentiate them from the Creole way of life (the term "creole" refers to those who are not indigenous) (6).

With the western expansion at different times in history, many indigenous peoples suffered from sociocultural, economic, and political transformations (7). It is estimated there are between 45 and 50 million people of more than indigenous 600 groups living in 24 countries in America (the term "America" here refers to the whole continent from Alaska to Patagonia). The existence of these peoples constitutes the basis on which the plurality of multicultural, multiethnic, and multilingual societies in the region is built (8).

Based on the latest round of censuses available in Latin America, it is estimated that indigenous inhabitants in the region are 38 million, which represents around 7 % of the total population. Mexico, Guatemala, Peru, and Bolivia have the largest indigenous populations in absolute and percentage terms, concentrating more than 80 % of the total indigenous population (30 million). On the other side, Argentina, Venezuela, Paraguay, Costa Rica, El Salvador, and Brazil have the lowest percentage of indigenous populations, with El Salvador and Costa Rica being the countries with the lowest indigenous populations in absolute terms (13,310 and 10,143 inhabitants, respectively) (9).

In Venezuela, according to the 2011 census, 725.148 people declared to belong to one of the 51 ethnic groups that inhabit the country. Some of the most numerous are: Wayúu, Warao, Kariña, Pemón, Guahibo (Jivi), Kumanagoto, Añú, and Wótjüja (Piaroa) (4). These groups are concentrated in three regions: south (states of Amazonas, Apure, and Bolívar), east (states of Sucre, Delta Amacuro, and Bolívar), and west (state of Zulia).

The Guahibo/Guajibo people are originally from the Venezuelan and Colombian plains. Currently, it is a heterogeneous population that is scattered both in the southeast of the national territory and in the east of Colombia (5). In the state of Amazonas in Venezuela, they are located particularly in the municipalities of Atures, Autana, Atabapo, and Manapiare. Guahibos are established in the basins of the Sipapo, Autana, Cuao, Guayapo, Samariapo, Cataniapo, Paria, Parguaza, Ventuari, and Manapiare rivers; the road axes that connect Puerto Ayacucho, capital of the state of Amazonas, with the port of Samariapo to the south, the middle Cataniapo basin to the east, and the states of Apure and Bolívar to the north (4). In the state of Apure, Guahibos are located in the municipalities of Achaguas, Biruaca, Páez, and Pedro Camejo. In the state of Bolívar, most of the group resides in the municipalities of Cedeño, Gran Sabana, Raúl Leoni, and Sucre, on the banks of the Vichada and Orinoco rivers (from the Guaviare to the Meta river mouths), Tomo, Tuparro, Meseta, Bita, and Alto Capanaparo. In addition, they occupy some smaller channels of these rivers due to their fertility, in contrast to the open plain whose soils are poor in nutrients (2).

The Guahibo society is of the extended matrilocal type, that is, when a man marries, he moves in with his in-laws until he forms his own household. Preferential marriage occurs between cross-cousins (the male preferably marries the mother's brother's daughter), being prohibited between parallel cousins (the male cannot marry the mother's sister's daughter). Marriage is carried out by agreement between the parents of the two young people, with the male having to present a pre- and post-marital service to the father-in-law. In the communities with more contact with the Creole world, especially families living in Puerto Ayacucho, the trend is to adopt Western marriage rules (2).

In Guahibo communities there is no formal political structure. However, there are community chiefs whose functions include maintaining community unity, organizing community work, and serving as liaison with the Creoles. Currently, in each Guahibo community in Autana, Amazonas state, there is a captain and a commissioner. The former is appointed by members of the community and the latter is appointed by the regional government based in Puerto Ayacucho. Community control generally occurs informally, with the family being the nucleus of reference (2).

Traditionally, the cure for most illnesses is provided by the shaman, one of the most important figures within the Guahibo organization. In addition to providing care in cases of disease, shamans participate in divination and interpretation of dreams and in mediation with higher entities (5).

Health is one of the main problems for the indigenous population of Venezuela (4,10-27). Access to health services to receive conventional treatments has been affected by discriminatory national health policies and the state of isolation in which they live (28). Some consider their popular health care practices have allowed this population to survive over time (2,11). For years, they have had a limited access to health care, generating high prevalence of preventable diseases, which is higher than the rest of the population, with high rates of morbidity and mortality.

In addition to the limited access to health services, there is a lack of knowledge of Guahibo's culture and language by the health personnel. This has created communication and attention barriers. Therefore, it is necessary the health professional acts in balance between knowledge, beliefs, and cultural practices indigenous people have about health, disease, life, and death. This could start with a fluid communication, a process in which the knowledge of the indigenous language is key (12).

The Guahibos do not escape this reality. Being immersed in a political, economic, and social system that is alien to their cultural essence, like most of the indigenous peoples of America, they are at a great disadvantage. Many of them do not speak Spanish, or do not know the political and legal order of the Creole society. Likewise, they are discriminated and isolated within the same system in which they are almost involuntarily immersed (5,28).

The health-disease-care process is understood as a universal fact that is carried out differently in each society. Each culture develops models of care from which it seeks to understand and face the disease and, if possible, recover health (13). This process can be affected by the geographical characteristics of indigenous settlements (14).

There have been some studies on the health of indigenous peoples in Latin America. Among others, the nutritional health of the indigenous population in Peru was studied (15). In Chile, an analysis of inter-culturalization and competencies in health practices with the indigenous population resulted in the improvement of health centers (16). The factors associated with dental caries and periodontal disease in indigenous peoples of Brazil have been investigated (17,18). In Ecuador, studies looked at the prevalence of caries in indigenous children (19).

In Venezuela, there have been publications on indigenous peoples' health. A study on the chronology and sequence of permanent teeth eruption in Wayúu schoolchildren identified health protective factors related to cultural practices, such as a low rate of premature extractions, prolonged breastfeeding, and consumption of solid foods at an early age (20). Temporomandibular joint dysfunction (TMD) and the chronology and sequence of eruption of permanent teeth of members of Wayúu communities were also studied (21). Another investigation in this indigenous group found a high prevalence of caries, dental fluorosis, periodontal disease, and TMD (22). Another study described communication problems between dentists and indigenous people (23).

Investigations in the dental field have also been reported in Pemón communities (24), as well as in Sanema and Ye'kuana people established in the state of Bolívar (25). In the state of Mérida, the use of medicinal plants for oral health was studied in the indigenous communities of Lagunillas (26). In Delta Amacuro, a study looked at the cultural knowledge on prevention and treatment of oral diseases in the Warao community of Delta Orinoco (10). In the state of Amazonas, analyses have included cultural knowledge on the prevention and treatment of oral diseases in the Wótjüja people of Autana. Those studies have concluded that the knowledge of indigenous peoples is composed of a syncretic practice that contemplates their empirical wisdom through the use of medicinal plants, mineral products, animal products and religious rites, together with conventional dental practices (27).

Health intervention mechanisms are influenced by people's perceptions, which may arise as a syncretism as a consequence of the influence of Western health practices (27). The perceptual process is the highly complex sensory-cognitive mechanism by which the human being feels, selects, organizes and interprets stimuli, in order to better adapt them to their understanding and allows them to subjectively form a coherent and meaningful picture of the real physical world of which they are a part. Thus, it identifies, retrieves, and responds to the information received through the senses (29).

Regarding the health-disease process in the dental field, the perception people have can influence preventive and curative care practices and determine, somehow, its success (10,26,27). The literature reviewed shows the general and oral health conditions of indigenous Venezuelans are precarious (20-25). In addition, in Venezuela there have been no studies on the oral health of the Guahibo people, particularly, their perception of oral health. Therefore, the present study aimed to analyze the oral health perception of members of the Guahibo community in the municipality of Autana, Amazonas state, Venezuela.

MATERIALS Y METHODS

A qualitative descriptive study with a phenomenological design was carried out. It used observation techniques and interviews with indigenous informants (30). The study sought to characterize a concrete situation indicating peculiar features and distinctive characteristics, from the perspective of the Guahibo community. It reflects, as much as possible, people's reality, their world vision, and situation. We used some ethnographic tools to

describe and interpret events or situations in the natural contexts where they occur, in this case, some Guahibo communities of the municipality of Autana, state of Amazonas, Venezuela.

The study group consisted of 44 people of the Guahibo ethnic group from Isla del Carmen de Ratón, Autana municipality, Amazonas state, Venezuela. They were women, men, older adults, shamans, heads of family and representatives of the ethnicity. The number of participants was sufficient to qualitatively study the perception of oral health in the Guahibo community.

For data collection, ethnographic interview techniques (semi-structured, unstructured, and informal), participant observation, and extensive field notes were used. All interviews and conversations were conducted in Spanish. In the cases in which informants did not speak Spanish, an interpreter helped. The Guahibo language has been classified as independent since it does not have the characteristics of any other native languages of Venezuela (5) (figure 1).

What diseases have you found in the mouth?
How do you treat dental cavities?
Do you know other ways to cure dental cavities? Which ones?
Have you noticed anything unusual in the mouth?
How do you treat bad breath?
Which mouth diseases have you had?
What have you done to get better?
Why do you get it pulled out [the tooth]?
What else can be done to avoid pulling it out [the tooth]?
What do you do to avoid having dental cavities?
Besides, toothbrushing, what else do you do to avoid having dental cavities?
Which mouth diseases have found more often among people from here?
What causes pain?
How can a decayed tooth be treated?
What do you do to avoid getting decayed teeth?
Besides toothbrushing, what else do they do to have healthy mouths?
Which plants and natural products do they use?
Which other mouth diseases do they know?
Have you been to a dentist?
Why have you seen the dentist?
Which mouth problems have you had?
Why did your teeth hurt?
What do you do when there is food between your teeth?
What does the community do to avoid having mouth illness?
What have you done to reduce pain?
What does the community do to treat mouth diseases?
At home, besides toothbrush, what else do you use?
How do you cure bleeding in the mouth?
When they have tooth pain, what do they use?

FIGURE 1
Questions Used in the Interviews
Source: the authors.

The data collection instrument was the transcription book of the recorded interviews. For the interviews/conversations, interviewers first asked broad questions in Spanish, which sometimes were translated into Guahibo, to identify interviewees' perceptions of oral health. Then, more specific questions were asked to help the interviewer get an idea of interviewees' viewpoints in terms of risk factors, methods to prevent diseases, treatments used, and expectations or care needs, depending on the responses, until the conversation was limited to more precise content. There was not a standardized questionnaire and questions varied from one interviewee to another.

Other resources used during the interviews included a camera, a voice recorder, a laptop, a notebook, clinical records, a pencil and, occasionally, an interpreter.

Procedures

First, there was an immersion phase to collect general information, share it with community members, learn about their social and cultural structure, and explore types of health services available to the community. In this phase, we collected as much information as possible about the community, visited the place to observe its dynamics and take field notes, and spoke with key members to learn more about the community. In the same way, we collected information in the rural outpatient center about the frequency of dental visits and their relevance, as well as most frequent reasons for consultations as a sort of epidemiological screening. Afterwards, the immersion consisted of visiting the communities and selecting the members who were willing to participate in the study.

In the second phase, we carried out observations, interviews, and preliminary data analysis. Once finished the collection, we carefully reviewed and organized the data, listened to the recordings, and transcribed the interviews along with the field notes, which consisted of reflective comments by the researchers, their perceptions of direct and indirect observations, and/or bibliographic references that helped explain observations, all this taking into account the research objectives.

Data Analysis

To increase trustworthiness and reliability, the findings were triangulated. According to Berg (31), triangulation refers to the combined use of different modalities (usually three) during the study of a phenomenon: sources of information, data collection techniques, moments, places, theories, and researchers, among others. This method is interpreted as a means to measure reliability and validate the data by combining different strategies to obtain a better representation of reality. Berg (31) proposes four modalities of triangulation: data triangulation, investigator triangulation, theory triangulation, and methodological triangulation. For this study, we used data-related triangulation was used, which consisted of the combination of data sources and techniques, moments, places, informants and conditions. Only the coinciding and recurring content from the interviews to the members of the Guahibo community was selected. Then, findings were grouped, classified, categorized and conceptualized.

Moreover, we used the constant comparison method (32) for data analysis, considering three complementary perspectives: open, axial, and selective. For the open analysis, general themes and global concepts were identified and grouped into general categories. Likewise, the axial analysis consisted of identifying, within the general group, patterns and subcategories supported by the evidence. Finally, the selective analysis was useful to identify key patterns and elements, and thus select representative examples from each category.

RESULTS AND DISCUSSION

44 members of the Guahibo ethnic group participated in this study. They belonged to the communities of Isla del Carmen de Ratón, Autana municipality, Amazonas state. 24 participants were males, of whom 21 were farmers and fishermen and 3 community leaders or representatives of the ethnicity. The other 20 participants were women; 2 of them were household heads or representatives of the ethnic group and 18 did housework. Their ages ranged from 15 to 65 years.

Up next, we present the findings obtained in the field work. They are organized taking into consideration the categories on the perceptions generated from the analysis: prevention and treatment of oral diseases, recognition of oral diseases, and need for dental care.

Prevention and Treatment of Oral Diseases

Historically, the Guahibo people have implemented different oral hygiene techniques, generally associated with indigenous cultural practices, due to their geographical location, which makes it difficult for them to access conventional dental care. Since ancient times, they learned to use natural methods with the tools available, using medicinal plants, products of animal origin, minerals, and mythical-religious practices carried out by the shamans of their communities. They consider they have shown to be highly effective in caring for their health, which has allowed them to survive over time.

Comprehensive Oral Hygiene Practice

The Guahibo community takes their oral hygiene as a preventive method with great importance, combining conventional Western techniques, such as the use of toothbrush and toothpaste, with the indigenous methods learned by their ancestors. This may be due to the influence of Creoles in their region, or because the foods they eat are no longer the same they used to consume in the past. Among the natural methods, they use infusions of plants and roots typical of the region as mouthwashes; wooden toothpicks to replace the toothbrush to clean food residues; and sand as an abrasive to clean the teeth. Moreover, some interviewees acknowledge using oral hygiene techniques as a preventive measure:

1. I brush three times a day and, when we don't have a brush, we use a plant that is cooked and rinse with that water.
2. I brush and, when I don't have a toothbrush, I clean with a toothpick.
3. My grandfather prepares a water made of wood, which prevents diseases and cavities.
4. They used to chew *capi*, which is a bitter root that helped preserve teeth healthy. Currently, we use toothpaste and toothbrush and, if we have it, mouthwash.
5. I use mouthwash, wash well, and brush my teeth.
6. We use toothbrush and toothpaste and, when there is no toothpaste, we do not use anything; we brush every day twice a day in the morning and in the afternoon.
7. With fresh water if there are no brushes. When we buy, each one has one and they brush 3 times a day.

As seen in these excerpts, the Guahibo people are aware that they must clean their teeth daily. They even state using toothpaste, toothbrush, and mouthwash. However, when they do not have these tools, they use their own methods to perform oral cleaning, as shown in examples 1-4. This is similar to what was found in studies on oral health in Venezuelan indigenous communities of Delta Amacuro (10), Lagunillas, Mérida (26), and Amazonas (27). It also coincides with the findings of a study on alternative oral hygiene techniques in the community of Los Nevados, Mérida state (33), in which most participants stated they used toothpicks to remove food remains that were between the teeth and caused some kind of discomfort.

In addition to using Western techniques in conjunction with those of their own culture, the interviewees consider avoiding or reducing the consumption of cariogenic, sweet food in their daily diet as a preventive measure.

8. Not to eat much sweet.
9. Brushing because there are no dental offices here, not eating so many sweets.
10. I brush my teeth and try not to eat candy.

Water has also been fundamental as a preventive measure when they do not have the necessary materials to perform oral hygiene in a conventional way. In a study carried out in Los Nevados (34), participants stated they did not use any instrument to clean their teeth; they usually rinsed their mouths

just with water; thus they were able to remove food debris from their mouth. The practices reported in studies on oral health in the Warao indigenous community of the Orinoco Delta (10) and Wótjüja from Autana, Amazonas (27) are also similar.

In this case, the interviewees do not think that using only water for their oral hygiene is sufficient. However, they do declare to consider it as a useful resource in the case of not having the most commonly used tools, as expressed in the following testimonies:

11. We brush and, when we do not have a toothbrush or toothpaste, we rinse with warm water.
12. We use toothbrushes, otherwise just water.
13. I don't use anything; I just rinse with water. I don't have a toothbrush.
14. We clean with toothbrush, when we have, and water.

It is evident that this community has been influenced by Western oral health methods, since they have knowledge about the use of toothbrush, toothpaste, and rinses, including how often teeth must be brushed daily. Possibly, these findings are related to immersion activities in these communities, reinforcing the much used talks, brushing technique practices, in schools or sometimes during home visits. Prevention activities have always been among the most effective since they seek to minimize the increase in morbidity of oral diseases and, in turn, the need for dental treatment. On the other hand, clinical results show that oral health is poor, which suggests that the activity is infrequently reinforced, possibly because this community is located in areas of difficult access limiting immersions by the dental team, or that members of the community have to travel to distant centers to receive dental care.

Therefore, a strategy emerged, on the part of the medical and nursing team, to train a little more in depth, a member of the community who is interested in learning basic knowledge, to collaborate in simple aspects of general health of the indigenous people of the region. Likewise, the initiative of instructing on basic oral hygiene and caries prevention knowledge arose to be complemented with recommendations on diet and oral health, and correct application of toothbrushing techniques, which results helpful for routine oral health promotion activities.

Interculturality in Dental Treatment

Regarding the treatment of injuries and illnesses, the Guahibo people treat illnesses regardless of the diagnosis, with water being again the common denominator in their daily practices. They combine it with mythical-religious practices, as highlighted in the following excerpts:

15. There are people in the community who pray the water [i.e., blessing the water with a prayer]; you drink it, and the pain subsides. If not, at the hospital you receive medicine to calm the pain.
16. Water is prayed and blown; the shaman gives it to you, and you take it to get rid of the pain.

During the visits to the community, we had the opportunity to witness the ritual in which a shaman "prepared the water" to be used for therapeutic purposes. In this regard, thanks to the transculturation process to which the Guahibo people are exposed, due to continuous contact with Creoles, they share knowledge, and it is evident that they know how to merge their traditional practices with Western treatments. They go to the nearest health centers when they require it, either to the public centers provided by the State's health network or to private clinics if they can afford them, as can be seen in the testimonies below:

17. Well, I go to Ayacucho, if necessary, when I have a discomfort.
18. We go to the shaman, or we go to the dispensary; they give us a painkiller there.
19. I don't know of natural remedies for that; we go to the clinic to get something.
20. Sometimes we have to go to the hospital in Ayacucho.
21. We go to the health center; if what you have is more serious, you go to Ayacucho.

Use of Medicinal Plants and Religious Rites

The Guahibo people employ medicinal plant-based therapies they have learned culturally from their ancestors. They use leaves, stems, sap, roots, and religious rites provided by shamans or elderly specialists within the ethnic group, all with the aim of reducing symptoms (26,33-36). This is what the informants affirm:

22. [The person] goes to the healer or shaman; depending on what you have, herbs are searched.
23. We take a plant called *carretolendo*; the leaves are boiled with a little salted water, and we rinse our mouths with that.
24. You take herbs or medicine; *Rayo* ointment is applied with a cotton ball where it hurts.
25. For the toothache there are prayers the shaman makes, and the pain is calmed; just one time is enough; or the toothpaste is prayed and then applied where it hurts, and pain goes away.
26. We go to the health center to receive medicines. If not, we cook our herbs; there is one called *mata bachaco*. Another is called *caña la india*, which is used with another plant. If not, the shaman does some prayers.

Mangifera indica L

The Guahibo people affirm to use *Mangifera indica L* leaves, commonly known as mango tree. Some report mention the use of extracts of *Mangifera indica L* leaves and stems that have been used in traditional medicine as an analgesic for the treatment of dental pain and other kinds of aches. This finding coincides with previous studies that have also identified the therapeutic use of this plant (26,38).

27. We look for the grandfather who prepares the remedy; they give us natural medicines such as lemon sprouts, mango sprouts.
28. In my case, we take the most tender mango leaves; they are cooked and then rinse the mouth or do gargles; also the shell of *merey* serves to heal.

***Musa x paradisiaca* (plantain)**

Musa x paradisiaca is a herbaceous plant known as a plantain bush or *platanote*, which is cultivated par excellence in tropical climates, mainly for the consumption of its fruit. It is known for its medicinal effects for the treatment of diarrhea. On the other hand, some studies indicate that, in addition to the fruit, the rhizome, the axis of the inflorescence located within the stem, is used (39). Within the wisdom of the Guahibo culture, this plant is used to treat toothaches is contemplated:

29. There is a plant that we call platanote that produces a milk and is applied as a painkiller where it hurts.
30. We go to the shaman who prays until we get cured; we drink platanote that they pray or make a balsam with the prayed leaves.

Medicament Intake

The influence of Western medicine in certain towns is very noticeable, with medicament therapy being one of the first options for some the Guahibo people. This is due to some health education practices or the distribution of drugs through government operations or by non-governmental and religious organizations. In addition, Western treatments are effective for them because they rarely fail, perhaps only in cases of misdiagnosis. However, despite being an option, it is not always within their reach.

31. Sometimes we take pain pills, not home remedies.
32. We take pills.
33. We take amoxicillin or something for healing.
34. We take painkillers.

These findings are consistent with a study carried out in the Wótjüja community of the municipality of Autana, Amazonas state (27), in which some interviewees stated taking medicaments as the first option when facing symptoms of illness.

Diagnosis of oral diseases

In the Guahibo community, someone is mainly seen as sick when there is pain involved. Without pain, there is no disease, and this is expressed by the following testimonies:

35. The only one that I know is tooth ache.
36. Pain when I eat because there are food residues between my teeth.
37. Tooth pain and tooth cancer.
38. Tooth pain and children get a White thing that goes out of their lips.

As seen in these testimonies, the presence of pain for the members of the Guahibo population is the main indicator of illness, for which they seek medical attention. They can see the shaman or self-medicate. However, there are other symptoms, such as cavities, bleeding gums, halitosis, ulcers, and oral warts that also alert them of the presence of a disease.

39. I know I am sick because I don't feel well when I have a tooth decayed in my mouth.
40. Gum bleeding, in the teeth, and when losing teeth.
41. Bad breath, cavities, sores, gum bleeding, and sores on the tongue.
42. Sores on the lips and cavities.
43. Sores on the lips, decayed molars, warts, and bleeding gums.

This coincides with the findings of the study with the Wótjüja, which showed members of this ethnic group do not recognize being sick unless there is the presence of pain as a result of a pathology. Any other symptomatology is considered normal (27). Likewise, a study with the Warao community in the Orinoco Delta indicates they only pursue treatment of the symptoms and not the disease itself. Waraos also consider that asymptomatic lesions are normal or not pathological since they do not cause discomfort (10).

Need for Care

The indigenous peoples of Venezuela have some of the most serious health problems in the entire country; Guahibos are no exception. This is due, in part, to the isolation in which they live, a lack of knowledge of Guahibos' culture and language, and ignorance of Creoles regarding Guahibos, on the one hand, and the community's ignorance of conventional treatments, on the other. Furthermore, discrimination negatively affects Guahibos (28). This results in the absence of medical-dental care for the members of these communities. Most have never seen a dentist or, if they have, it has been when health care teams reach the community. Only a few have attended a hospital to receive care. This is because communities are located far from urban centers. They cannot afford to commute.

44. No, To be treated it is necessary to go to the health center.
45. No, I've never been to one because they are not close.
46. Because we do not have a dental office nearby and there is not enough money to go to a clinic.

The testimonials above show how some members of the Guahibo community have never attended a dental office, arguing mainly that the hospital is distant, and they cannot afford to travel. For this reason, they value medical-dental care services when offered in the same community (28).

47. We take advantage when there are dental care days here.
48. This is my first time because it's here in the community; I come to get a rotten tooth pulled out. Otherwise, it is too far for me.

Moreover, we observed there is a lack of necessary means to preserve health, which led us to think the government has not invested enough in this issue. Hence, the community lacks adequate medical-dental care and must decide between moving to other locations to get care or taking care of themselves through their cultural or empirical practices about health (27,28).

To finish, it is key to think interculturality in health is a under-construction concept that causes confusion among health professionals due to the limited training in anthropology in medical schools. Interculturality in health requires a paradigm shift in medical practice that can be included to recover classical medical tradition, which was put aside by the biomedical approach in the 19th century (40).

CONCLUSIONS

The most commonly used method preventive oral health in the Guahibo community of Autana is toothbrushing or, lacking it, rinsing the mouth with water, which is the common denominator in terms of preventive measures.

Guahibo people, on the prevention and treatment of oral diseases, combines Western with the ancestral practices, using religious rites, plants, and mineral products.

The presence of disease is determined by the existence of pain.

The most commonly used treatments include plants and religious rites.

RECOMMENDATIONS

For future qualitative studies with the Guahibo community, it is necessary to spend more time collecting data to achieve ethnographic depth, including a period of immersion to become more accepted by the community members and more meaningful findings.

Moreover, the researcher ideally should have knowledge of the Guahibo language or, at least, have an interpreter who is a member of the community.

Due to the oral health care needs of the Guahibo community, it is necessary to design permanent medical and oral health care programs, to contribute to improve their quality of life.

Because of the difficulty to commute by dental personnel to the community and/or Guahibos to attend dental health care centers, we recommend training some members of the community as oral health care promoters.

Prevention and primary oral health care practices directed at the Guahibo people should respect their worldviews. Educational and therapeutic practices should harmoniously and respectfully link both perspectives, Western and indigenous.

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