CHAPTER FOUR

4. PERSISTENCE AND CHANGE IN MEDICAL PLURALISM

This chapter presents medical pluralism in Addis Ababa in relation to the changes it underwent and the aspects maintained in the process. The chapter together with the previous one furnishes a stepping stone to discuss the theoretical and policy implications of medical pluralism in the study area. The major focus of this chapter is therefore, to highlight on the trends of the practice of medical pluralism on the one hand and the old strands persisting along with the new trends on the other.

4.1 Trends in Health Care

Health care was the responsibility of individuals in a family or kinship before the government formally began to deliver organized health care services in Ethiopia. Each family looks after its member through culturally relevant practices such as the application of popular herbal remedies and prayers. People bring the case beyond the capacity of the popular sector to the attention of folk healers who in earlier times were rarely fulltime practitioners. Health care gradually became a shared responsibility of individuals, families and the government due to the intermittent exposure to biomedicine and Western bureaucracy. Through these quest for better health care by individuals, practitioners and the government there appears to exist changes on the one hand and persistence on the other. Therefore, I shall present these aspects of medical pluralism in the study area in the subsequent pages.
4.1.1 The Role of Traditional Medicine

Traditional medicine served as the major source of health care in Ethiopia especially before biomedicine turns to become another option. Some historians argue early medico-religious manuscripts and traditional pharmacopoeias date back to the 15th century AD (WHO, 2001:14). Others suggest a literature of traditional medicine in the local language of Geez and Amharic dates back to at least the second half of eighteen century. The literature contains thousands of prescriptions for a wide range of diseases. However, the medico-religious manuscript of traditional medicine did not make clear distinctions between the medical and extra medical aspects of disease. Disease is not treated in any different manner from other problems of human beings. The literature for instance contains prescriptions not only for the treatment of epilepsy, syphilis, rabies, kidney trouble, hemorrhoid, sterility, snoring but also magic formula to assist in dealing with various concerns such as averting the evil eye and overcoming demons (Pankhurst, 1990:113).

Traditional medicine in Ethiopia plays both preventive and curative roles. The vegetable kingdom is an extensive source of the traditional Ethiopian pharmacopeia. The leaves, flowers, seeds, bark, sap and roots of a wide variety of plants used. Moreover, honey, butter, sheep fat, certain insects with medicinal properties constitute the input from the animal kingdom.
The history of traditional medicine in Ethiopia shows that healers put much emphasis on the supernatural. Although practitioners practically deal with tangible problems for example bone setting, traditional surgery, inoculation and cautery historical evidence shows that there were innumerable prayers for the prevention and cure of diseases. The accounts of travelers of early 19th century for instance shows that people in central Ethiopia at that period place more reliance on the efficacy of the charms, spells and amulets than on the actual medical treatment (Pankhurst, 1990:113-120).

In any case, traditional medicine was the source of health care services for the general population except for a privileged few groups of people before the expansion of biomedicine. It seems because of this fact and the healers’ traditional medical support to the patriots during the Italian invasion that the proclamation soon after the liberation of the country from the Italian invasion recognizes the practice of traditional medicine. The proclamation NO.27/1942 which demanded the registration of medical practitioners in the country stipulated:

Nothing contained in this proclamation shall be construed so as to prohibit or prevent the practice of systems of therapeutics according to indigenous methods by persons recognized to be duly trained in such practice…provided that nothing in this article shall be construed to authorize any person to practice any indigenous systems of therapeutics which is dangerous to life. (Pankhurst, 1990:250).
Nonetheless, little has been done on the part of the government to enhance the contribution of traditional medicine to health care. The quest for biomedicine by the rulers at different times was often made at the expenses of indigenous knowledge in general and traditional medicine in particular. The role of traditional medicine has not been either integrated into the National Health Service or got any support from the government except a few attempts by the military government (1974-1991) to implement the Alma Ata Declaration by integrating traditional birth attendants to Primary Health Care Units. However, traditional medicine is still one of the major options for patients in Addis Ababa despite the absence of the official technical and financial support from the government. I will present more on the changes it underwent and its persisting features under the subtitle of new trends and old strand.

4.1.2 The Introduction of Biomedicine

Historical evidences suggest that Ethiopia’s interest in foreign medicine goes back to 16th century long before the country took its current shape and size (Kloos, 1998:89). A barber surgeon from Portugal, Joa Bermudes is the first practitioner on record and whose services were considered very valuable that he was forced to stay in Ethiopia longer than he expected. The then ruler of Ethiopia is reported to have officially requested the king of Portugal for foreigners who were able to make medicine, physicians and surgeons to cure illness (Pankhurst, 1990:139).

Ethiopia’s quest for foreign medicine which began with the service of Bermudes however, continued into the 19th century without taking roots in institutionalized form.
Many travelers and missioners who were trained in the basics of Western medicine engaged in the treatment of mainly the royal family before the official introduction of biomedicine that targets the public at large. In fact, such medical services were meant to ease the exploration or diplomatic relations with the country and hence the expansion of biomedical service was not their primary objective.

The exposure of earlier Ethiopian rulers to biomedicine entered new phase during the reign of Menelik II that ruled as king of Shewa from 1885 to 1889 and as emperor from 1889 to 1913 (Kloos, 1998:89). The emperor had at the Palace a building which served as a combined pharmacy and clinic. The combined pharmacy and clinic expanded regularly. It was also the storehouse of many foreign gifts especially surgical equipment and drugs.

The 1896 war of Adwa was in some sense instrumental for the establishment of the first biomedical hospital in the country. Pankhurst (1990:172) states “the Russians as Orthodox Christians sympathized with Ethiopia in the conflict and accordingly dispatched a medical mission which arrived in Addis Ababa in July 1896, four months after Minelik II’s victory at Adwa.” The Russian medical mission established the Russian Red Cross hospital in Addis Ababa which was also the first biomedical hospital in the country. The mission further produced the first modern medical text in local (Amharic) language at the personal request of Menelik II.
Although the Russian Red Cross hospital was a landmark in the medical history of the country it soon evoked considerable hostility from European powers especially Britain. Britain was suspicious of Russia that the hospital could be a means used by Russia to integrate itself with and gain popularity among the Ethiopian people. Such integration and popularity of Russia in Ethiopia became a concern to Western powers because they suspect Russia may interfere in the politics of the country and north east Africa as well as the line of commerce in the area which at the time was dominated by Britain (see Pankhurst, 1990). The fear among foreign legation in Ethiopia in early 20th century about the role of Russia in the country led them to add medicine to their diplomatic activities. While Italy set up a clinic in its legation compound in Addis Ababa, other Europeans began to appoint physician officers to their legation staff in Addis Ababa. Despite its historic landmark, however, the Russian Red Cross hospital was not sustainable. The main challenge to its sustainability was a disagreement between the hospital and the Ethiopian government on its modus operandi. The other was the political situation in Russia itself. Therefore, the first public hospital was founded by emperor Menelik II in 1909 on the site of the Old Russian Hospital. The hospital was initially directed by foreign physicians although the first two Ethiopian young physicians who studied medicine in Russia were the first national medical staff in the hospital. On the other hand, the first private retail store and pharmacy was opened in 1910 in Addis Ababa by a Georgian Doctor, whose engagement in the private practice together with other foreigners gradually increased the import and penetration of medicine by the first quarter of 20th century (Pankhurst, 1990:185-205).
Successive governments consolidated the expansion of biomedicine in Ethiopia since then.

Biomedicine was accessible to residents in the city more than anywhere else in the country at the beginning. But the private practice in clinics established by foreign nationals in Addis Ababa was not a lucrative business because the poor could not and the rich did not wish to pay for the medical services (ibid). The health care service limited to the capital city gradually expanded to other towns as well as rural areas. The expansion of the health service began in an organized form through the Ministry of Public Health during Haile Selassie I in 1950s. Moreover, a national health policy was formulated by external advisors during this period. Biomedicine has won the attention of successive governments in planning and implementing national health care policies from this time onwards.

Therefore, biomedicine became the official public health care service run by the government. The poor have the opportunity to free access to medical services where as others pay nominal fees for the services in the public biomedical health service institutions. Of course, private practice was in place since the introduction of biomedicine into the country. The private practice went through three major episodes in the history of biomedicine in Ethiopia. It is an important alternative within biomedicine to residents especially of Addis Ababa before and after the Military Rule (1974-1991).
Foreign nationals are credited for the beginning and expansion of the private biomedical practice in Addis Ababa before the Military government (1974-1991). Such a practice took marginal status during the Military government due to the policy and political ideology of the socialist government. But the practice revived again from 1991 onwards in unprecedented scale. Private practice is the fast growing biomedical health care service in Ethiopia in general and in the study area in particular. This time unlike the early periods during the introduction of biomedicine, the nationals are the major owners of the private practice. But it is biomedicine in the public sector run by the government which takes the lion’s share in the biomedical health care service in the country.

4.1.2.1 Medical Education

The first medical students from Ethiopia were sent to Russia in early 20th century for education. But the first steps in modern medical education within the country were taken towards the end of 1935 when medical auxiliaries were established at Menelike Secondary School in 1935. The training establishment within the country targeted not only the population at large in which graduates would serve in the provinces but also be attached to the army because it was a time of looming Italian invasion. Further, the threat from Italy led to the establishment of the Ethiopian Red Cross Society and the Ethiopian Women’s Work Association in 1935 both of which rendered medical help to the Ethiopian Army during the war that lasted from 1936 to 1941 (Pankhurst, 1990:181-216).
The country’s first medical school came into existence in 1964 by incorporating the school of pharmacy which was established two years earlier. The Ethiopian Medical Association and the Ethiopian Medical Journal precede the medical school by two years in their inception. Hodes and Kloos (1988:918) noted:

...Ethiopia’s main medical school at Addis Ababa University opened with 28 students...At that time there were 28 Ethiopian physicians all trained outside the country....The present course include a premedical year of English, science and Marxist studies. The curriculum then resembles that at American Medical School with two years of basic sciences followed by two years of clinical rotation and one year rotating internship.

The number of medical schools and physicians increased gradually since then although brain drain has become another challenge to the country at the moment.

The Central Laboratory and Research Institute was also established in 1951 resulting from an agreement between Ethiopia and the French government. It had links in the beginning with the Pasteur Institute in Paris. A French personnel was responsible for its leadership until 1968. This Institute has currently broadened its scope and built its capacity to become a renowned Nutrition and Health Research Institute in the country. It is also this Institute that tests the safety and efficacy of the material medica used by traditional healers.
4.1.3 New Trends and Old Strands

4.1.3.1 New Trends

The practice of medical pluralism has witnessed significant changes in the study area mainly since the introduction of biomedicine in general and over the last two decades in particular. Some of the changes had been gradual while some others are dramatic. Biomedicine has gradually set deeper roots to influence public health policy. It has now built its muscles to the extent of marginalizing other medical practices which were in place before its arrival as well as which made their way to the study area very recently. It is the most expanding medical practice in Addis Ababa. Although successive governments in Ethiopia tried to promote biomedicine since early 20th century, its tremendous expansion was observed in the city over the last two decades. The recent policy encouraged not only the expansion of public Primary Health Care Units but also the private practices to a significant scale. In spite of the growing private practice however, biomedicine in the public domain constitutes the lion’s share of biomedical health care service accessible to the majority of the people in the study area.

The private practice is growing rapidly over the last two decades and provides relatively better quality service with more expensive cost than the public one. The flourishing of the private biomedical practice results from the change in the government and the national policy in 1991. The new policy encourages the participation of private investors in the provision of health care services. The trend of the private biomedical practice has
influenced the practice in public hospitals however. The private practice is available from a small clinic to specialized hospitals which are better equipped and staffed than the public ones. It is the destination for many physicians resigning from public hospitals. It is also known for enticing physicians with better payments. Some of these private biomedical clinics and hospitals have established medical colleges which train medium level biomedical health professionals.

Another important aspect of change especially in recent years is the expansion of medical education and the increasing number of graduates from medical schools. The Federal Government and its partners worked progressively on the expansion of medical schools and their capacity of admitting students. It is rare nowadays compared with the past that students are sent abroad for biomedical medical education of a general practice. But the graduates from these medical schools flock to the private practice in the study area and neighboring countries in search of better payment which makes biomedicine in public domain vulnerable to shortage of health professionals and poor quality service. So, public hospitals have now introduced a new package entitle “private in public” to mitigate this challenge. The package allows patients to bypass the referral system and seek treatment at hospitals. But the this opportunity also entails about 10 -20 % rise of treatment cost higher than the cost through referral system. This package is arrraged between 5:30 to 10:00 PM after the usual civil service working hours. The health professional were subsidized from the income generated through this package. The idea is patients could get better quality service equivalent to the one at private practice while health professionals
would also get extra incentive from the income generated through the “private in public” package. This way, the government tried to reduce health professionals turn over often to the private practice or neighboring countries.

New trends are also emerging in the study area in connection with the diversity of pluralistic medical practices. Alternative medicines such as acupuncture, chiropractic and organic supplements have been introduced to the study area over the last two decades. These practices have successfully attracted many patients not only from Addis Ababa but also from far places within the country despite their recent arrival. The Chinese company uses network marketing to promote the sales of its organic supplements. The company inclines more towards business than health care service in this regards. Some of the patients lamented about the high cost of the organic supplements at times higher than the cost of treatment at higher private clinic. What makes the business of the company easier compared with other medical practices is the regulation of the country categorizes supplements under food items. But the company explains the general health limitations of any human being and proposes its supplements to rectify the health problems.

Chiropractic made its way to Addis Ababa by an Ethiopian who lived in the United States. It is the other major recent trend next to the sales of organic supplements in Addis Ababa as non-indigenous alternative medical practice. Although chiropractic depends on imported medical equipment and does not have professional and institutional links with biomedicine in the study area, a fulltime professional physiotherapist graduated from
medical school is working in the clinic with the Chiropractic Doctor. The pioneer female Chiropractic Doctor is expanding the service in the study area as well as in major towns in Ethiopia. However, it should be noted that the Chiropractic Doctor sees only a few patients per day that most of the treatments are carried out by the physiotherapist graduated from medical school and his support staff. In fact, the chiropractic doctor is available once a week for four hours at each branch clinic of the three branches in Addis Ababa. The doctor takes more consultation time with patients whose number she limits during consultation appointment. I observed for instance, and learned from a receptionist during fieldwork that a business woman from Addis Ababa negotiating for her daughter to see the Chiropractic doctor. The receptionist clearly replied to the business woman that the Doctor advised her not to book consultations of more than twenty patients a day because she wants to take more time with patients.

Another important aspect of chiropractic in the study area is the nature of its interaction with biomedicine. There is no formal institutional cooperation between biomedicine and chiropractic. Nonetheless, chiropractic tends to integrate some biomedical practices into its services. For instance, the clinic employs a qualified physiotherapist graduated from one of the country’s oldest medical schools. They prescribe drugs and use injections in their practices. Moreover, their treatment heavily relies on X-ray and Magnetic Resonance Imaging (MRI) reports of a patient’s condition from biomedical diagnostic laboratories. Such gesture is however, yet to happen on the part of biomedicine.
Acupuncture is known to the patients in the study area for about twelve years. But its popularity grew gradually. It went through both rough and smooth times with biomedicine. The goodwill of an official at the Ethiopian Nutrition and Health Research Institute was a good opportunity for Korean practitioners to introduce acupuncture to patients from the Institute’s premises. But the changes of the responsible official led to the removal of acupuncture from the Institute’s compound on the ground that the practice falls short of scientific standards. A key informant at the Institute who was part of the measure against acupuncture reiterated that neither the practice nor the acupuncturists went through scientific procedures before opening the services to the public. So, acupuncture was expelled from the compound. Fortunately, it fell in the hands of a private biomedical clinic whose owner is a nurse. Therefore, acupuncture became one component of medical service in her clinic side by side biomedicine. Both practices are now operating in the same compound under one roof separated by walls which adds to the new faces to the practice of medical pluralism in the city.

The higher clinic delivers ranges of biomedical services by qualified health professionals. On the other hand, a Korean female treats patients with acupuncture, physiotherapy, bloodletting and moxibustion. Patients coming to the higher clinic first consult a physician and the physician will refer the patient to either biomedical treatment or acupuncture depending on the nature of reported illness/disease. If the patient is suffering from back pain, paralysis, muscle cramp, palsy, depression etc, acupuncture will be his/her destination. The patient will get biomedical treatment if he/she reported and the
laboratory report confirmed the existence of infection, fractures, etc for which a physician believes biomedicine is the better solution. In any case, there is a tendency to integrate acupuncture into biomedicine at limited scale in this private biomedical higher clinic. This is a new trend of an attempt to integrate biomedicine and acupuncture.

Nonetheless, the move has neither a legal ground by which every clinic or hospital would integrate acupuncture to its services nor a support from all physicians. A physician key informant in the clinic for instance commented that he did not learn at medical school about the meridians used for treatment in acupuncture. He is conscious of the fundamental differences between his biomedical knowledge and the practice of acupuncture. Therefore, the practice of acupuncture in the clinic is simply a bold decision taken by an individual nurse that runs a private biomedical higher clinic. The sustainability of “the integration” is also at a stake since the Korean acupuncturist has not yet trained a single person in acupuncture. Nor there exists any college of acupuncture in Ethiopia.

Traditional medicine is not a practice closed to the medical practices surrounding it. One would identify significant new trends in the practice of traditional medicine; trends some of which are not older than decades. There is a growing tendency by traditional healers except faith healing towards self-motivated utilization of some aspects of biomedicine and imported equipment in their healing. The white coat is no more reserved for a physician. Traditional healers provide their services in a white coat previously associated
with biomedicine. They began using bandages, antibiotics, injections, electric massage chair, bloodletting tube and stretchers with which they buttress traditional medicine. The healers also use consultation cards similar to biomedicine for which patients pay up from 10 to 15 Ethiopian Birr and which is more expensive than the consultation fees at public hospitals. In this respect, traditional medicine has made a good stride towards biomedicine although it could not receive similar gesture from the other side.

Another trend of medical pluralism in the study area is the ever increasing marketing strategies. While the biomedicine in the public domain does not work on marketing for it is already operating under pressure from greater patients to health professionals ratio, the private biomedical practice and traditional healers are engaged in huge marketing activities to attract patient to their services. The private biomedical practice widely uses the government owned electronic media and road side banners.

On the other hand, electronic media are not open to traditional medicine for advertisement. In connection to this, the healers blamed the electronic media of distorting the image of traditional healers. So, the healers advertise their services through private newspapers, magazines and leaflets stating the lists of illness they are capable of healing effectively. Moreover, traditional healers are no more part-time practitioners from their own homes. They are engaged in traditional medicine in separate compound specifically meant for it throughout the day with lunch break in between. Some admit inpatients to the beds in their compounds when they treat patient from outside Addis Ababa for specific
disease such as hemorrhoid because the drugs used to treat hemorrhoid needs a close supervision of the healers. They also provide services through their cell phone to patients especially from the upper class who do not wish to come to their clinics for various reasons.

A change in the income from the private biomedical practice and traditional medicine excluding faith healing has been significant. Patients blame the private practice of profit maximization from every step of the medical service. Patients often complain about the lists of irrelevant laboratory tests recommended by physicians during the treatment which in view of the patients serve nothing more than the profit maximization of the private biomedical practice. The physician key informant agrees to the existence of such an inclination. This is quite contrary to the private practice in early 20th century run by foreigners in Addis Ababa. Evidences suggest the private practice was not a lucrative business at that time (see Pnkhurst, 1990).

Traditional healers except faith healing are no more traditional income wise. They charge at times greater than the cost at public biomedical hospitals. Some have used their income to expand their service while others still operate in rent houses. The trends in ever increasing income generated by traditional healers could be observed for the private vehicle they use for their activities in a country where ownership of vehicle is among the indicators of wealth and social status. One of the healers even traveled to the other part of
the country during my fieldwork by plane in order to gather medicinal plants for use in his clinic. So, traditional healers are generating more income from their services.

Nonetheless, all healers do not agree on the charges by traditional healer. The oldest living traditional healer in Addis Ababa, who was 95 years old, criticized the ever increasing service charges by other healers. He remarked that he did not learn from his mentors such a thing as accepting high service charges from patients. It appears that he is living to this principle that he practices traditional medicine from two separate rooms within a compound. One is a large hall which accommodates about three hundred patients at a time whereas the other is a small room that does not accommodate more than twenty patients at once. The service charge in the large room is relatively high but still by far lower compared to the charges at other traditional health centers. According to the healer, he pays income tax from his income in the large room. But he charges patients nominal fee or none whom he himself treat in the small room. He charges only the production cost of the drugs for the healing service in this room. Even then, when some patients report they have nothing to pay, the healer treats them for free. However, such benevolence is exceptional among traditional healers in Addis Ababa at the moment. Perhaps, the source of such benevolence of the oldest living traditional healer may have partly come from the fact that he owns medicinal plants on about 1000m² land in the compound where he renders the service.
Traditional healers have begun to “modernize” their drug preparation. Healers use electric grinding and oil processing mills to prepare some of the drugs. In other words, they are replacing human labor by imported machines for drug preparations. In connection to this and as part of their quest for experience sharing, some have visited China, many African and Arab countries. A traditional healer who stated his experience sharing visits to China triple times lamented his eagerness for mass production of the drugs using imported machines. But he equally concerned about the efficacy of the drugs which he suspects may be endangered in the process of mass production. He was not sure whether or not the medicinal power of the material medica would be affected in the process of the production using modern technologies. The concern is mainly for some aspects of the traditional medicine where healers apply fresh leaves or roots in their healing. So, the he was not sure how to integrate such drugs to the production by using modern technologies. This traditional healer added that he is trying to seek the assistance of a private pharmacist to standardize the production of his traditional medicine although he was not sure about its success.

On the other hand, the pressure on traditional healers from the government is growing more than ever. The government demands every traditional healer, except major religious based faith healing, to prove the safety and efficacy of the practice through scientific procedures. In fact, all traditional healers in Addis Ababa were operating without license. A key in formant at the Federal Drug Administration and Control Agency who was a pharmacist by training underscored the importance of safety and efficacy testing in order
to protect patients from harmful consequences as well as any fraud committed by healers in the process. The pharmacist went further to suggest the need for traditional healers to transform themselves by “specializing” in such a way that a healer should not at the same time be a pharmacist who prepares and sales the drug. He added drugs prescribed in traditional medicine need to be labeled with specifications of their ingredients, counter reactions and their expiry date.

The other important trend was a rising threat to medicinal plant species due to deforestation and the assistance of traditional healers in saving the endangered plant species. The traditional healers especially the herbalists have strong links with the fauna and flora of the country for the material medica from plants, animal products and minerals. This link has come under threat due to the dwindling species of the sources for their material medica. Deforestation has left the country with less than 3% of forest cover from about 50% over the last century (Kuru, 1990 in Badeg, 2001:12). Encroachments on forests for agricultural land and timber have led to the scarcity of medicinal plants. The healers had noted a dwindling availability of the medicinal plants due to deforestation. Their scarcity is among the factors by which they justify the rising cost of their healing when a patient attempts to complain. The healers argue it takes longer distances and more hardship to collect the material medica nowadays.

It was cognizant of the problem posed by deforestation that the Ethiopian Institute of Biodiversity Research Institute and Gene Bank took the initiative to work with traditional
healers in order to save the medicinal plant species. The Institute encouraged traditional healers to form a National Association of Traditional Medicine. It also provided the Association with a furnished office within the Institute’s premises. The major goal of the partnership between the Association and the Institute was to preserve the endangered medicinal plant species. So, both began the operation in 1996; the Institute represented by a botanist and the Association by a Chairperson. The division of labor was in such a way that the Chairperson together with other traditional healers escort the botanist to places where they collect medicine plants. The healers show to the botanists which medicinal plant species have become scarce. The botanist then recommends the preservation of genes of the medicinal plants in the gene bank of the Institute. In addition, the endangered species once identifies were propagated through the nurseries at field research sites of the Institute as indicated below.
However, the noble partnership of its kind between traditional medicine and the Institute of Biodiversity Research did not last long. The disagreement had two sources. One, the Association began to issue license to practice traditional medicine which was not under its jurisdiction. This triggered the legal action by the Ministry of Justice to ban the Association. Second, the partnership between the Institute and the Association was not based on mutual trust and equal footings. The Institute restricted the role of traditional
healers to the identification of endangered medicinal plants. The healers on their part had concerns about the sharing of their knowledge without any patent. This absence of the mutual trust and the skewed power towards the Institute in the partnership gradually turn the interaction between the healers and the botanist rough. Therefore, the National Association of Traditional Healers was banned prematurely and lost legal entity to represent traditional healers in the country.

In addition to the threat to traditional medicine due to deforestation, a looming threat to traditional medicine lurks under the selected seeds distribution to farmers. The Agricultural Research Centers in Ethiopia first conduct experimental research on different crops to improve their productivity. The traditional healers on the other hand prepare some supplement drugs from cereals they purchase from local markets. The key informants for instance proudly stated they have supplements prepared by mixing the powder of different types of crops. They explained that they use the supplements prepared from the cereals especially when dealing with patients in poor physical conditions. I also had the opportunity to observe the lists of the crops they mix for the traditional medicine. However, the looming challenge now days is that the selected seeds from Agricultural Research Centers being distributed to farmers for better productivity have the probability to affect the efficacy of supplement drugs that healers prepare from cereals they classify according to local taxonomies.

In a nutshell, new trends are emerging in the expansion of biomedicine, the increasing diversity of medical pluralism, the marketing strategies to entice patients, the rising cost
of health care in general and traditional medicine in particular and the changes in modus operandi of traditional healers. Changes in the modus operand of traditional medicine mainly over the last two decades are significant. None the less, there are persisting features of the practice of medical pluralism in Addis Ababa in spite of the above changes. These major persisting features will be presented below.

4.1.3.2. The Old Strands

Despite many important new trends in the practice of medical pluralism in Addis Ababa, one can still trace the persistence of old strands all along the way. The boundary between biomedicine and other medical practices is still bold because little institutional links have been established for collaboration between these practices. It is only traditional healers and the alternative medicine recently arrived from Asia and the United States of America that attempted to utilize some aspects of biomedicine. On the contrary, biomedicine relegates other practices beginning from the training at the medical schools through to the practice in hospitals. The curriculum of medical schools is packed with Western sciences. Students do not have the opportunity to learn and understand the non-biomedical aspects of medical practices at medical schools. No medical school incorporates a course about indigenous knowledge including medicine in its curriculum. This is partly the legacy inherited from the formative years of biomedicine in the country when most of the government’s technical advisors were foreigners for whom traditional medicine was nothing more than a superstitious activity. Therefore, such legacy is even deep rooted in
the medical schools and health institutions that biomedicine guards its practices from traditional and alternative medicine.

However, the institutional level *modus operandi* is still susceptible to the prevailing socio-cultural contexts in which the health professionals themselves are socialized and practice biomedicine. I realized from my interactions with the physicians and nurses at the study area that the health professionals have still some attachment to traditional medicine (faith healing) as an individual person. A head nurse at public hospital stressed she believes in the role of supernatural being in health and healing. She also underscores her experiences with physicians who pray to God before working on complex surgeries. Moreover, another nurse at other medical institution replied to my inquiry if she has any comment on this case, she opined, “*Kinin wachii kemittlegn tsebel techii betelegne emertalehu*” literally “I prefer holy water to biomedical drugs”.

My interaction with health professionals in different biomedical institutions confirms the fact that some aspects of traditional medicine is infiltrating into biomedicine through individual health professional’s behavior which in turn results from the larger sociocultural milieu. For instance, I observed health professionals with a small Cross or a black thread on their neck and nurses who wear *hijab* that give clues to their religious beliefs brought to the compound of biomedicine by an individual health professional. The

---

6 A head wear by female Muslims to cover their hair. The Cross could be worn by both Protestant and Orthodox Christians while the black thread on the neck is solely worn by Orthodox Christians. All have however, one message in common. They convey and symbolize religious meanings.
other angle from which one realizes this issue is the response by a physician to greeting or to express compliments. I like any other person in the hospital compound greeted the health professionals as “Tena yistiligne; endemin aderk Doctor?” The usual response is “Abro yisteligne; Egizeabeher yimesgen” Literally, it means “May you are blessed with health; how are you this morning Doctor?” and the reply goes “May we both be blessed with health; thank God I am good.” On the other hand, the traditional role of family and kin and close friends in looking after the sick is clearly observed in the hospital compounds. It is this group of people that provide psycho-social support to their sick member at hospitals.

Furthermore, traditional herbal healers revealed during fieldwork that some health professionals seek private arrangements for healing. The health professionals prefer private arrangements in order to avoid the publicity of their visits to the center according to traditional healers. But I did not observe any biomedical health professional at a traditional medicine center and neither could I confirm whether biomedical health professionals do seek healing at these centers. In any case however, the overall behavior of individual health professionals reveal the subtle persistence of some aspects of traditional medicine and health beliefs even after years of training at medical schools which do not have a single course about traditional medicine in their curriculum. The subtle persistence of an old strand among health professionals may be attributed to the impact of the socio-cultural milieu in which the physicians were brought up and still working in.
Traditional medicine has persisted in the study area not only by introducing new practices but also by maintaining some aspects of its old strands. In other words, the practice still makes reference to non-empirical causation explanations and the relevant healing interventions. I had the opportunity to get access to the reference books of one of the famous traditional healers in the study area which he allowed me to skim through. The book consists the techniques of healing illness that have personalistic causes. This old strand persisting in the practice of traditional medicine in Addis Ababa is mentioned on the advertisements that healers make about their services. This is among the major old strands persisting in traditional medicine at the study area.

Moreover, traditional healers still use rudimentary tools to prepare their drugs though some improvements have been observed. The collection, preparations and stocking up of the drugs in large quantities is a trend emerged gradually. But the tool they use for processing the material medica has not proved much sophistication. Neither does their products packed with specific details regarding the content of the drug, its production or expiry date and its chemical reactions.

The method of initiation of healers is the other old strand that haunts traditional medicine in Addis Ababa. No traditional medicine training school exists to date in the study area where new healers would acquire the knowledge and skill to practice traditional medicine. Healers still acquire the knowledge mainly through individual efforts being an apprentice to a healer. The healers to date incline towards secrecy about their knowledge
though one may observe some attempts to make transnational experience sharing with healers in other countries. Moreover, traditional healers and their patients still externalize the causes of many illnesses. There is no wonder to observe traditional herbalists dealing with illnesses which they claim have personalistic causes. Perhaps, what is interesting about the traditional herbalist here is they deal with these illnesses usually in a white coat and sometimes wearing hand gloves which is associated with biomedicine. Faith healing is however, an exception. Unlike traditional herbalist, faith healing is an organized service by the Ethiopian Orthodox Church that is conducted according to preexisting Church rules and regulations without reference to biomedicine. In general, despite a number of new trends or changes in the practice of medical pluralism in the city, the above old strands are persisting along the new trends.