CHAPTER FIVE

5. DISCUSSION, THEORETICAL AND POLICY IMPLICATIONS

5.1 DISCUSSION

Medical pluralism obviously entails the existence of pluralistic medical traditions in a society. But the nature and result of interaction among these medical traditions may take different forms (Dunn, 1976; Janzen, 2002; Kleinman, 1978, Baer, 2004; Geissler, 2005; Leslie, 1992; Ohnuki-Tierney, 2005; Young, 1976). The concept is employed in this research in a sense that it refers to the existence of organized medical practices based on observable differences in their approaches to health, illness and healing at the study area.

The major medical practices in Addis Ababa may broadly be grouped into three categories. The first and most common is biomedicine. Biomedicine set its foot at the study area through medical diplomacy before a century. Unlike other African countries where its early history has colonial tags and met with resistance (Baer, 2004:332), biomedicine has a privilege to earnestly been sought by successive rulers of the country until Menelike II finally succeeded in putting its lasting footprints about a century ago. Nonetheless, it was a transplant that did not have a space for preexisting indigenous approaches to health, illness and healing. Biomedicine began its operation from the beginning based on the scientific conceptualizations of health, illness and healing. This perhaps, could be due the fact that the technical persons in its transplant were not themselves nationals who understand local contexts.
On the other hand, indigenous traditional medicine is the oldest and still widely used medical practice in Ethiopia. Studies estimate at least 80% of the population in Sub Saharan Africa utilizes traditional medicine mainly in rural areas (Janzen, 2003; Goods, 1987; Mekonnen, 1991). Traditional medicine has significant demands in urban areas such as Addis Ababa too. The most common organized traditional medicine in the study area is traditional herbal medicine and faith healing. But the boundary between the two at times turns fluid since herbalists ultimately refer the source of their knowledge to religion (either Ethiopian Orthodox Church or Islam). The fluidity of the boundary becomes eminent when both deal with illnesses of personalisitc causes. But contrary to the reliance on prayer, holy water and oil in faith healing, traditional herbalists widely employ herbs, minerals and animal products for healing. The traditional herbalists also keep naturalistic explanation side by side the personalisitc one. They relate many somatic illnesses to infections. Faith healing in Addis Ababa is slightly narrow in its scope because studies from rural areas (Girmay, Mirutse, Tilahun etal,2007) indicated monks and nun have a very good knowledge of herbal medicine in addition to the use of prayer, holy water and oil for healing.

Non-indigenous Alternative medicine is the third major category of medical pluralism in Addis Ababa. This category represents those newly emerging and non-indigenous medical traditions. They are designated Alternative by the government office in the study area in order to differentiate them from indigenous traditional medicine. This category
consists acupuncture, organic supplements and chiropractic. The first two base their practices on the assumption of the disturbances to body back to balance and their treatment is meant to bring the body into a state of equilibrium. The maladjustment of musculo-skeletal system is the central causal explanation for chiropractic. Proper adjustment of the maladjusted ones then is the primary intervention by chiropractic.

Some studies tend to show gender, socio-economic status and geographic accessibility determine to a large extent patient’s consultation of traditional or biomedicine. Stekelenburg, et al (2004) for instance suggests the tendency of females over males to consult traditional healer where as other studies (Leonard, 2002; Press1978; Goods, 1987) emphasized economic factors in patient’s choice of traditional over biomedicine. But no significant gender based variations at traditional herbalists and alternative medical centers in Addis Ababa was observed. The number of females was rather relatively higher at faith healing sites of the Ethiopian Orthodox Church. So, both sex from rural and urban areas come to traditional and alternative medical centers seeking treatment. In fact, the difference in terms of age is more observable than gender. Rarely do children are brought to traditional as well as alternative medicine. The youth are the second least demographic category found in the traditional and alternative medical centers for treatment. The findings of this study agree partly with the findings of Stekelenburg, et al (2004) on why patients consult traditional healers in the presence of biomedicine. Stekelenburg found that waiting time or failure to get appropriate help on time at biomedical hospitals, the perceived type of sicknesses such as demon possession, and
cost turned out to be the major factors for preference of traditional healers by patients. But Cost was not always the major reason in Addis Ababa because traditional herbalists charge comparatively higher cost and it is not always the poor only that consult traditional healers. Hence, the finding from Addis Ababa about the cost of traditional medicine is rather congruent with Good’s (1987) study in Kenya.

Moreover, socio-economic status was not an impediment to patient’s plural consultation of different medical practices. Socio-economic status was rather found to generally be associated with the choice of costly private biomedical hospitals where the poor and even the middle class find it difficult to afford. However, the capacity to afford biomedicine at costly private biomedical hospitals did not restrict patients from traditional and alternative medicine depending on the outcome of biomedical treatment and the pressure from family and close kin. The finding of this study agrees to the study by Janzen (1978) that family members and close kin are influential in the assessment of symptom and the decision of subsequent treatment process of a patient. On top of this, the attempt by patients of high socio-economic status to avoid publicity about their use mainly of traditional herbal medicine in Addis Ababa is similar to the practice in Nairobi where Good(1987) reports “It was and is widely believed that persons of higher socio-economic status who patronize TMPs [Traditional Medicine Practitioners] usually attempt to make themselves inconspicuous, preferring to come after dark or to arrange a consultation at private venue” (Goods, 1987:233). The traditional herbalists in Addis Ababa revealed that they provide service to group of patients on telephone and
by visiting the patients at their home. On the other hand patients may also visit the traditional healers after working hours when the probability of publicity is very low.

Neither the accessibility of biomedicine nor its affordability limits patients from treatment seeking behavior at medical practice centers other than biomedicine. Two major factors could be identified which push patients to look for plural consultations at different medical practice centers. The first is the commonly held belief about the etiology of the disease and its culturally appropriate therapy. Secondly, the dissatisfaction with the treatment outcomes at biomedical hospitals or clinics would push patient to go for plural consultations. For instance, the belief in personalistic (sorcery, demons, ancestral spirit etc) causes of illness is common among patients and traditional healers. I came across many patients whose illness was suspected of personalistic causes by patients themselves and their close family members and hence, brought to the attention of traditional healers. No patient consults biomedicine for this kind of illness because every patient and his/her family members clearly know biomedicine does not treat this kind of illness. Moreover, when patients are desperate about the improvements of their condition after biomedical treatment, they consult another biomedical clinic or hospital that they think delivers better quality service. On extreme cases, patients may even quit biomedicine and turn to traditional healers or non-indigenous alternative medicine such as acupuncture and chiropractic. Therefore, a combination of socio-medical and cultural factors such as accessibility, cost, acceptability, and etiological concepts and
world views (Kroger, 1983:147) sound desirable to understand the factors that determine the patient’s pathways to treatment seeking in Addis Ababa.

However, patients go through complex decision making processes before consulting any of the medical practices or shifting from one practice to the other in Addis Ababa. It is the decision by one’s kin or family members, a pressure from one’s social network and the dissatisfaction with prior treatment outcomes that brings a patient to the door steps of one or more medical practices. Physicians at times misunderstood the decision as non-compliance by a patient. The field data from my study area supports the idea that family members, kin group, and people in one’s close social networks play significant role on whether a patient should comply or not to a treatment regimen. An interesting experience during fieldwork worth mentioned here. A patient refused to exhaust her treatment at a private biomedical hospital and came to a traditional healer. The major factors behind this decision were the influence of family members and the people in the family’s social circle. The daughter of a patient appears to blame the influence of these people indicating the patient did not even exhaust the treatment for which payment was effected at the private biomedical hospital. On top of this, the nature of interaction between the healer and the patient seems to make feel this sixty years old patient at ease because the healer intentionally makes culturally relevant humors during treatment. For example, he suggested “Emete, medihanitun estemicherisu ginignunet madireg kilkil newu” which literally mean “Madam, you should abstain from sex until you exhaust this drugs” knowing the patient is not in a condition to do sex. The intention
was simply to make the patient smile and at feel at ease. The healer adds "mintew tegeremu. Gena wondi ligi yiwoldalu." This again is a psychological support to the sixty years old patient by inquiring “why you are so surprised. You are young madam. And you may have a baby boy if you have to.” But this kind of interactions is hardly available at biomedical hospitals.

Significant variations are at work in the arrangement of the patterns of resort at the study area. The nature of plural treatment seeking behavior in the study area could take any one of the following arrangements:

1) A patient may begin with traditional medicine and shift to biomedicine and finally end up at the door step of alternative medicine;

2) Treatment may begin with biomedicine then shift to traditional medicine and then to alternative medicine;

3) Patients may begin with biomedicine and then shift to traditional medicine; and

4) Simultaneous use of both traditional and biomedicine.

The patterns of resort identified at the study area were under great influence of treatment outcomes and the pressure from what Janzen (1978) calls therapy management group. However, the resort goes both ways in the study area rather than incremental hierarchy that begins with traditional medicine. Self treatment for mild illness is quite common in
Addis Ababa. But once a patient suffers that brings him/her to the door step of organized medical practice, the patient being influenced by the therapy management group and the treatment outcomes may shift from one medical practice to the other. Moreover, resorts were not only hierarchical at my study area but also parallel. Patients at times shift from one biomedical clinic to the other or from one herbalist or holy water site to the other depending on their satisfaction and evaluation of the therapy management group about the treatment outcomes.

The most common simultaneous use of pluralistic medical practice was observed among patients seeking treatment for HIV/AIDS and tuberculosis by the integration of biomedicine with faith healing. These patients use biomedical drugs side by side faith healing. The integration comes about due to the fact that patients failed to comply with biomedical prescriptions in favor of faith healing. Such non-compliance concerned public health officials and compelled them to implement massive media campaign to aware patients that biomedical drugs do not have counter reaction with faith healing such as prayers, fasting, and holy water. The media campaign has been successful and many patients at the faith healing sites apply simultaneous treatment with biomedicine and faith healing. However, the idea of integration should not be stretched too far here. The integration is more of a strategy devised by public health officials to reduce non-compliance in the treatment of tuberculosis and HIV/AIDS where many patients incline to faith healing than biomedicine. The officials are concerned about the effects of non-compliance by patients on the public health policy to control tuberculosis and
HIV/AIDS. So, they engaged in large scale media campaign explaining patients may apply faith healing together with biomedical drugs for tuberculosis and HIV/AIDS. One should note the intention here is not the integration of the two practices but to reduce the non-compliance of patients to biomedical drugs.

The diversity of pluralistic medical practices and their modus operandi in Addis Ababa have changed with some persisting aspects at the study area. Although biomedicine has been privileged to secure strong financial and policy support at the expense of traditional medicine, medical pluralism tends to increase in diversity especially over the last two decades. Non-indigenous alternative medicine from Asia and the United States of America have now joined the medical practice at the study area, hence, increased the diversity of medical pluralism.

The private practice of biomedicine is fast growing recently. Private practice which was run by foreign nationals about a century back has now become the icon of quality biomedical service owned by nationals. Further, the geographic access to primary health care has reached 100% in the Addis Ababa. But this does not imply 100% utilization by the people at the study area.

Contrary to the traditional healers in other African cities (Good, 1987) individual traditional healers in Addis Ababa appear more organized logistically. The traditional herbalists in Addis Ababa do not operate from squatter settlements or slum corners. Their
clinics are found mostly in accessible locations of legal urban settlement neighborhoods. Some operate from their own buildings where as others rent villas or small rooms for the practices. A case in point is a traditional healer that operates from his own two story building. The other healer also renders the service in a large hall which the healer himself owns. However, the traditional healers in Addis Ababa lag far behind the traditional healers in other African countries in the organization of the national associations of traditional healers. Traditional healers in the study area do not have a national association and the interaction among the healers is accompanied mostly by suspicions.

The traditional herbalists have gradually incorporated many biomedical disease terminologies and equipment into their practices. Lists of infectious disease are common to read on the service advertisement banner of the traditional herbalists. Scholars of biomedical background (Ashenafi etal, 2008) also criticize these healers of adulterating modern pharmaceutical drugs with traditional medicine. The critics reported that they found through laboratory analysis that the herbalists adulterated 51% of their drugs included in the sample for the study and the cost was also higher than the cost of full dose unadulterated pharmaceutical drugs at retail pharmacies. This case however, could not be verified by the healers by this study except the fact that the healers remark they use antibiotics to supplement traditional medicine on specific cases. What is more visible is their use of imported biomedical equipment that does not require advanced biomedical knowledge to operate. These healers incorporate the use of bloodletting tube, injection
syringe and electric massage chair into their traditional medicine. Moreover, traditional healers have begun transnational experience sharing with healers from China, and African countries. Yet, this is an individual initiative by the healers without direct support from the government.

Among the new faces of medical pluralism in recent times is the introduction of non-indigenous alternative medicine from China, Korea and the United States of America. Despite the absence of official cooperation between alternative and biomedicine, alternative medicine is penetrating the environment of medical practice mainly due to the commitment of individual practitioner and the positive attitudes of patients. Acupuncture is being practiced by the Korean in cooperation with biomedicine within the same compound. What makes the coexistence of acupuncture with biomedicine in the same compound is the fact that the owner of the private biomedical clinic had prior awareness about acupuncture while working with Koreans in public hospitals. Chiropractic maintains an independent clinic but heavily relies on biomedical laboratories. Biomedicine is complementary in some sense for the alternative medicine at the study area because they rely heavily on its diagnostic laboratories. So, one may safely argue the \textit{de jure} dominant biomedicine at times turns to a \textit{de facto} complementary medicine to the newly arrived alternative ones in Addis Ababa.

Despite increasing diversity of pluralistic medical practice and the changes in modus operandi especially of traditional medicine, these changes did not foster official
cooperation or integration of the pluralistic medical practices at the study area. One of the barriers is the causal explanation by traditional healers and the limited awareness of government officials about non-indigenous alternative medicine. Traditional healers still kept dearly the personalistic explanations side by side the naturalistic one. Their expertise on personalistic causes of disease is embedded in the overall socio-cultural environment in which they are operating because clients bring such case to the attention of traditional healers but not to biomedicine and non-indigenous alternative medicine. This aspect of traditional medicine appears to fit to Young’s (1976) remark in this regard that the persistence of particular belief of sickness and health lies in its ability to remain convincing and useful to people. The beliefs about personalistic causes of illness together with appropriate interventions are widely held at the study area. The family and religious institutions play key role in the persistence of such ideas. The healers therefore deal with the problem of patients by ascribing meanings to a seemingly meaningless illness to the outside observer or symbolically reconnect a sick person to her or his social world.

However, this study does not support Young’s idea on the efficacy of traditional medicine on self-limiting sicknesses. Young (1980:105) suggests traditional healers take credit for effective healing intervention against self limiting sicknesses. But traditional herbalists at my study area implement their healing with the herbal medicine which they know quite well about its health outcome. It is important to note that other studies also indicate “an estimated 25% to 50% of the pharmacopoeia of indigenous peoples has been demonstrated to be empirically effective by biomedical criteria. Various biomedical
drugs, including quinine and digitalis, were originally derived from indigenous peoples.” (Baer, singer, and Susser, 2003: 314). The seasons when the healers in my study area gather the herbs for drug preparation takes into account the high concentration of substance in the herbs of medicinal value. My study result agrees rather with Green and Janzen (2003) that the healers perform the healing with sound empirical knowledge of the content of the herbs they apply for treatment. But the gap in their diagnosis and the establishment of cause-effect relation is still wide though some healers have began to base their drug prescription on biomedical laboratory test reports for blood pressure, diabetes, internal parasites, cancer and HIV/AIDS.

Moreover, the diffused and the secretive aspects of knowledge transmission among traditional healers are persisting in Addis Ababa. Partly due to this secretive aspects and the absence of consistent realistic support from the government, it is the healers who mostly collect and prepare the drugs manually. The fact that healers want to keep the knowledge secretly, their lack of essential resources on the one hand and the lack of realistic policy back up for indigenous knowledge on the other impede the transformation of traditional medicine from running formally organized training schools and the mass production of drugs salable at retail pharmacies. The marginal status of traditional medicine compared to biomedicine is persisting. Biomedicine undermines the possibilities for cooperation with other medical practices just like at the time of its introduction. It pretends to be self-reliant and hence, fails to forge institutional based and
policy backed cooperation with alternative and traditional medicine. But its global institutional cooperation with biomedicine has been significant.

5.2 Theoretical Implications

Medical pluralism exists to the degree and nature it had never before at the study area. Traditional medicine was the sole source of health care before biomedicine sets its footstep a century ago. Other practices such as Acupuncture, Chiropractic and the sales of supplements have recently joined the pluralistic medical practices in the Addis Ababa. The increasing diversity of pluralistic medical practice and the changes in the modus operandi especially of traditional medicine at the study area has beyond empirical significance.

Faldon (2004) suggests the domestication thesis to understand the outcome of the interaction between Complementary and Alternative Medicine with biomedicine where CAM became popular among the postmodern Western societies. She also opined the theme is applicable to understand the outcomes of similar interactions among different medical traditions even in countries with low human development index. The theme of the domestication reveals patients “domesticate” health, illness and healing ideas originally from other cultures. The domestication of these ideas and practices to locally palatable tastes was linked with the dissemination about CAM by the popular press and the professionalization of CAM through clinics and colleges. Domestication in turn becomes a force behind integration that abolishes many of the original differences
between CAM and biomedicine and which makes the foreign, in this case, CAM, familiar and palatable to local tastes.

Conversely, the indigenization theme (Geest, 1997; Geisseler and Pool 2005) suggest the adaptive adjustment of biomedicine to fit to local socio-cultural environment of non-western societies when it becomes part of their medical system. So, indigenization in this context implies the inclusion of non-western medical traditions into the practice of biomedicine.

The use of non-indigenous alternative medicine has been common at the study area over the last twenty years. The non-indigenous alternative medical practices include acupuncture from Korea, Chiropractic from the United States of America and Tianshi organic supplements from China. Unlike the popularity of CAM and its domestication to locally palatable tastes in Western societies (Faldon, 2004) the data from Addis Ababa does not imply similar discourse. CAM is available to patients through the efforts of individual practitioners and known either through the mass media or social networks. But their popularity is not equivalent to the domestication that transcends the dichotomous differences between biomedicine and CAM. For instance, among the main ideas of the domestication theme was the fact that while the popular press disseminate about CAM, the clinics and colleges professionalize it. The dissemination and professionalization then brings about the domestication of these practices to palatable local tastes. The process promotes integration that abolishes the differences between Cam and biomedicine.
However, although Faldon (2004) was optimistic about the applicability of this theme to non-Western societies, CAM is gaining popularity in Addis Ababa under different contexts. There is no non-indigenous training college at the study area. Acupuncture, for instance, was practiced by a Korean that did not train nationals so far. The owner of the clinic did not hesitate to reveal her concern over the sustainability of the service in case the acupuncturist goes back to Korea for whatever reason. The biomedical hegemony also does not let the practitioners and the owner of the clinic at ease. Moreover, the recourse of patients to the non-indigenous alternative medicine does not reflect the postmodern alienation with biomedicine or the domestication of CAM to a society that has an established tradition of biomedicine. For instance; the public biomedical hospitals are overcrowded by patients seeking treatment for they are affordable than the private biomedical hospitals. But the public hospitals run poorly equipped diagnostic laboratories and poor patient-physician relations. Recourse to CAM under this contest therefore, reflects more of a dissatisfaction with the poor quality services of biomedicine at affordable public biomedical hospitals and a desperate search for alternative therapy than the domestication of these therapies to locally palatable tastes. In addition to this, the professionalization of these practices through colleges and their official integration with biomedicine has not been attempted. Above all, the domestication theme failed to reflect the nature of illness behavior at my study area where the role of therapy management group (Janzen, 1978) influences much of a patient’s choices.
On the other hand, scholars such as Geest (1997), Geissler and Pool (2005) suggest the theme of indigenization to understand the nature of medical pluralism resulting from the import of biomedicine by societies such as African societies with indigenous medical traditions. The main assumption here is that biomedicine has many contrasting features opposite to the indigenous medical traditions in other societies, it has to undergo many adaptive adjustments to render medical services in these societies. Accordingly, the data from Addis Ababa shows some aspects of indigenous medical traditions in the compounds of biomedical hospitals. One of the contrasting features of indigenous medical traditions with biomedicine is their religious dimension where religion is linked with every aspect to human existence including health, illness and healing. This aspect of indigenous medical tradition has been mixed with biomedicine through the behavior of individual health professionals. It is not uncommon to identify the religious symbols of the two major religions (Christianity and Islam) in biomedical hospitals among health professionals. A physician may tie a Cross necklace to demonstrate his faith in Jesus Christ or he/she may pronounce the supernatural with affirmation in greetings. The prayers to the Supernatural before complex surgeries by some surgeons are another strand of the indigenous medical tradition in biomedicine.

Moreover, the social factor where relatives of a patient look after the patient entered biomedical environment in Addis Ababa. Relatives are culturally responsible to take care of the sick. If someone fails to visit and provide the cultural psycho-social support to a sick relative or close friend, that would be a source of disturbance to health social
relations among them. So, these features of indigenous culture are present in hospitals at Addis Ababa. Relatives and close friends are preoccupied with numerous activities such as feeding a patient, helping him/her to bath room and going out to buy medicine for the patient. This aspect of biomedicine is the other source of overcrowding in biomedical hospitals that the hospitals have fixed patient visiting times by relatives and close friends. Perhaps, the wishes of visitors to a patient when leaving the room worth mentioned here to illuminate on how far indigenous traditions have penetrated biomedicine. Up on leaving a patient, visitors say “Egizeabiher yimarih” literally means “May God have mercy on you.” So, visitors and relatives expect the ultimate healing power not from the physicians but the Almighty God according to their religion.

None the less, these indigenous ideas of health, illness and healing among health professionals and those of visitors are not official institutional endeavors to indigenous biomedicine. Biomedicine does not officially accommodate indigenous ideas of health, illness and healing.

On the other end of the spectrum, some aspects of biomedicine tend to become popular among traditional herbalists. These healers have begun to dress themselves in the white coat, list many biomedical nosologies, use biomedical equipment and apply antibiotics. However, this popularity and integration of some aspects of biomedicine by traditional healers does not have legal backgrounds.

Therefore, one may infer from the experience at Addis Ababa is the indigenization theme partly explains the practice of biomedicine in Addis Ababa where some aspects of indigenous socio-
cultural features persist in biomedical hospitals through individual behavior of health professionals and relatives of patients. However, there is still a large cliff between biomedicine and indigenous medical traditions at official level.

The history of biomedicine in the study area is slightly different from the experience in other African countries although the nature of its interaction with indigenous and non-indigenous alternative medicine resembles the one in many African countries. Biomedical theories and practices were introduced to African patients during colonial era. On the other hand, it was the Ethiopian government that facilitated its way into the country through medical diplomacy in the case of Ethiopia. The study area is the first city in the country where biomedicine was introduced and sustained. Traditional medicine based on emperico magico-religious practices was also in place before biomedicine. Personalistic and naturalistic etyolgical explanations were commonly held in the practice of traditional medicine. Another group of medical practices such as Acupuncture, organic supplements and chiropractic have been introduced to the study area over the last twenty years. Therefore, we expect changes in the practice of medical pluralism at the study area especially from the externalizing aspects of traditional medicine to internalizing one in the process (Young, 1976a; 1980). Moreover, the production of medical knowledge by traditional healers should become more systematic and organized.

Clearly, there have been major changes at the study area in the practice of medical pluralism due to the influence of biomedicine, government policy and individual initiatives. Traditional herbalists have begun to adopt biomedical nosologies. Herbalists
advertise their competence in lists of disease such as amoeba, diabetes, blood pressure, rheumatism, cancer etc which are not indigenous terminologies for classifications of disease. While the indigenous knowledge and skill of dealing with these diseases pre date biomedicine, healers have now adopted biomedical terminologies to explain their treatment in biomedicine dominated environment. Traditional herbal medicine is in fact dynamic and healers are trying to transform their modus operandi. Individual healers have travelled overseas for experience sharing not with biomedicine but with traditional healers. Some of the healers integrated electric massage with imported equipment into their treatments. On top of this, the traditional herbalists have begun to apply antibiotics.

Nonetheless, the dynamism in their modus operandi does not extend to the expectation that internalizing medical belief system would replace the externalizing approaches to sickness (Young, 1976a; 1976b; 1980; 1983). In fact, both explanations persist side by side despite a century old influence of biomedicine and decades of non-indigenous alternative medicine in the study area. The healers clearly indicate their competence of healing illness attributed to personalistic cause side by side the naturalistic ones. The healing of personalistic caused illness takes primacy in faith healing although traditional herbalists do also deliver the healing service to patients with similar cases. The data from fieldwork shows a well organized faith healing of illness attributed to personalistic causes. On the other hand, the Ethiopian Orthodox Tewahido Church does not object biomedicine where physicians treat patients based on the theories of medical sciences. Hence, traditional medicine did not give up externalizing medical belief systems in favor
of internalizing ones despite the influence of biomedicine and the complexity of division of labor in the study area. It is rather a side by side practice. The data from Addis Ababa suggests the changes or the new trends do not entail paradigm shifts on the ideas of health, illness and healing from externalizing medical belief systems to the internalizing one. But this does not mean to deny the dynamisms of medical pluralism at the study area. Much change has been evident. Traditional herbalists have integrated some aspects of biomedicine to their services. Some are travelling overseas for experience sharing with traditional healers. However, the changes are largely the transformation of the modus operandi of how to deal with sickness. In fact, the old strand of the externalizing medical belief system is still one of the specialty areas of traditional medicine at the study area.

The side by side practice of externalizing and internalizing explanations is embedded in the overall socio-economic and cultural milieu. Urbanization did not break the link between urban and rural areas. The link is active through rural to urban migration as well as urban-rural kinship ties. Such link maintains the externalizing system in the urban environment which is usually associated with low literacy in rural areas. Further, religious institutions such as the Ethiopian Orthodox Church maintain the idea of personalistic causations that has important implications on the medical beliefs of its followers. The church survived about two decades of campaign by the socialist government (1974-1991) against the church to discourage the belief in the Supernatural being and in personalistic causes of illness. On the other hand, ideas of faith healing are infiltrated into biomedicine through the behavior of some physicians and nurses. Such
behavior include prayers before surgery, the cross necklaces and the contents of greeting words which all entail the role of the supernatural in one’s life in general and the health in particular. It is important to note however, these are individual behavior and do not reflect the position of biomedicine towards other medical practices. Therefore, there is no wonder that the initiative by traditional healers to substantiate their healing with antibiotics and modern biomedical equipment, their transnational experience sharing are though steps forward, it does not have a fundamental effect on the changes of pre existing medical belief systems as suggested by the externalizing–internalizing model.

Moreover, non-indigenous alternative medicine has arrived lately without modifying its theoretical bases. Acupuncture, organic supplements and chiropractic are being practiced in line with internalizing explanations. But they made their modes operandi flexible such as the applications of biomedical drugs in the case of Chiropractic.

In general, the data from Addis Ababa shows the changes in the modus operandi especially of traditional medicine and the expansion of biomedicine did not led to the abandonment of externalizing medical belief systems in favor of the internalizing ones. The fieldwork data suggests that medical pluralism is being practiced in such a way that each medical tradition renders services based on its pre-existing major strands of health, illness and healing buttressed by new trends of modus operandi.
5.3 Implications for National Health Policy

The practice of medical pluralism in Addis Ababa has important policy implication. About four decades ago, the World Health Organization recognized the role traditional medicine could play in enhancing access to primary health care mainly in developing countries (WHO, 1976; 1978). Many countries used the Alma Ata Declaration as a turning point for policy imitative to integrate traditional medicine into mainstream biomedicine. African countries such as Ghana, Nigeria, Tanzania and Kenya went to commendable degree in this regard (Good, 1987).

Medical pluralism has been a *de facto* than *de jure* practice before the Ethiopian Government enacted the first ever proclamation regarding traditional medicine as part of the public health matter in 1942. The public and official attitudes towards traditional medicine have been accompanied by ambivalence before and after the introduction of biomedicine in Ethiopia. Some aspects of traditional medicine such as non-mainstream spiritual healing, sorcery and witchcraft were not welcome by successive Ethiopian rulers before and after the introduction of biomedicine. This was partly because of the influence from the teaching of mainstream religion (the Ethiopian Orthodox Church) which at the same time had been able to maintain the personalistic causes of some sickness that could be exorcised by holy water and priests (Bishaw, 1992). But herbalists, bone setters and traditional birth attendants did not face equivalent pressure against them for they have
little or nothing in common with non-mainstream spiritual healing, sorcery and witchcraft.

The public health proclamation of 1942 as well as the legal provision made in 1957 regarding the status of traditional medicine did not yield tangible outcomes until the 1978 Alma-Ata Declaration. The Alma Ata Declaration gave policy insights on the role traditional medicine could play in the provision of primary health care in developing countries. So, the training and assignment of traditional birth attendants was among the policy outcomes in Ethiopia.

However, the fact that the policy imitative emphasized the problem of access to health care and the socialist ideology of the government created a loophole to limit the role traditional medicine. Attempts were made to train and assign traditional birth attendants to rural Primary Health Care Units. But healers were often persecuted for quackery by the socialist government. The media campaign against traditional healers mainly during the early revolutionary zeal throughout the country was counterproductive to the promotion of traditional medicine. The media reports on many instances about traditional healers that were arrested, charged, and punished for allegedly exploiting the masses. Bishaw (1992) reported in this regard a total of 287 zar-shamans and 39 debtera-herbalists brought before court between 1976 and 1986 in Ethiopia.
The traditional medicine unit at the Ethiopian Nutrition and Health Research Institute examines only the antimicrobial and toxicity of the drugs used by traditional healers. The relationship between the healers and the Institute is often accompanied by suspicion. The Institute suspects healers of quackery and the healers suspect the experts in the institute of “robbing” their indigenous knowledge. The experts at the Institute often use biomedical language and yardstick to communicate with traditional healers. The misunderstanding between the healers and experts working in government institutions has also been the cause for the dissolution of the National Association of Traditional Healers.

The government has recently declared Food, Medicine and Health Care Administration and Control Proclamation in 2009. This proclamation recognizes medical pluralism adding non-indigenous alternative medicine and organic supplements unlike the previous one. But the tendency to evaluate traditional medicine by biomedical yardstick still resonates in the proclamation. The practice of medical pluralism in the study area has however, far more important policy implication in order to tape the benefits of pluralistic medical practices.

It is quite clear from this study that there exists non-compliance to biomedicine or physicians by patients due to socio-economic and cultural reasons. Given their active role in the health care, the government needs a policy which recognizes traditional and alternative medicine as partners for health care service delivery rather than judge them by biomedical standards. The reality on the ground calls for cooperation than integration.
because integration is likely to displace the socio-culturally meaningful practices of traditional medicine with which patients and healers identify themselves.

Traditional medicine is based on indigenous knowledge and skill that is meaningful to patients. Patients travel long distances from rural areas to consult traditional healers in Addis Ababa. Patients bypass many biomedical hospitals and clinics on their way because they believe they would not get appropriate treatment from biomedicine for their sickness. Biomedicine on its part does not consider local socio-cultural contexts. Therefore, the cooperation especially between traditional and biomedicine medicine is more viable than their integration. The cooperation could be technical support to traditional healers in order for them to better organize their services. Traditional healers could for instance hygienically mass produce their drugs with technical cooperation and support from biomedicine. Further, the cooperation could extend to education whereby healers establish colleges to train potential healers with traditional medicine. Students at medical schools would also get the opportunity to learn about indigenous ideas of health, illness and healing which has important impact on their future career.

The experience from other African countries also found integration less feasible than cooperation. Konadu (2007) shows cooperation is more feasible although both integration and cooperation are often a monologue guided by biomedicine. The initiatives have been criticized for marginalizing the traditional medicine in the process. Good (1987) cited several divisive features that could thwart the linkage between traditional and
biomedicine. Two of the major divisive features that endanger the linkage are the conflict of paradigm and the negative attitude often held by some biomedical practitioners. This study shares the obstacles identified by Goods (1987) and Kondadu (2007) in the process of creating the linkage between the two. But cooperation is the best policy option to tap the best outcome from medical pluralism in a society where there is high noncompliance to mainstream medicine on the one hand, and indigenous medical knowledge and skills is crying for strong policy back up in order to provide cost-effective and culturally relevant health care services.