CHAPTER SIX

6. SUMMARY AND CONCLUSION

In spite of tremendous changes in the understanding about health, illness and healing since antiquity, the quest for health, avert illness and heal the sick has yielded rather multiple approaches. Such coexistence of medical practices based usually on different conceptions of causal attributions, system of diagnosis and techniques of therapy has become common features mainly with the introduction of biomedicine to developing counties.

This research is the result of fieldwork conducted from July 2011 to August 2012 in Addis Ababa with the intentions to understand the changes and continuities in the practices of medical pluralism in Addis Ababa, the capital city of Ethiopia. Biomedicine was transplanted to the city a century ago without much consideration for indigenous conceptions of health, illness and healing. The preexisting conceptions about health, illness and healing do not fit perfectly into biomedical explanations. They are broader in their scope than biomedicine. The most common organized traditional medicine in the study area are traditional herbal medicine and faith healing. Acupuncture, chiropractic and organic supplements are non-indigenous alternative medicines that have joined the plural medical practice over the last twenty years.
Medical pluralism in Addis Ababa has witnessed new trends of diversity and modus operandi. Ever since the introduction of biomedicine the therapeutic space limited to indigenous traditional and biomedicine has been shared by non-indigenous alternative medicine such as acupuncture, chiropractic and organic supplements over the last twenty years. The role of private biomedical practice is dramatic as well. Further, traditional healers have transformed some aspects of their healing services. They began to mix biomedical nosologies in advertising their services. Traditional herbalists have also found to apply antibiotics and injections. Above all, some traditional healers appear to transform their healing through transnational experience sharing and the use imported medical equipment. But they are selective and use only medical equipment that does not require advanced biomedical knowledge and skill to operate.

Nonetheless, despite a century old interaction between traditional and biomedicine as well as the non-indigenous alternative medicine over the last twenty years, some aspects unique to specific medical practice still persist in Addis Ababa. The boundary among the plural medical practice is bold with biomedical hegemony. Little institutional links have been established among these medical traditions. Only traditional and alternative medicine appears to utilize limited biomedical technologies. Biomedicine does not accommodate the ideas of traditional and alternative medicine.

Moreover, each medical tradition maintains their causation explanations and the appropriate therapy which in some ways define their distinctive features. Biomedicine
relegates other practices starting from its curriculum at medical schools to the medical practices in biomedical hospitals. It is hardly possible to trace a medical school that incorporates a course about traditional indigenous and non-indigenous alternative medicine in its curriculum. The attitude towards traditional medicine is partly a legacy 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 engagement. Hence, this legacy is institutionalized that biomedicine guards it practice against the ideas and practices from traditional and alternative medicine.

Closely linked with the practice of medical pluralism in Addis Ababa is the pattern of resort by patients. The illness behavior at the study area is embedded in the socio-economic and cultural milieus that involve complex decision making processes. The role of family members and close kin is crucial in the assessment of a sick person’s status. The power of this group of people extends far beyond the assessment of symptoms and influences the decision as to where the sick person should seek treatment. Unfortunately, this is often misunderstood mainly by physicians as non-compliance by patients. Neither accessibility nor its affordability alone limits patients from treatment seeking at medical practice centers other than biomedicine. The major factors that often push patients to look for plural medical consultation were the commonly held belief about the etiologies of the disease and its culturally appropriate therapy and the dissatisfaction with the treatment outcomes at biomedical clinic or hospital. Cost turn to become a limiting factor for
seeking treatment at private biomedical higher clinics or hospitals. Hence, a combination of socio-medical and cultural factors such as accessibility, cost, etiological concepts and worldviews sound desirable to understand the factors that determine patients pathways to treatment seeking in Addis Ababa.

The findings of this study support the idea that medical beliefs and practices persist because they have practical and social relevance to patients. The persistence of indigenous medical traditions without official support is a case in point. The persistence of traditional medicine owes much to these practical and social relevance that always keep the flow of patients to traditional healers in a city where the geographic accessibility of biomedicine is 100% and free medical services are available to the poorest of the poor at public hospitals.

One of the themes to understand the outcomes of the interaction between indigenous medical traditions and the expansion of biomedicine was the idea that indigenous medical traditions that externalize the causes of illness outside a patient’s body including, references to human social relations, spiritual and cosmic order, would gradually transform themselves to internalizing ones (Young, 1976; 1980). Nonetheless, such transformation has not been substantiated by this study. In fact, externalizing explanations and subsequent therapies are among the subspecialties for traditional herbalists and the primary focus for faith healing in Addis Ababa. It is also among the main factors for plural medical consultations by patients. The externalizing discourse of
indigenous medical traditions is deep-rooted in the socio-cultural system of the society. The beliefs in such causations external to a patient’s body are perpetuated through religious teachings and the enculturation of children in their families. Hence, the traditional healers render healing services to patients from this kind of socio-cultural background. But despite the persistence of the externalizing medical beliefs and practices among indigenous traditional healers, they are open to incorporate simple biomedical tools and antibiotics to deal with illnesses that they think do not have personalisitic causes. In this sense, biomedicine has proofed itself popular among traditional herbalists.

One could observe some degree of appeal from the finding of this study to the theme of indigenization (Geest, 1997; Geissler and Pool, 2005). Some aspects of indigenous medical traditions such as their religious and social dimensions have entered biomedical hospitals not officially but through the behavior of individuals. Despite the absence of clearly stated legal or policy framework to integrate indigenous medical traditions into biomedicine, one would identify easily identify aspects of indigenous medical traditions in biomedical hospitals. Some health professionals appear to blend indigenous ideas with biomedicine in their daily practice. These include for instance, prayer before surgery, necklace symbolizing their religion and affirmative responses to greetings reflecting the role of the supernatural in health. Moreover, the local cultural expectations from relatives and friends of a patient to provide psycho-social support are evident at biomedical hospitals. Relatives and close friends are responsible to console, feed and help a patient. Every hospital has patient visiting hours by relatives and close friends in order to control overcrowding in the hospital. The phrases used by these people to console a
patient reflect their faith in the supernatural while the patient is under biomedical treatment. One of these may worth mentioned here. A relative or close friend may express his/her wish to a patient saying “egiziabeher yimarih” literally means “May the Almighty God have mercy on you.” So, one senses a limited degree of an informally indigenized biomedicine in the absence of official endeavor to adapt biomedicine to local contexts. However, the domestication (Faldon, 2004) theme does not seem to help us understand the use of CAM in Addis Ababa. Among the contexts under which CAM operates at my study area is their sustainability owes much to the perseverance of individual practitioners and the prospect of government policy towards CAM. There is no CAM training school in Addis Ababa so far. Neither does the health policy hints their integration to biomedicine. Moreover, the role of therapy management group (Janzen, 1978) influences much of the illness behavior at the study area including whether to use CAM or not.

In general, much change has been evident in the practice of medical pluralism in Addis Ababa especially over the last two decades. Along with these changes, one would trace the persistence of the old indigenous strands of health, illness and healing. When put into theoretical framework, the changes in the practice of medical pluralism at my study area does not substantiate the externalizing-internalizing discourse in relation to the causal explanations of indigenous medical traditions. Indigenous medical traditions still externalizes the causations of some illnesses outside the human body. But they have incorporated limited biomedical equipment and antibiotics to deal with illness of naturalistic causes. On the other hand, the theme of indigenization appears to shade some
light on the nature of biomedicine in Addis Ababa. One could identify the religious and social dimensions of indigenous medical traditions brought informally to biomedical hospitals by the relatives of patients and some health professionals.

In general, what could be understood from this study is the expansion of biomedicine and urban life do not necessarily lead to the abandonment of indigenous ideas of health and healing such as the externalizing discourse that locate the origin of illness outside the human body. The influence works both ways where biomedicine supplements and complements the practices of indigenous traditional and non-indigenous alternative medicine on the one hand, and some aspects of indigenous medical traditional informally influence the practice of biomedicine at the hospitals in Addis Ababa. The local context of the changes and persistence of medical pluralism has been influenced by broader national socio-cultural and political experiences. The regime change in 1991 and subsequent policy amendments have a major stake in this.

Finally, the practice of medical pluralism in the study area would be a useful resource not an obstacle to better health care if supported by the cooperation among different pluralistic medical practices and a health policy which is not lopsided.