CHAPTER ONE

1. CONCEPTUAL FRAMEWORK AND RESEARCH DESIGN

1.1 Background
Illness and the need to treat the sick are common to human societies. However, many factors influence the experiences of health, illness and. The natural environment, genetic inheritance, and above all socio-cultural and economic circumstances interact with one another, in complex ways, to influence the health of any human population (Brown, 1998: 1). Therefore, how societies view health and the therapeutic techniques to deal with illness vary considerably from one society to another (Howard, 1986:388).

There are ranges of variations in medical systems of different societies. Yet, medical systems share essential features in that they have some sort of the theory of causation, a system of diagnosis, and techniques of appropriate therapy (Foster 1998:110). The causation theory includes the conceptions of health and the causes of disease and illness. Foster distinguished between the personalistic and naturalistic systems in this regard. The personalistic explanation of illness is a condition when illness is thought to purposely be caused by supernatural forces or by human beings through witchcraft and sorcery. In contrast, the naturalistic system explains disease causation in impersonal and more systematic terms. This casual explanation commonly posits illness results from failure to maintain equilibrium within the body. The main premises are when natural external
factors (heat, or cold) or internal forces (such as strong emotions) upset the body balance, illness results. “Natural explanations are scientific explanations in the sense that through experimentation or observational studies, one can demonstrate that these naturally occurring factors do cause illness” (Levinson, 1997:2007). Most of contemporary naturalistic explanations have been largely derived from the medical traditions of ancient civilizations particularly Greece, India and China (Howard, 1986:399).

The other common feature of medical systems in addition to the theory of causation is the existence of systems of diagnosis and techniques of appropriate therapy that bring together the healer and a patient. Diagnosis could be carried out through divination or observation with or without the aid of biomedical technologies. The healer may be assisted by aides and in the case of complex societies; he/she may work in an elaborate bureaucratic structure such as a clinic or hospital in the process of therapeutic service. The healing may also be performed by a single person with the assistance of his/her family members in the case of non-Western traditional medical practices (Anderson and Foster, 1978; Baer et al., 2003:9).

Studies have shown that medical systems are usually plural manifesting cooperative or competitive coexistence (Baer et al., 2003:9; Helman, 1992:54). Pluralistic medical systems have roots in increasing patterns of social stratification (Baer, 2004:109) although the concept became popular after 1970s (Bury et al., 2004:109). Less stratified societies such as foraging and village level societies are assumed to lack institutions or
systems of medicine as opposed to chiefdoms and early state societies. In most chiefdoms and early state societies, systems of medicine constitute an elaborate corpus of medical knowledge which continues to embrace aspects of cosmology, religion and morality. More importantly, chiefdoms and early state societies exhibit the beginning of medical pluralism manifested by the presence of a wide variety of healers including general practitioners, priests, diviners, herbalists, bonesetters and midwives who undergo systematic training or apprenticeships (Fabrega, 1997; in Baer, 2004:110).

Scholars argue less stratified preindustrial societies exhibit a more or less coherent medical system in contrast to state societies which manifest the coexistence of an array of medical system or medical pluralism (Baer etal, 2003:9). Along with this, some insist on a significant change from externalizing\(^1\) to internalizing medical systems (Young, 1976a; 1976b; 1980; 1983). The Internalizing systems give prime importance to biological or physical signs. Furthermore, illness is not conceptualized as a social problem unlike as in externalizing system. Illness in internalizing medical belief systems is an individual problem. Externalizing systems on the other hand approach illness as a social concern and ascribe importance to events outside the ill person’s body. Pathogens are viewed as purposive and often they could be humans or anthropomorphized. The diagnosis involves the discovery of the factors that brought the ill person (individual) to the pathogenic

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\(^1\)The externalizing medical belief system externalizes the origin of illness to outside the human body linking causation to the attack of spirits and the damaged social relations with members of a community. It is strongly related with morality and religion. The internalizing one on the other hand, puts much emphasis on the physiological signs of illness and the focus is on what is going on inside a patient (Young,1976;1980).
agent's attention which lead to their attack on the individual. Unlike internalizing systems, externalizing ones do not focus on the proximate causes of illness. They instead focus on the ultimate ones. The thesis of externalizing-internalizing systems then, views the change of medical systems from externalizing to internalizing ones. The change takes place as societies grow complex where division of labor becomes important. The expansion of biomedical knowledge and practice play important role in this regard (Ibid).

Others suggest the theme of domestication and indigenization to understand the changes that accompany the growing medical pluralism in a society (Fadlon, 2004:70; Geest, 1997:904; Geissler and Pool, 2005:41). This approach to the changes in medical pluralism does not hinge on a dichotomous shift from one to another. Rather, it approaches the changes as a process from which comes medical pluralism that appeals to local test as for instance when Alternative Medicine is introduced to the societies in industrialized countries or when biomedical knowledge and services are expanding to developing countries. **Hence,** the fieldwork data was analyzed for the theoretical implications in light of Young's (1976a; 1976b; 1980; 1983) model of the externalizing - internalizing model and the theme of indigenization (Geest, 1997:904; Geissler and Pool, 2005:41). Although criticized for oversimplification (Sobo, 2004:7; Faldon, 2004:70), the externalizing-internalizing model is used in this study because Young himself conducted a study in Ethiopia before three decades and speculated about the likelihood of changes in this direction. Much has been changed since then including regime and health policy. On the other hand, since domestication and particularly the indigenization theme provides
approaches alternative to the dichotomous analysis, they are used to make sense of the implications of empirical data from Addis Ababa.

In Ethiopia, traditional medicine was the exclusive source of health care for the majority of people until fairly recently. Traditional mechanisms of dealing with illness have emprico-rational and magico-religious elements and had been utilized for centuries. Some of the practices include the application of plant and animal products, inoculation, thermal water, cauterization, counter irritation and traditional surgery (Pankhurst, 1990; Zein, 1988 in Abraraw; 1998:33). Traditional medicine has still wider popularity and acceptance throughout the country (Slikkerneer, 1990; Nigusse, 1988; Abraraw, 1998) in spite of the expansion of biomedicine. Studies indicate that the practitioners provide diagnostic, preventive and curative services. The medicinal plants, the scripts from the Bible and Quran and the practitioners’ accumulated medical knowledge are widely utilized. It was estimated that there were about 25,000 indigenous healers in Ethiopia out of which about 10,000 were registered (Miryassa, 1993:46; Girmay et al., 2007). The latest figures of these healers were not available in concerned government offices during fieldwork for this research.

There has been increasing expansion of biomedicine in Ethiopia through public health care policies and programs although non-mainstream medical practices remain a side business in the absence of official support. Previous researchers in Ethiopia have clearly documented the practice of medical pluralism in the context of rural areas. But they neglected urban areas particularly Addis Ababa where the practice of medical pluralism
is conspicuous. Urban areas are the place where the mainstream biomedical health care services have concentrated over the past several years and probably drove traditional medicine underground. More importantly, there is a dearth of research on how and why medical pluralism persists in spite of non-conducive government policy towards traditional medicine and its practitioners. On top of this, how traditional healers deal with challenging health policy often formulated with the assistance of health professionals and the ever expanding biomedical services on the one hand, and the national health policy implications of the practice of medical pluralism in Addis Ababa on the other worth close scrutiny. Therefore, this study is an endeavor to understand the persistence and changes in the practice of medical pluralism in Addis Ababa where medical practices from different medical traditions are providing medical services.

The thesis is organized into six chapters. I discuss the conceptual framework, data sources and methods under the first chapter. The discussions in the first chapter dictate the structure of subsequent parts of the thesis. The second chapter provides the national contexts in which the research was carried out. So, the chapter discusses about the socio-economic, cultural and political context of the study area. Illness behavior and the pluralistic medical practices in Addis Ababa are presented under the third chapter. The fourth chapter deals with the persisting and changing features of the plural medical practices at the study area. The fifth chapter is the extension of the previous ones where I discuss the major findings of the research together with their theoretical and policy implications. Finally, I summarized the main points and put concluding remarks under the sixth chapter.
1.2. CONCEPTUAL FRAMEWORK

1.2.1 Plural Medical Systems

Every society has a shared belief and behavior about the prevention and treatment of illness. These shared beliefs and behavior about the prevention and treatment of illness constitute the medical systems of a society (Levinson, 1997:136; Sobo, 2004:6). Medical systems may simply be conceptualized as “community’s ideas and practices relating to illness and health” (Geisler and Pool, 2005:40). Young (1983:1206) defined medical systems as an “equivalent to the social and economic order in which one or more medical traditions are used to produce and distribute medical services and outcomes in a particular community or region.” Kleinman (1978:86) emphasizes that medical systems are cultural systems that include people’s beliefs and the patterns of behavior and it is cultural rules that govern these beliefs and behaviors.

Clearly, variations exist from culture to culture in terms of dealing with illness. However, every medical system has at least three basic components. These are theory of etiology, a system of diagnosis and techniques of appropriate therapy. Levinson (1997:137) elaborated the three components of medical systems common to every culture in such a way that every health care system is assumed to share common elements such as the definitions of health and illness, the beliefs (theories) about the causes of illness, treatment strategies, the healers, specific methods and techniques of treatment, and a decision-making process for using the health care system.
Medical systems usually manifest a cooperative or competitive coexistence of medical traditions. The cooperative or competitive coexistence of medical traditions is known as medical pluralism. Medical pluralism has roots in increasing patterns of social stratification although the concept became popular after 1970s (Baer, 2004:109; Janzen, 1978; Johannessen, 2006:2-3).

Medical systems and medical pluralism are concepts which entail points of departure for argument among medical anthropologists. The idea of medical system has, for example, faced many criticisms due to the underlying assumptions of how the system works especially in the early literatures of socio-cultural anthropology. The concept “system” for instance suggests the existence of unity and integration while in practice the ways in which people define and deal with their illness and health on the one hand and the way in which medical systems work to perform their functions are not integrated and coherent whole (Geest, 1997:904). In other words, the “system” views of society and of medicine face critique because of its overemphasis on idealized static models of a systematic society and culture. It fails to explain the exercise of power as well as the forces of historical change in the way that social institutions work (Janzen, 2002: 215).

In fact, Janzen further pointed out that there exist some gaps in the works of scholars such as Kleinman’s three sector perspective of health care. He argues that one encounters ambiguity when one tries to trace the status of a particular therapy or group diachronically and when one tries to compare them from one setting to another (Janzen,
2002: 217). We observe lots of mess, chaos, indeterminination in the process. It was also argued by some anthropologists that such “functionalist views” of medical systems was one of the reasons for theoretical impasse in the approaches to medical pluralism (Brodwin, 1996:15; Lock and Nichter, 2002:2). The concept is used in this research too with the understanding that medical systems are not static, close and integrated systems. They are open to changes resulting from different factors both internal and external. Yet, the interruption or changes in the medical systems may not necessarily be absolute for there could be some aspects that may remain persisting.

The concept “pluralism” has been used differently in early social theories especially in political phenomena. Its popularity became eminent in reaction to the monistic 19th century social theories. Pluralistic oriented social theories emphasize that there are ranges of social interests and interest groups. But it became a key concept across social sciences and among social scientists who wish to understand the existence of multiple identities, social relations, subs cultures (McLennan, 1995:6 in Bury, etal, 2004:183).

Medical pluralism in anthropology refers to the existence of more than one type of medical traditions in a society. A pluralistic medical system incorporates more than one medical tradition. The medical traditions are distinct combinations of ideas, practices, skills, apparatus and material medica (Young, 1983:1206). Therefore, it is these distinctive medical traditions grounded on different principles and worldviews with regard to health, illness and healing which together form a pluralistic medical system (Bury etal, 2004:183; Pramukh, 2008:8).
Medical pluralism has become among the major concepts in medical anthropology after anthropological fieldworks in Africa, Asia and Latin America. Leslie’s work on pluralism in Asian Medical systems is considered as a breakthrough in anthropological approaches to pluralistic medical systems. His work introduced anthropologists to the coexistence of biomedicine and other medical traditions in China and India to the extent that Chinese medicine system in China and Ayurveda and Unani in India are practiced by professionals graduating from educational institutions where the training is based on major medical texts of its kind. Leslies work alarmed anthropologists to reexamine the idea of biomedicine as the only kind of sophisticated and well developed medical system for treating the sick. The plural character of health care systems across cultures was recognized by anthropologists since then (Johannessen, 2006:2-3). The works of Janzen (1978) in Zaire and Ohnuki-Tierney Emiko (1984) in Japan added important dimensions to such awareness about pluralistic medical practices.

The interest in the concept was especially high in late 1970s and in the 1980s after anthropological research on the healing practices of the different cultures. Anthropologists gave specific attentions to these healing practices in their study areas. They also look into the possibility of collaboration between indigenous or traditional and biomedicine in Africa, Asia and Latin America (Bury et al 2004:184). Moreover, some health organizations’ interest in these anthropological researches further brought anthropologists much closer to health policy research as well.
Scholars created different typologies to reflect the phenomenon of medical pluralism. What emerges from these studies is the fact that medical pluralism could be classified and understood either from their ecological settings (Dunn, 1976:135), levels of incorporation (Cant and Sharma (2000:426) or from the therapeutic options available in a society to alleviate the physical discomfort or emotional distress (Brodwin, 1996:14; Helman, 1990:72; Kleinman, 1978:86).

From the cultural ecological settings, pluralistic medical systems may consist of local, regional and cosmopolitan medical systems (Dunn, 1976). The categories in this classification represent respectively, the folk (indigenous), those which cover larger regional ecological areas such as Ayurveda in South East Asia and biomedicine.

On the other hand, the classifications of pluralistic medical systems could also be made based on the differences on ideas of health, illness and healing as well as the level of incorporation of their adherents and practitioners into the mainstream medicine. Therefore, pluralistic medical systems may include in this regard, any of the three types. The first is the main stream medicine view. This view recognizes only one medicine as it is practiced in main stream hospitals and clinics while all else is Alternative. In this type of pluralism, main stream medicine is institutionalized, legal and professional where as Alternative medicine are marginalized, unofficial, at times illegal and rarely professionalized. Scholars refer this kind of medical culture as an exclusivist system. The mainstream or biomedicine became the most state favored and supported medical system.
mainly in Western countries from middle or late nineteenth century onwards. Cant and Sharma (2000:426) vividly summarized the forms of professional privileges enjoyed by biomedicine due to the recognition by the state as:

registration of the medical profession along with a high degree of professional autonomy; direct provision or funding of biomedical services for the populace (as in Britain and many other European countries); regulation or organization of insurance schemes covering biomedical but not (until recently) other forms of health care, heavy reliance on the biomedical professional’s advice on all public issues relating to health and the body.

Such privileges have further been taken stronger stances with the “medicalization” of the society—a situation where more conditions are increasingly defined in terms of medical models of disease as well as an increasing tendency for medical profession to achieve practical power over patients. Moreover, such practical power of the medical profession extends to control health care services other than biomedicine (Cant and Sharma, 2000).

The second category of pluralistic medical systems from the point of level of incorporation appears when state legislation makes “justice” to all medical practices in a society. Here, the state treats and ranks representatives of different medical traditions equally. Hence, they are either equally incorporated or equally unincorporated. This type of pluralism is termed by scholars as tolerant systems. The third type has little differential or parallel incorporation of the medical traditions. “Here we might speak of this as a kind
of thematic pluralism or as an integrated system” (Last, 1990:359-60; Janzen, 2002:235).

Yet, distinctive ideas and therapies are still recognized in integrated systems as deriving from distinctive traditions. For instance, with little differential incorporation, practitioners of historically recognized distinctive traditions may begin to borrow and adapt technology, ideas and practice (Janzen, 2002: 234-236; Leslie, 1992).

In any case however, medical pluralism as a reflection of the regulatory systems impacting on them could be exclusivist, tolerant or integrated systems (Baer, 2011). Therefore, the relationship between biomedicine and alternative medicine is very complex ranging from outright rejection of alternative medicines to their incorporations. The role played by patients perception about alternative medicines as well as the political will in any country are important in shaping the degree of legitimacy and security for alternative medicine (Sharma, 2000:427).

Finally, medical pluralism could be classified from the perspective of the therapeutic options available in a society to alleviate the physical discomfort or emotional distress. The therapeutic options may be available from the professional, folk and popular sectors of health care systems (Helman, 1990:72; Kleinman, 1978:86). The main reference in this typology is “who provides care and in what context.” (Sobo, 2004:8; Winkelman, 2009:164). So, pluralistic medical systems in light of this typology consist the professional, the folk and the popular sectors.
The Professional sector as the name indicates is the one where medical practice is undergoing in organized manner by trained professionals. This includes “the wide range of medical and paramedical professionals, each with their own perceptions of ill health, forms of treatment, defined area of competence, internal hierarchy, technical jargon and professional organization.” (Helman, 1990:79). The professional sector takes a modern biomedical approach in medical practices although indigenous professional medical traditions like Ayurveda and Unani in India and classical Chinese medicine are classified under this sector in some societies (Kleinman, 1978:8; Sobo, 2004:8).

In societies where the professional sector is less tolerant of other sectors, biomedicine is usually considered to be the only relevant aspect of medical system to the extent that public health problems and priority settings are largely under the influence of biomedicine. Moreover, the process of socializing professionals and subsequent internalization of the subculture of biomedicine make the professionals to take their views as objective. So, the professionals are seldom willing to accept the local and lay interpretations of sickness and health because they consider them unscientific. Biomedicine has also extended its sphere of influence to wider areas of life. What was considered to be outside the realm of professional sector now takes place in medical institutions under the supervision of medical experts (Geisler and Pool, 2005:40-41).

The Folk or traditional sector overlaps with the professional sector in one end and with the lay sector in the other. Kleinman (1978) regards the traditional sector as the non-professional, non-bureaucratic specialist sector of health care. The folk sector consists of
two aspects - the sacred and secular - healing. The sacred aspect involves the use of supernatural power in healing while the secular uses non-supernatural forces as in the case of herbal treatment and bone setting. Their practice is based on a cultural traditions and philosophies (Kleinman, 1979:86-87; Sobo, 2004:8). The folk sector mainly views a patient holistically from social, physical, moral and, psychological dimensions. This sector considers good health as “a dynamic relationship between the individual, friends, family and the environment within which we live and work.”(Heleman, 1990:75).

The other sector in the pluralistic therapeutic options available in a society is the popular sector. The idea about health and interpretations of symptoms acquired through enculturation that begins in a family plays important role in the popular sector. The sector includes those therapeutic options which people utilize without payment as well as without consultations of folk and biomedical professionals. Winkelman (2009:164) succinctly summarizes this sector as:

The cultural understandings derived from family socialization provide principal interpretations of health and generally preempt biomedical care, constituting a first line of resources. Family members and other interpersonal relations and social networks generally assist in assessing maladies and making decisions regarding treatment, including seeking biomedical care. The popular sector primarily involves what people, without recourse to specialists, believe and do about health care, including ignoring symptoms, and decides whether biomedical care is necessary or whether recourse may be made to the folk sector.
This sector is the least studied sector according to Kleinman (1978). It is the sector of health care system whereby non-specialists such as oneself, family members, friends and other kin provide treatment. The treatment here is based on shared cultural understanding and is generally occurs in a family or a household context (Sabo, 2004:8).

The popular sector influences people’s medical choices to a greater extent. Regarding the popular sector, Kleinman (1978:86) argues that it is not the professionals that organize health care for lay people. The lay people decide when and whom to consult, whether or not to adhere to treatment and when to switch to another treatment. On top of this, people resort to self-management at times which professionals label as non-adherence. Some scholars however, pointed out that the label may give more sense when we look at it from the power constellation between doctors and patients where the patients’ actions are reinterpreted in the context of the professional sector (Trostle, 1988; in Geisler and Pool, 2005:41-42; Winkelman 2009:164).

Studies have noted that patients get access to different strands of medical knowledge, explanatory systems and healing traditions. (Brodwin, 1996; Good etal, 1993; Nitcher, 1989; Good and Good, 2000).The access to plural medical practices by patients involves complex transactions among diverse systems of technologies, meaning and power. Hausmann-Muela & Muela Ribera (2003:97) indicated there is a sequential and integrative form of treatment for malaria in Tanzania. The studies reveal the fact that mothers first apply traditional medicine for their sick children from malaria as a kind of
first aid and then seek biomedical treatment not as separate courses of therapeutic alternatives but as complementary hierarchies of treatment. The study further suggests the hierarchy is not rigid and it can be adapted to concrete situations. When the hospital treatment is proved unsuccessful after two or three attempts, parents in Tanzania would opt for traditional health services of different kinds.

In general, pluralism in medicine revolves around the multiplicities of health care systems. The classification could be made from different angles. And yet, the main reference points is either their conceptions about the body, health, disease and illness while the other could be the extent to which state legislation recognizes their activities as to the standard and beneficial to the maintenance of wellbeing. However, the dominance of biomedicine led to the categorization of all other systems under the rubric Alternative medicine.

Medical pluralism exists under different contexts for various reasons. In industrialized countries, the use of complementary and alternative therapies became popular since 1970s due to the limitations of biomedicine on the one hand and the qualities of complementary and alternative therapies which tend to overcome the limitations identified with biomedicine. In this case, alternative therapies are popular among people with higher annual income. On the other hand, the use of alternative therapies in economically poor societies is related to poverty or lack of access to conventional medicine (see Goods, 1987; Leonard 2002; Press, 1978; & Sekelnbarg et al 2004). In
addition, diverse views about the human body, health and illness are important variables for the existence of medical pluralism (Agdal, 2005:S67-S68). Chung-tung (1998) has a notable point from Taiwan in this regard. The common understanding about the illness by a doctor and a patient as well as social class tend to influences patients to consult either traditional healers or biomedical doctors. Patients tend to use mainly biomedicine in emergency, acute diseases and surgical conditions, whereas traditional medicine is mainly for long-term chronic problems. But some specific incurable diseases such as cancer force patients of whatever class to traditional medicine (Chung-tung, 1998:6-7).

The lay public uses an eclectic approach in accepting health concepts and services based on their cultural interpretation of reality and perceived effectiveness of treatment. For instance, ethnographic studies have shown that some local illness categories are identified by the people in North East Thailand as untreatable by biomedical health providers. Pylypa Jen (2007:349) noted that khai mak mai (fruit fever), is an illness which is believed to be incompatible with several substances including some fruits, biomedical injections and intravenous solution. Patients fear these treatments may induce death. Consequently, fevers suspected of being khai mak mai are treated by herbalists while biomedical health services are avoided and feared. The same study reveals that it not only the local conceptualizations of illness that impede patients from biomedical health service but also the failure of biomedical practitioners to understand patient concerns about khai

\(^2\) S refers to supplement
mak mai by discrediting them. Pylypa (2007:363) described the tension between the patients and professionals as follows:

What is clear, however, is that informant narratives are replete with references to conflict with, and distrust of, the health care system. Not only do biomedical practitioners fail to understand patient concerns about khai mak mai; they are also accused of being dismissive of them. In other contexts, informants complained of the condescending attitude of health care staff, their failure to properly explain diagnoses and treatments to patients, and, occasionally, outright dishonesty or maliciousness on the part of health providers. These emotionally charged accusations might lead one to suspect that a conflict between local, explanatory models of illness and biomedical models is not the sole, or even the primary, impediment to successfully negotiating the biomedical treatment of patients who fear they have khai mak mai.

Nonetheless, this does not mean that patients shun and reject biomedical health care services. People assess the course of the treatment with traditional herbal medicine and if there is no progress in the health of a patient, they may resort to biomedicine. In this connection, Pylypa (2007:365) also argues that culture does matter in health behavior, but how it matters is influenced by the intersections of political-economic contexts, and cultural meanings as a function of broader contexts in which they are enacted. Hence, the conflict or incompatibility between biomedicine and other medical practices could be negotiated.
1.2.1.1 Medical Pluralism versus Medical Syncretism

The other area of interesting debate among scholars is whether pluralistic medical systems imply medical syncretism. While medical pluralism refers to the “coexistence of ideas and practitioners from several traditions occupying the same therapeutic space in a society” (Janzen, 2002:234), syncretism is a term that made its way to medical anthropology from religious studies which means “unifying or reconciling different or opposing schools of thought” (Geissler and Pool, 2005:41).

The unification or reconciliation of the beliefs and practices of different medical traditions could be analyzed at two levels. One is by looking at the health seeking behavior of individuals. The other is by analyzing the relationship between the different health care systems.

Patients may follow a pattern of resort in the use of different sectors or medical traditions available to them. The pattern of resort may take three forms as, people may use one sector separately like when East African villagers go to health center for the treatment of infection and to a diviner for the treatment of mental illness. The second form is a hierarchy of resort in which people switch between different sectors step by step such as first self medication, then biomedicine then alternative forms of treatment etc. The third form is simultaneous use where by people use different kinds of treatment at once. So, the core of argument for scholars such as Geisler and Pool (2005:45) is that the coexistence and the use of these medical traditions reflect a shift from pluralism to
syncretism. Health seeking behavior from this perspective involves a creative process where one would recognize the role of health seeking people who refute to being passive recipients of what is available within the confines of specific medical tradition.

The relationship between medical traditions is another angle from which one may approach medical syncretism. We expect the tolerance and complementarities among different medical traditions if we are subscribing to the idea of medical syncretism. In medical syncretism, health care providers incorporate elements of medical practices from different traditions into their healing methods to the extent that the borrowings of the medical practices blur the distinction between these practices such as between traditional and modern health care (Stoner, 1986:45).

Such phenomena could be observed to some extent in China, India and many other Asian countries (Leslie, 1992:205). Medical syncretism is explained better perhaps, by examining the practices in Asia such as the case of a Kanpo clinic in urban Japan. The medical practices in urban Japan are characterized by the integration of East Asian medical traditions and biomedical approaches to the diagnosis and treatment of health problems. The nature of syncretism in urban Japan is manifested in such a way that Kanpo doctors are licensed Medical Doctors who utilize mainly cosmopolitan notions of specific, cellular level disease causation, cosmopolitan and East Asian diagnostic techniques, and a totally East Asian system of therapy. And such mix of biomedical and
traditional medical knowledge and practice makes it difficult to delineate the boundary between the two (Lock 1980:142; Stoner, 1986:45).

However, some anthropologists argue against the concept of syncretism even in Asia on the ground that it is too narrow to reflect the medical realities of contemporary societies. Nisula (2006:209) for instance argues “integration” is more appropriate than “syncretism” in the current situation of India because syncretism is both narrow and problematic to elucidate a state of affairs. The integration could take place in various contexts in the field of health and healing such as in public health care, in medical education and training, in the drug industry and in therapeutic practices (ibid).

Other studies reveal the emergence of integrative health care than medical syncretism which results from the interactions of pluralistic health care systems in Australia (Baer 2008). The Baer shows that some biomedical physicians and nurses in Australia have gradually come to adopt various alternative therapies in their regimes of practices. The main reason behind this integrative approach are the growing interest on the part of many Australians in complementary medicine, and a recognition that biomedicine is not effective in treating a number of chronic ailments. So, some physicians and nurses have come to embrace integrative medicine that blends best practices from complementary and biomedicine. The integration and development of integrative medicine on the part of the physicians and nurses according to Baer (2008) is the national manifestation of the co-option of complementary and alternative medicine. So, it is a strategic move made by
physicians and nurse to incorporate alternative therapies in order to protect them from losing patients to holistic healers. Baer (2008) in this regard argues:

> despite efforts on the part of proponents of holistic health to develop an alternative to biomedicine, what in reality has been developing in Australia is the beginnings of the co-option of complementary medicine under the rubric of integrative medicine or integrative health care.....Cross-cultural research has repeatedly indicated that the integration of biomedicine and Complementary and Alternative Medicine tends to preserve rather than eradicate biomedical dominance (Baer, 2008: 62-63).

Ethnographic accounts from other societies such as Uganda in East Africa however, appears to refute the existence of tolerance and complementarities between health care systems. Teuton et al, (2007) examined the relationships between service providers involved in caring for people with psychosis in Uganda and came up with a finding that does not support the idea of medical syncretism and even integration. Instead, the relationship between these service providers is characterized by complex conceptualizations of each other’s competences in treating people with psychosis. The relation among the service providers in Uganda is such that:

> Healers vary in their attitudes towards other parts of the healing context. The indigenous and religious healers were tolerant of allopathic medicine, although the religious healers were inclined to explain success in terms of a Christian or Islamic framework. In contrast, the allopathic healers made little reference to religious healers and were ambivalent towards the
indigenous healers. The relationship between the religious and indigenous healers was one of conflict. The religious healers consistently negated the beliefs and methods of the indigenous healers, whilst the indigenous healers regarded indigenous spirituality and evangelical Christianity as incompatible. The question arises: why do the indigenous, religious and allopathic healers develop different strategies in relation to the pluralistic healing context? (Teuton, et al., 2007:1270).

Furthermore, similar even more tense relations exist between health care systems in Nigeria. Offiong (1999:126-127) reports the existence of strong antagonism between biomedical and traditional medical practitioners. So did exist strong objections to the idea of integration. The antagonistic relationship should not however, blur the existence of plural medical practices in Nigeria. Patients consult both traditional and biomedicine in times of need. The main problem that impeded the integration of health care systems in Nigeria was primarily the hostility by the practitioners of biomedicine against those of traditional healers. It is important to note that the major source of their antagonism lies in the conceptualization of health, illness and the appropriate therapeutic procedures. The conceptualization of health, illness and the therapeutic procedures in traditional medicine is by far broader and holistic than biomedicine. Hence, the cases from Nigeria, Uganda (Teuton, et al., 2007) and other African countries (Barbee, 1986) tell us medical pluralism did not lead to either medical syncretism or the integration of the pluralistic medical practices.
Therefore, the idea of medical syncretism needs further anthropological data from different societies. The context and the historical experiences of the societies which the proponents of syncretism used for their arguments are not similar to for example the context and historical experience of the one in Ethiopia. In other words, we understand from Leslie’s study (1992:179) that medical syncretism in Asian context underwent different historical circumstances. From his first survey of the indigenous medical schools in Asia he noted:

…the 1960s appear to be the closing decade of more than a century of medical revivalism inspired by the Orientalist rhetoric. By the end of the nineteenth century its advocates held common cause with the independence movement, and during the 1920s and 1930s they trained a generation of practitioners who imagined a comprehensive national medical system that would be inspired by Ayurveda and that would assimilate cosmopolitan medicine to indigenous culture. (Leslie, 1992:179).

Another case from Botswana by Barbee L. (1986:75-80) shows the concept of pluralism gives more sense in Botswana than syncretism. The largest biomedical personnel in Botswana are nurses. These nurses are often caught in dialectical tension between their acquired knowledge of biomedicine and their traditional health beliefs regarding the integration of traditional medicine into biomedicine. They oppose the cooperation between biomedicine on the one hand and spiritual and traditional healers on the other. Barbee found that the nurses mediate the main contradiction created by the dialectical tension between their traditional and biomedical health beliefs in two ways. While a
small group of nurses have chosen to reject their culture in favor of the biomedical concept of health and illness and hence tend to denounce the cooperation with traditional specialists, the majority of the nurses have adopted a position of peaceful coexistences with traditional medicine because there is some value in traditional medicine. The nurses in the second category base their position on empirical grounds that they know people who have been cured by traditional specialists. Nonetheless, all nurses in the study area believed the connection between traditional specialists and sorcery. Hence, all nurses were either against the cooperation with traditional medicine or view the use of traditional medicine is a patient’s private affair. In connection with this, the nurses believe that traditional specialists should refer patients to biomedicine but biomedicine should not refer them to traditional medicine. In general, ethnographic accounts from African societies and the context of my study area makes medical pluralism more relevant than syncretism in this study.

1.2.2 Approaches to Changes and Persistence in Medical Systems

Approaches to the study of changes in plural medical systems have been fraught with controversy in anthropology. The debate begins with the definition of the concepts such as medical systems due to its functionalist connotations. Such controversies motivated some anthropologists even to shift their focus to the “body as a site of coercion, and resistance, the political economy of health and health services, the hegemonic power of biomedicine and the hermeneutic construction of clinical realities.” (Brodwin, 1996:15). Pluralistic medical systems are approached in this study not as stable and integrated but a
phenomenon open to change due to internal and external dynamics. These changes however, do not necessarily displace or replace preexisting practices all in all. Some aspects of the medical pluralism are likely to be maintained or persist alongside the changes that did take place. I will present the approaches to change and persistence of medical systems in subsequent pages using the externalizing-internalizing discourse (Young 1976; 1980; 83) and domestication Faldon (2004) and indigenization (Geest,1997; Geissler and Pool 2005) themes.

1.2.2.1 The Changes from Externalizing to Internalizing Systems

Studies suggest that the practice of medical pluralism could undergo changes due to different factors. Capps (1994:161) demonstrates the Hmong refugees of Kansas City have an eclectic health beliefs and practices which have been influenced by “their long history of migration and contact with other ethnic groups, their relatively recent adoption of Protestant Christianity, and their interaction with Western biomedicine.” These experiences of the refugees have led to some major changes in their conception of health and illness some of which include the abandonment of shamanism and ancestral worship. Further, a prayer in Christian tradition becomes one of the major responses of the refugees to illness while Hmong herbalists and Western biomedicine remain vital to the wellbeing of the community. Yet, Capps (1994) noted certain elements of continuities remain along the changes regarding illness causation, patterns of response and treatment among these refugees. The Hmong of Kansas City draw ideas and practices from
biomedicine, Chinese traditions, and Christianity selectively, depending on circumstances.

Further, some scholars tend to analyze the changes from folk to professional medicine in light of cultural evolution which often views the change in unidirection from folk to biomedicine. However, such approach to the changes in medicine is too crude to reflect the diversity of the results of changes in folk medicine due to the influence of biomedicine. Hufford and O’Connor (2001:13-14) for instance, argues in this regard that it is an erroneous presumption to expect that improved access to biomedicine accompanied by education and acculturation will lead to the replacement of folk medicine by biomedicine. In other words, the changes may not be uniform as portrayed by the evolutionary views of culture.

Young (1976) on the other hand suggests the basic reason for the persistence of medical beliefs and practices lies in their practical and social meanings (Young 1976:19-20). These meanings will be accessible if we understand the sickness episode in light of what those involved in healing expect from the episode, how disease etiologies are narrated and the process through which cures are enacted. Young (1980) maintains similar take when he suggests that medicine in traditional societies largely lack empirical efficacy. He contends what keeps these practices persistent is the nature of sickness in these societies. The fact that a major portion of sickness episode are self limiting dominated by infectious and parasitic diseases, malnutrition, and traumatic injuries contributed to the
persistence of traditional medicine not based on medical rationality determined by scientific proof (Young, 1980:105).

The practical and social meanings of medical beliefs and practices are therefore, the major factors that enforce their persistence but not their empirical efficacy based on stringent scientific standards. In other words, people’s medical beliefs and practices are persistent in traditional societies because they answer people’s instrumental and moral imperatives, and they are symbolically effective. This does not mean however, that they are effective by the standards of biomedical notions. It does not also mean these medical beliefs and practices always yield the results which the people hope for. For instance, Young (1980:103) notes locally meaningful justifications are commonly given for failure of an amulet to protect its wearer in Ethiopia. The failure of the amulet may be justified that it has effaced through exposure to rain or perspiration where in the eyes of scientific proof does not lead to a sound conclusion. So, the persistence of such beliefs and practices depends on the extent to which they affect the people who participate in the sickness episodes such as the sick person’s relatives, healers and their assistants in addition to the sick person. The introduction of biomedicine into such societies is expected to affect people’s exclusive dependence on traditional medicine and hence affect these kinds of medical beliefs and practices associated with traditional medicine. On the contrary, the persistence of scientifically and empirically efficacious practice depends ultimately on how they are believed to affect the sick person or those threatened by the sickness (Young, 1975:5; 1980:104).
The externalizing-internalizing approach recognizes the dichotomy between traditional and conventional medical practices. It is used in this research with the intention to understand the changes and persistence of pluralistic medical practices in a cosmopolitan city where the Federal Government finances only biomedicine and where the residents are assumed to be better aware of biomedical disease causation theory than their rural counterparts. Furthermore, the model explains why changes have occurred if there are any, and which aspect of the practices are still persisting and why? In this case, the model would be important to make sense of the implications of the fieldwork data collected from Addis Ababa. What makes this model important in this study is the fact that Young (1976) himself conducted a study in northern Ethiopia and suggests that there is a tendency for externalizing medical belief systems to change into internalizing medical belief systems with growing social complexity (Young, 1976; 1977; 1983; Baer and Singer, 2007:106). Young (1983:1205) refers here by medical belief systems to “sets of premises and ideas which enable people to organize their perceptions and experiences of medical events and to organize their interventions for affecting and controlling these events….they are ways of defining problems and generating solutions to these problems.”

The process of the change from externalizing to internalizing systems was explained by Young (1976:147) as:

Internalizing systems develop when these circumstances change, that is as the division of labor grows increasingly complex and leads to the transformation of the homogeneous and self-sufficient community and
the appearance of specialized politico-jural institutions and broadly competent professional healers. The assumptions here are that: (1) systematic explanations of sickness are necessary for organizing medical action and defining and legitimizing the extraordinary behavior and events connected with sickness. (2) the main kinds of medical explanation are etiological and physiological, and etiological explanations (and externalizing systems) tend to dominate in simple societies, (3) as the conditions which foster this dominance disappear, it becomes both possible and necessary for alternative explanations (i.e. physiological ones) to develop.

Biomedical theories and practices were introduced to African patients during colonial era. Different healers from various cultural backgrounds deliver services to patients who travelled long distances to consult them before the introduction of biomedicine. Nowadays, these healers from different cultural background still provide health service in Africa. Healing based on religious thought patterns (Christianity as well as Islam) and a biomedical practice which is practiced in hospitals, clinics and dispensaries are available (Jacobson-Widding and Westerlund, 1989: 11). The interaction between and/or among these traditions is a great anthropological significance. Both externalizing and internalizing systems are characterized by distinct features. Therefore, I shall discuss these features in light of the thesis suggested by Young (1976; 1977; 1983) in subsequent paragraphs.

**The Externalizing Medical Systems:** - The externalizing medical systems are one in which health practices are having interlinked strongly with cultural domain such as
religion. The practices have little conceptual autonomy in that there is little phenomenological domain which people can distinguish from coordinate jural and cosmological systems. Externalizing health practices according to Young (1976) focus on social and cosmological relations. They externalize the sources of illness outside the sick person's body.

Externalizing medical system is assumed to characterize the medical practices of non-western, small-scale societies where illness etiology is often related to beliefs about misfortunes in all its kinds. The diffusing nature of medical knowledge is another feature of this system. The medical practitioners seldom communicate with one another and they usually hold their knowledge secretly. There is no opportunity for medical knowledge to be shared through conferences or training institutions. Therefore, medical knowledge in externalizing system is diffusing in contrast to internalizing systems where medical knowledge is assumed to be accumulating. (Young, 1980:114; Baer, 2007:107).

On the externalizing explanation of causes, Arhem (1989:79) has interesting fieldwork results on the Maasai cosmology. The Maasai conceptualize disease from two angles. One is that God may directly and unmediated bring disease on human. They refer here to the extreme or serious form of disease in which the patient may die. This class of diseases is intimately associated with nature and is treated by crude plant medicine. Secondly, the disease may ultimately be caused by God but mediated by powerful diviners. i.e. due to sorcery. This category of disease is treated by ritual medicine which is in the hands of powerful specialist. In the same vein, Paarup-Laursen (1989:60) indicated that the Komas
in Nigeria attribute illness to the actions or problems in the past. But unlike biomedical systems, where treatment is based on symptoms, the Koma are interested in these as long as they indicate the cause. i.e. social causes and afflicting agents have more causal explanations. They also distinguish between illness caused by sprits and those caused by humans.

The Meru people also explain misfortunes and almost any illness by curse. If someone cuts his finger accidentally while using local jungle—knives or if there is a road accident, stomach troubles, headache, bareness, impotence etc, and curse is the most popular explanation. i.e. some one must have cursed the victim. In fact, Harjula (1989:129) observed the use of curse as possible causal explanation has far more implications. Harjula explained:

A curse is not only a popular explanation is the collective Meru tradition in general but it also appears in the same function in the specific ethno medical tradition and practice. Secondly, at the same time as the healer takes the curse seriously, he tries to penetrate “behind” the curse and find the broken human relationships in the patient’s life(ibid).

Studies suggest that an enquiry into the causality of ill-health is the single unifying theme in African traditional medical practice. Scott (2008) for instance illuminates this point by indicating the patient consulting a traditional practitioner in Africa will ask ‘Why am I ill?’ in contrast to his or her counterpart in the western allopathic system whose question
is ‘What is the nature of my illness?’ However, the causal explanations in African traditional medical practice are not limited to externalizing factors. Several possible agencies constitute the causal explanations in African traditional medicine, such as a) natural causes, e.g. normal developmental processes, life stages and seasonal changes b) behavior offensive to the patient’s ancestral spirits, e.g. an immoral act or the transgression of a social code and; c) supernatural forces, e.g. witchcraft or intervention by evil spirits (Scott 2010:86).

Moreover, indigenous medical systems are not closed systems. Ingstad's (1989:254) fieldwork results in Botswana shows that the chief of one of the tribe in Botswana kept a Zulu healer as his main advisor in 1920s. Healers used to travel widely including outside the country in order to acquire new knowledge. The reason behind this is perhaps the belief that by obtaining new "medicine" not known to local competitors, one becomes a stronger healer which means more patients, better chance of success in healing and better protection of oneself from witches. Moreover, Leslie challenged the assumption that traditional medicine is less dynamic arguing no medical traditions are inherently conservative. He insists "all bodies of medical knowledge are dynamic and change as the result of political and social factors as well as the diffusion of knowledge and technological innovations."(Lock and Nichter, 2002:2)

**The Internalizing Medical System:** - The internalizing medical belief system has the opposite features of the externalizing one. Contrary to the previous system, the focus here
is on proximate physiological mechanisms and the concern is with what is going on inside a patient. So, this type of medical practices subscribe to the naturalistic disease causation than personalistic ones. It is more organized than externalizing system. Knowledge accumulations and knowledge sharing through training and conferences are its basic features.

Young (1976; 1980; 1983) also noted the trend that medical systems usually changes from externalizing to internalizing ones. By implication, we should expect the dwindling importance of indigenous medical practices based on the externalizing system as biomedicine takes deeper roots in Addis Ababa over the last one hundred years. This is among the core areas of the research which would be clarified after fieldwork. Yet, some scholars argue that the externalizing and internalizing dichotomy are rarely exclusive. They pointed out that there are always areas of overlap between them although one of them seems to predominate in most societies. In addition, closer historical analyses of the externalizing systems reveal that there had been diversity and change within this system. A case in point is pre-modern African medicine (see Sobo, 2004:7; Freierman and Janzen, 1979; Westerlude, 1989:177).

The internalizing approach to medical practices assumed to result from a gradual transformation of the externalizing one. Many factors could be the driving force for this change. One of these factors in the African context was the role of colonialism in promoting the internalizing approach to medical practices. Scott (2010:82) states:
With two exceptions (Liberia and Ethiopia), all African states have at some period of their history been governed by European powers. One of the products of colonial occupation was the introduction to Africa of the western allopathic system of medicine. The traditional medical practices of the continent, despite their ancient origins, were largely ignored by colonial authorities. Traditional practitioners (TPs), although highly respected members of their communities, played almost no role in the establishment of formal healthcare systems in Africa.

Many factors are accounted for the changes which affected the role of traditional healer since their contact with Europeans in Africa. Ingstad (1989:255) indicated that the chief in Botswana used to consult the traditional healer for different purposes before their contact with the Europeans. The introduction of modern administration altered such practice. Moreover, the “Witch Act” was introduced in 1927 though it is largely dormant. The Witch Act criminalizes the activities related to witchcraft that were in place. It prohibits the use of magic to harm another person and accusing of someone of witchcraft. Moreover, the Act criminalized the use of divinations to decide on matters of guilt and causality. Consequently, the possibility of using divination to trace the causes for misfortune according to traditional beliefs became unofficial. Similar study from Kenya reveals that colonial rule and the spread of Christian mission posed unprecedented challenge to the integrity and character of indigenous religions as well as their system of traditional healing in Kenya (Good, 1987: xii). Therefore, as these and many other studies indicate changes in local administration and power relations, socio-economic
transformations, the expansion of Christianity and the gradual introduction and expansion of modern health care services are credited for the changes in the practices of traditional medicine based on externalizing system.

In general, the thesis of changes from externalizing to internalizing systems is used in this study to make sense of the fieldwork data of its theoretical implications. Young’s thesis is especially important because Young himself conducted a study in Northern Ethiopia and suggests the tendency for changes in medical systems from externalizing to internalizing ones. Yet, it should be noted that his thesis has been criticized for oversimplification (Sobo, 2004:7; Faldon, 2004:70).

1.2.2.2 Domestication and Indigenization

Domestication (Faldon, 2004:70) and indigenization (Geest, 1997:904; Gessiler and Pool, 2005:41) are the other models to understand the result of interaction between different medical traditions in pluralistic medical systems. Fadlon (2004) approached the analysis of medical pluralism using the domestication discourse. She argues domestication transcends the limitations of its predecessors in the study of medical pluralism in that it does not hinge on dichotomous interpretations of traditional or modernity and dominance or resistance. It is rather an important theme in the socio-anthropological study of the flow of culture. She argues the domestication discourse has good implications for the theoretical and analytical approaches to Complementary and Alternative Medicine (CAM) in Western societies. The dissemination about CAM by the popular press and the
professionalization of CAM through clinics and colleges are the two major processes through which domestication becomes evident. Domestication in turn becomes a force behind integration that abolishes many of the original difference between CAM and biomedicine and which makes the foreign, in this case, CAM, familiar and palatable to local tastes.

In retrospect, the first studies of CAM approach their inquiries from dichotomist perspective like traditionalism and modernity. In this dichotomy, the assumption was that the process of modernization would gradually bring about the abandonment of traditional, non-scientific medical practices (Haram, 1991 in Fadlon, 2004:71). Fadlon further clarified the positions of prior approaches by referring to the theoretical analysis of Farge (1977) where Farge described the recourse to traditional health systems by Mexicans living in the United States as an indicator of low acculturation into the mainstream of modern American society. Another study by Miller (1990) argues the weakening of traditional health beliefs among immigrants is a function of successful acculturation to the host society. Further, Press (1978) suggests the practice of folk medicine under pressure from effective modern medical and welfare systems in urban milieu “appears to serve functions of acculturation, guilt displacement resulting from failure to achieve, and subgroup identity maintenance, among others.” He seems mainly to associate the use of folk medicine in urban setting with low income groups who face socio-cultural and economic marginality (Press1978:1).
However, subsequent research on heterogeneous urban population in Western countries revealed that users of Complementary and Alternative Medicine are not only migrants but users came from all sectors of the society. Two theoretical themes then developed to explain the growing popularity of CAM among these heterogeneous urban population in Western societies (Astin 1998; Ronen, 1988; Fadlon 2004: 70). The first theme posits the growing use of CAM serves as an indicator of the rejections to biomedicine due to its deleterious side effects and growing alienation because of its highly technological procedures and specialization. The main point is then the idea that the limitations of the biomedicine and the patients’ awareness about these limitations have led to the growing popularity of CAM. The second theme took the dissatisfaction with biomedicine to higher level and considers the growing medical pluralism through the popularity of CAM as “counter culture and equated with ideological concern for the ecology; preoccupation with the body and fascination with the super natural; a cultural alternative to the materialist Western philosophical traditions. (Bakx, 1991; Glassner, 1989; Lupton 1994; Fadlon 2004:70). So, it is about the level of dissatisfaction with biomedicine where the limited dissatisfaction views CAM as a second resort where as the general dissatisfaction with biomedicine views CAM as counter culture.

Nonetheless, the empirical studies conducted in heterogeneous population groups have not been able to illustrate the existence of a comprehensive and consistent cultural profile of CAM users (Astin, 1998; Fadlon, 1999; Furnham et al, 1994; in Faldon 2004:71). Patients resort to CAM reflects more of the practical choices made from the available options in the postmodern environment than the rejection of biomedicine or an esoteric
choice by patients. Therefore, domestication (Faldon 2004) is posited to better explain the cultural translations and modifications of CAM into palatable local tastes in Western societies. The domestication process combines elements of imported entity like food, clothing, philosophy and medicine with local culture. The core idea of domestication is not the legitimation of medical pluralism which recognizes the differences between the major modalities but the abolition of the original major differences between CAM and biomedicine.

Conversely, indigenization is the theme suggested to explain the changes in the medical systems that accompany the introduction of biomedicine to developing countries (Geest, 1997:904) since nowhere is biomedicine received into a society devoid of some ideas of health, illness and healing (Lock et al, 2010:62). The imported biomedical systems in Africa for instance have many contrasting features with the indigenous medical traditions (Geest, 1997). Indigenous medical traditions are broadly characterized by having religious dimensions and the social character of medical reasoning which often externalizes disease causations. Therefore, biomedicine has to undergo some adaptive adjustment to fit local socio-cultural environment of non-Western societies when it becomes part of these contrasting medical traditions. The indigenization in this context implies the inclusion of non-Western society’s medical traditions into biomedicine (Geissler and Pool, 2005:41). Indigenization may ultimately lead to medical syncretism depending on the degree to which biomedicine allows the inclusion of indigenousness traditions.
To sum up, I would primarily use the externalizing–internalizing discourse (Young, 1976; 1980) and the indigenization theme (Geest, 1997; Geissler and Pool, 2005) to understand the theoretical implications of the empirical data from Addis Ababa. Although the externalizing-internalizing model is criticized for being oversimplification (Sobo, 2004:7) and dichotomous approach (Faldon, 2004:70), it would be relevant to this study because Young conducted a study before three decades in Northern Ethiopian and suggested the likelihood of gradual change of practices based on externalizing discourse to the internalizing ones. Much has been changed since then in Ethiopia including regime changes and the expansion of biomedicine. Hence the model is relevant to sense if these changes have brought about the transformations of the externalizing discourse.

On the other hand, I used the indigenization theme to understand the nature of medical pluralism that results from the introduction and expansion of biomedicine to other societies with its indigenous medical traditions like Ethiopia. On the other hand, although the domestication theme was primarily meant to analyze the popularity of CAM in the post modern societies of Western countries, Faldon (2004) proposes is applicability to understand similar trends in other societies of developing countries. Therefore, I supplement my quest to understand the implications of empirical data from Addis Ababa with domestication.
1.3 Statement of the Problem

Studies have documented the ideas of health, illness and healing underwent several changes since antiquity. However, the changes in the understandings of the etiologies of disease, and subsequent preventive measures and/or treatment have not led to the emergence of a single medical tradition. It is common to come across pluralistic medical practices in societies across the world (Pramukh, 2008:40-58). Research shows that medical pluralism including traditional medicine is persistent and common in Ethiopia despite government’s effort to discourage the traditional ways of dealing with sickness (see Abraraw, 1998; Alemayehu, et al, 2006; Mirgassa 1993; Slikkerveer, 1990).

Traditional medicine forms an important element of health care in any society especially, in developing countries. Studies show that traditional medicine continues to maintain its popularity for instance in Africa where about 80% of the population (WHO, 2003:5) depends on it for their health care needs. It refers to “the sum total of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health, as well as in the prevention, diagnosis, improvement or treatment of physical and mental illnesses” (WHO, 2000:1). So, medical pluralism becomes more apparent (Westerlund, 1989:177) where biomedicine is introduced to societies that have indigenous medical beliefs and practices.

Nevertheless, since the biomedicine rarely fits to the indigenous beliefs and medical practices, change is likely in the process. The changes may take different courses. One
of these courses could be the changes from externalizing to internalizing medical systems (Young, 1976; 1980; 83). Young assumes that since societies with less complex division of labor are characterized by externalizing medical systems, changes into internalizing ones occur as the societies turn complex in division of labor and with the introduction of biomedicine. The other course of change is what Geest(1997:97) and Geisler and Pool (2005:41) call indigenization of the biomedicine. Indigenization refers to the adaptive processes that biomedicine undergoes in order to fit into the socio-cultural environment of non-Western medical systems. It could also mean a selective inclusion of “non-Western medical traditions into biomedicine.” Further, it is highly probable for indigenous beliefs and medical practices to make certain adjustments so that they accommodate the inevitable challenge from biomedical practices to indigenous medical traditions. Although the extent of indigenization and the shift from externalizing to internalizing systems is unclear, plural medical practices of mainstream biomedicine, non-indigenous alternative medicine (acupuncture and chiropractic) and indigenous medical traditions exist side by side in Addis Ababa, the capital city of Ethiopia and the headquarter of the African Union.

Diverse medical lore and local traditional pharmacopeia have been in place for long time in Ethiopia. The people used this medical lore and local pharmacopeia to prevent, treat and cure ranges of illnesses (Pankhurst, 1965; 1970). It was estimated that 90% of the country’s population use traditional medicine (WHO, 2003:5). Moreover, the country’s interest in foreign medical practices of all kinds dates back to 16th century even before the Ethiopia took its current shape and size. Early contacts with travelers and
missionaries from Portugal, Germany, Greek, Britain, and French were the opportunities which brought the rulers of the time in contact with foreign medical practices (Pankhurst, 1990; 1997). Despite these early quests for foreign medicine by rulers at different times, however, the first formally organized biomedical center was established in Addis Ababa in 1897 by the Russian mission. This was during the reign of Menelik II. Biomedicine had gradually been spreading to different parts of the country over a century.

Biomedicine is official and supported by the government in Addis Ababa. The support for biomedicine also comes from overseas in the form of technical and financial aid to enhance health care in the country. The biomedical health care services are delivered through public and private biomedical clinics and hospitals. Indigenous traditional and non-indigenous alternative health care delivery systems are the domain of private individuals. Contrary to the absence of official support to traditional and non-indigenous alternative medicine on the one hand and the availability of biomedicine for the urban population on the other, many are still using indigenous traditional and non-indigenous alternative medicine in Addis Ababa. Many of these medical service centers try to promote themselves through advertisements using newspapers, magazines and banners. Yet, the Ethiopian Ministry of Health certified neither these traditional indigenous nor non-indigenous alternative medical practices. Therefore, the practice of medical pluralism under such circumstances in Addis Ababa is of great anthropological significance which inspired this study.
Some scholars conducted studies on medical pluralism in the Eastern, South, South western and Northern parts of Ethiopia. Slikkerveer (1990) carried out a study on plural medical system in Eastern Ethiopia. Slikkerveer found the pattern of medicine of Babile (his study area) is a complex network of social and cultural traditions and institutions which for generations have enabled the community to deal with crises of illness and death.

Mrgassa (1993) on the other hand, documented the wider acceptance and popularity of indigenous medical practices in South western Ethiopia. In addition, Nugussie (1988) has a case from the ethnic complex southern part of Ethiopia on traditional wisdom of elderly women in parenting. Abraraw’s (1998) study on traditional medicine in Dessie town, 400 km to the North of Addis Ababa reveals indigenous medical practice is not effective merely due to the pharmacological properties of the medical substance alone. Abraraw noted that the social, psychological and spiritual influences created by traditional healers and their healing procedures have great importance for patients. Further, Alemayehu, Kebede and Biniam etal (2006) reviewed the literature on the historical practice of traditional medicine and government policy in Ethiopia. They stated clearly the limited studies on the practices and practitioners of traditional medicine in Ethiopia. While they made an important step to understand the least studied topic at national level, their study was rather limited to a crude review of secondary data which produced eight pages. In addition, their study constitutes only an ingredient for the study of medical pluralism for they limited their focus to traditional medicine.
Although these studies shed light on the nature of medical pluralism in Ethiopia, medical pluralism, its persistence and change is less researched in urban areas. The studies so far are conducted mainly in rural contexts and reasonably long time ago. They are also either synchronic, excluded biomedicine from their analysis or ignored the aspects of persistence and change in the practices. On top of this, the studies neglected or gave little attention to the influence from the expansion of biomedicine, national health policy and urbanization on medical pluralism.

Therefore, this study looks into the practices of medical pluralism in Addis Ababa, the major changes of the practices since the introduction of biomedicine and the aspects which still persist despite the influences of different factors. Moreover, I found it plausible to identify and analyze the areas of convergence and divergence in the practice of medical pluralism in Addis Ababa together with their national health policy implications.

In the meantime, the following guiding questions are used to lead the direction of my fieldwork: What are the major plural medical practices in the Addis Ababa? What are the assumptions about the etiologies, prevention and treatment of disease or illness in different settings of organized medical practices in the city? Who are the patients that seek treatment from plural medical practices and why? When do patients resort to medical pluralism? What are the changes and continuities in medical pluralism? How
compatible are the medical practices in the city? And what is the national health policy implication of medical pluralism in Addis Ababa?

1.3.1 Objectives

The general objective of this research is to look into the nature of medical pluralism in Addis Ababa. The study specifically intends:

A) To assess the major indigenous medical beliefs and practices in Addis Ababa.

B) To understand the changes in plural medical practices in the city and the aspects that still persist despite the influence of different factors.

C) To identify the areas of convergence and divergence between the different medical practices in the city.

D) To reflect on the implications of medical pluralism in the study area for the health care policy in Ethiopia.

1.4. Methods and Data Sources

Qualitative methods of primary data collection and review of literature were used to collect data for this research.
1.4.1 Data Sources

A) Secondary Data

I reviewed selected literature in the area of indigenous and alternative medicine, biomedicine and medical pluralism. Attempts have been made in the process to give emphasis to the literature on the ideas of health, illness and healing in developing countries in general and African countries in particular. The ideas from secondary sources served for conceptual framework in addition to their significance in indicating the gray areas for further research.

b) Primary Data

The second category of data for this study came from primary sources which I collected through fieldwork between July, 2011 and August 2012. Specific tools such as observations, focus group discussion, unstructured and semi-interviews were employed in the process to generate qualitative data until I arrive at the saturation point.

Observation

I made observations of the medical practices at biomedical, non-indigenous alternative as well as indigenous medical service centers in Addis Ababa. There were a number of public and private biomedical health institutions in study area. Their services range from simple diagnosis and injections of antibiotics to sophisticated surgeries. So, I secured permission from concerned authorities and was able to access and observe their practices.
In addition, a number of patients visit the indigenous traditional and non-indigenous alternative medical service centers in the study area in spite of the 100% physical accessibility of primary health care and relative accessibility of more sophisticated biomedical health care services. So, I observed the practices in these healing centers as well. However, my observation both in biomedical, non-indigenous alternative and indigenous medical service centers was limited to the extent ethically permissible in the medical services. The physicians, the nurses and the traditional healers were helpful in setting the limits of my observation. I also kept field notes of my observations, informal conversions and impressions of everyday fieldwork in relation to my research topic.

**Interviews**

The other specific tools used to collect primary data were unstructured and semi-structured interviews. I conducted these interviews with selected medical personnel (Biomedical, non-indigenous alternative and indigenous ones) and their patients. Moreover, I conducted key informant interview with officials in government offices responsible for the supervision and licensing of medical practices in Addis Ababa as well at the national level. The key informant interviews were tape recorded except under a few occasions when the informants express their inconvenience with the recording. I took notes of their responses on my notebook under such circumstances.
Focus Group Discussion

Ensuring the homogeneity of the focus group in urban setting is very cumbersome although it is believed to generate valuable ideas for qualitative research. On top of this, the nature of work the group members are engaged in complicates the use of focus group discussion in my research. I faced two basic challenges in the use of focus group discussion in this research. One was the health professionals were too busy to avail themselves for discussion in groups. Secondly, it was not easy to ensure the homogeneity of the discussant when I tried to organize the discussion for out-patients. With this challenge in mind, I organized the discussion for nurses in a hospital-ward where some nurses had to quit the discussion for some time occasionally and rejoin the discussion after helping a patient. Similar session was organized at a health Station with nurses. Focus group discussion with physicians and the traditional healers was not possible for the physicians were extremely busy with their patients and the traditional healers had no one around for focus group discussion other than their assistants. The discussion with outpatient was not without challenge as well mainly in ensuring the homogeneity of the discussants. Yet, the ideas from the discussion were essential to substantiate the data obtained through other techniques.

1.4.2 Sampling and Choosing Informants

I used non-probability sampling design in this study for the research is qualitative and I did not intend to estimate a parameter or proportion to the population. In other words, my sampling design is based on the assumption that:
Non-probability samples are always appropriate for labor intensive, in-depth studies of a few cases... This means, choosing a cases on purpose not randomly. In depth research ... requires non probability sampling. It takes months of participant observation fieldwork before you can collect narratives about topics like... bad experiences with mental illness or use of illegal drugs (Bernard, 2006:186).

In fact, Bernard (2006:147) condenses the issue of sampling in social research in such a way that it is the types of data that social researchers are looking for which influence their sampling method. He noted that the two kinds of data of interest to social scientists are individual attribute and cultural data. So, when the interest is in the individual attributes such as income, age, etc. and to make estimation of the population parameters from the sample statistic, probability sampling becomes very essential. On the other hand, cultural data ease the concern over representation because culture is assumed to be shared. Hence, a non-probability sampling becomes appropriate.

Accordingly, I used purposive sampling to select the biomedical, non-indigenous alternative and indigenous traditional medical centers in the city. Then, I applied the same technique to identify key informants from these centers. Snowball sampling was partly used to collect data from a few informants especially to locate the chairperson of the dissolved National Association of Traditional Healers. The selection of samples from government offices was relatively simple because the Ministry of Health, the Drug Administration and Control Agency and the Ethiopian Health and Nutrition Research Institute and the Addis Ababa City Health Bureau were the responsible offices in relation...
to my research topic. The key informants in these offices were identified without much difficulty since the offices assigned specific experts to specific positions.

1.4.3. Validity and Reliability of the Research

Validity and reliability have always been the other major challenges in social research. The challenge becomes even more serious in qualitative research where there is no way that a researcher is going to determine and control his/her error margins unlike quantitative research. However, scholars who are aware of this loophole devised the mechanisms by which qualitative researchers would reasonably ensure the validity and reliability of their research from which my research project has benefited. There is an argument that the intensive personal involvement and in-depth responses of individuals ensures a sufficient level of validity and reliability in qualitative research (Cohen et al., 2000:108). I made use of the benefits of triangulation in the process of in-depth responses and to enhance the validity and reliability of my research. The triangulation was used in two forms:

a) Combined level of triangulation where the data from individuals, groups, patients and medical personnel were crosschecked; and

b) Time triangulation where I cross-checked for similarity of data diachronically (stability over time during fieldwork) and synchronically (similarity of data gathered at the same time).
1.4.4 Data Analysis

I analyzed the data obtained through the above techniques qualitatively in order to answer my research questions and arrive at sound conclusions. The responses of key informants and focus group discussion were transcribed cautiously. My knowledge of local language was helpful in the process. I arranged my field notes and then cross-checked with responses from key informant interview and focus group discussions. The triangulated data were then organized into thematic areas in such a way that they would answer the research questions. Finally, I tried to make sense of the theoretical and policy implications of the finding by using the models discussed in the conceptual framework to understand the ideas of change and continuity of plural medical practices.

1.4.5 Ethical Clearance

Ethical issue is an elusive spot in anthropological research. What is ethically popular at one point in time may become ethically wrong in some other time (Bernard, 2006:74). I tried to the best of my knowledge in this research to stick to the ethical expectations in contemporary anthropological research with regard to the nature of my interaction with informants, the sources of fund for this research project, and the content of the final output of the project.

The whole process of primary data collection began by securing permission from concerned government offices and the officials of specific medical service centers in Addis Ababa. The next step in my interaction with the research participants was the...
disclosure of my research objective and the search for volunteers who were willing to share their experiences. So, participants had clear understanding of the purpose of my research and avail themselves for interviews with informed consent. Pseudo names have been used in order to protect the informants. One key informant also asked me to delete some statements from the tape after interview due to fear of possible persecution. So, I did not include those statements he asked me to delete from the tape in this research report. Moreover, no research grant was received from any organization with vested interest in the research in such a way that compromises the results of the study. Finally, I believe I presented complete and honest field report of the fieldwork in a structure that answers the research questions.

1.5. Scope and Significance of the study

This study focuses on the medical practices in an organized setting. By organized setting I mean a practice that has administrative and logistic arrangements necessary to provide the medical/healing service sought by patients. The complexity of the organization varies from one setting to the other. But medical practice is undergoing as a group effort in settings known to patients. Hence, indigenous traditional, non-indigenous alternative and biomedicine in their respective settings are the focus of this research. The clinics, the hospitals and the traditional medicine centers were both the focus of the study as well as through which I was able to come into contact with health professionals, healers and patient informants. Therefore, the scope of the research is limited to medical pluralism in the study area as practiced in the above settings. But the selection of informants extends
to government offices that are closely related to health care services and the preservation of medicinal plants used by traditional healers such as the Ethiopian Institute of Biodiversity Conservation Research and Gene Bank. I believe that the study would be a substantive input to the understanding of medical pluralism in urban Ethiopia and its implication for the health care policy of the government.

1.6 Fieldwork Experience

This study gave me the opportunity to work in urban setting with informants who are sensitive to time both due to the nature of their profession and urban life. Of course, some other informants are exceptions who work in bureaucratic organizations that are at times wished to demonstrate their status by abusing their official positions. Physician key informants were busy with their patients that I had to bear several consecutive appointments for interview with patience. Neither was the focus group discussion with nurses an easy going. I had to organize two focus group discussions, one in a hospital and the other at the primary health care unit, close to the ward so that they would avail themselves for service any time they are called in. It was unimaginable in both cases to share their views without interruptions in an environment where they are working under heavy workload. The situation at the Institute of Nutrition and Health Research was however, different. I had to test my patience to the limits to organize a key informant interview with an official responsible for the supervision for the safety and toxicity of traditional medicine. It was not the shortage of time on the part of the official as such to my knowledge but the usual abuse of power by some officials in government offices. One
would also imagine his negative attitudes towards traditional medicine which I was able to cross-check with the opinion of the healers towards this department of the Institute.

The emotional experience of the fieldwork in biomedical hospitals is worth mentioned. I had to go through many stressful moments when patients are discharged due to death. The agonizing sounds of patients for help were also real test to my emotions even after I left the hospital compound.

Establishing rapport especially with traditional healers was not easy task. They suspected me of being a journalist from government owned media or someone who tries to “steal” their knowledge. One of the famous healers prohibited me from taking notes as well as recording my discussion with him for three days. When I begin taking notes, the healer used to stop talking. But he gradually allowed me to take notes and tape record my interviews. He even allowed me to read the handwritten reference books he was using for traditional medicine. This healer told me that he had bad experience with visitors including foreigners whom he accuses of trying to steal a sample drug from his clinic. Similar accusations are common by other traditional healers. In general, I may conclude that anthropological fieldwork in urban setting offers the opportunity to learn how anthropological fieldwork once associated with rural and exotic people could be carried out in urban contexts.