THE NEED FOR INTEGRATING INDIGENOUS AND BIO-MEDICAL HEALTH CARE SYSTEMS: CASE STUDY FROM ADA BAI RETURNEE SETTLEMENT,

by Laura Hammond
for the UN Emergencies Unit for Ethiopia

November 1994

The Need For Integrating Indigenous and Bio-medical Health Care Systems: Case Study from Ada Bai Returnee Settlement Humera, Ethiopia[1]

by Laura Hammond, anthropologist

Executive Summary

Assistance to returnees in the Humera area of Ethiopia has been given under the guiding principle that rehabilitation should seek to integrate returnees into locally existing structures and levels of services rather than giving them preferential treatment over local residents. In the health care sector, this has resulted in a significant decrease in the level of care provided as compared to the care to which the returnees were accustomed while they were refugees in the Sudan. In evaluating the complete range of health care services presently available to returnees, however, it is necessary to consider both bio-medical and indigenous healing systems. This paper examines the role of indigenous medicine in one returnee community and suggests ways that the two systems might be better integrated to make maximum use of scarce bio-medical health care resources.

Health Care Available in Saffawa

Ada Bai is a returnee settlement of 7,500 people situated 17 km east of the northwestern border town of Humera in Region 1 (Tigray). All returnees in Ada Bai were repatriated from the Saffawa refugee camp in Eastern Sudan, having fled the famine and fighting in Tigray in 1984 and 1985. Saffawa was established as a reception centre in 1985. Although initially meant to be a temporary settlement, most Ada Bai returnees lived in Saffawa for eight years prior to being repatriated to Ethiopia in 1993.

Saffawa was divided into two camps, located approximately 7 km from each other. At the height of its population, Saffawa I had an estimated population of 3,000 and Saffawa II accommodated approximately 22,000 as of June 1988 (Crane: 1990).

Health services in Saffawa were provided by two international non-governmental organizations, and funded largely by the United Nations High Commissioner for Refugees (UNHCR). Services included two hospitals of 30-40 beds each, two outpatient clinics (OPDs), two tuberculosis clinics, a Mother-Child Health clinic (MCH), a supplementary feeding centre, a laboratory capable of running blood, urine, stool, and sputum tests, as well as four NGO-run and several private pharmacies. In addition, two health posts provided outreach treatment to the refugees. This included treatment of most of the children under five years of age, and provision of services such as growth monitoring, immunization, and distribution of supplementary dry rations. Screeners at the health posts dispensed oral rehydration solution, vitamins, iron tablets, aspirin, and (during the malaria season) chloroquine.

---

[1] The author is a PhD candidate in anthropology from the University of Wisconsin-Madison (USA). This study is part of a larger research project which examines the long-term process of reintegration following repatriation. This is the third report in a series submitted to the UN-EUE. For further description of the project, see the previous reports.

Examiners in the clinics had been given minimal medical training but prescribed antibiotics, antiparasitics, and antihelminthics.

Health staff at Saffawa included approximately 30 expatriates and over 200 Ethiopians, who served as nurses, examiners, dressers, pharmacists, laboratory technicians, guards and cleaners. Most of the Ethiopian workers were themselves refugees. Providing outreach in both sites were 26 home visitors and four traditional birth attendants (TBAs) who worked as salaried employees (paid by the NGOs).[2] The home visitors were involved in a programme of community education, disseminating information about health, hygiene and sanitation issues. They also brought children to the health posts and helped carry the sick to the clinic and hospitals. TBAs assisted with all deliveries and worked daily in the antenatal clinic, where monthly weighing was offered and supplementary rations were provided (Crane: 1990).

Medical Situation in Ada Bai

In Ada Bai, bio-medical health services are much more limited than they were in Saffawa. There is one clinic staffed by a health assistant/examiner, one technician who runs only blood films for malaria, one dresser and one pharmacist. The dresser is a returnee trained by the NGOs in Sudan who volunteers his time in the hopes of getting a paid position in the future.

The clinic is overseen by the Ministry of Health. Referrals are sent to Humera Hospital, which shares its four doctors with the outpatient department (located in a separate compound on the other side of the town). Humera Hospital does not have its own electricity generator and therefore only has power in the evenings. It does not have capabilities for either surgery or blood transfusions: patients requiring such treatment are further referred to Axum or Gonder (each 250 km away) or in the case of women experiencing difficulties in childbirth, to the Mother-Child Health (MCH) hospital in Tesseney, Eritrea (100 km away). Most people who are given referral letters never use them, for they lack the financial resources or are too sick to travel to the distant hospitals.[3] There is no ambulance available for referrals either from the Ada Bai clinic to Humera Hospital or from Humera Hospital to either Axum or Gonder. On rare occasions, the hospital vehicle is used to transport women to the MCH hospital in Tesseney.

Returnees' Familiarity with Bio-medicine

Having had such a relatively advanced level of health care available to them in the Sudan, the returnees are sophisticated in their awareness about both their illnesses and the treatments that doctors administer to them. It is not uncommon for people to know the names of the drugs they are given and to have an opinion of their effectiveness. One woman who has been diagnosed with advanced sexually transmitted disease and possibly AIDS, told me that she had been given first tetracycline and later ampicillin for her abdominal pain, but that neither medication had worked for long. She is

[2] Salaries for TBAs were phased out in 1990.

[3] In Rawayan, one of the other returnee settlements, the Relief Society of Tigray provided financial assistance to patients who were referred to Axum or Gonder. This service was available only to those returnees who were repatriated in 1994, as the 1993 returnees were assisted under a different agreement.

convinced that she has been misdiagnosed, and for all intents and purposes she is right, for the doctors reported that since they do not have the proper medications to treat her, they treat her instead for symptoms which might complicate her illness, such as parasitic infections.

Indigenous Medicine

While the level of bio-medical care available to Ada Bai residents has diminished, there still remains a thriving trade in indigenous medicine. The prevalence of indigenous medicine in this returnee settlement does not appear to be atypical for Ethiopia. Makonnen Bishaw (1988), citing a 1980 Ministry of Health report, states that over 80 percent of the rural population of Ethiopia utilizes indigenous medicine. Reflecting on his own investigations into the use of indigenous and bio-medical healing, he remarks that "even this appears to be an underestimation of the persisting popularity of indigenous medicine."

It could be argued that the decrease in level of bio-medical services available has led to an increase in the utilization of indigenous healers. Popularity of indigenous medicine is often attributed to a lack of access to bio-medical care. Information from Ada Bai seems to contradict this argument, however. Utilization of indigenous healing methods appears rather to be a product of a perceived failure on the part of biomedicine to adequately identify and treat certain illnesses.

For the purposes of this paper,the term "indigenous medicine" is used to refer to a variously defined body of knowledge that is concerned with healing but which can take many different forms.[4] It can refer to: the use of herbs and plants found locally and in highland Tigray as a drink, salve or inhalant; bloodletting; bone-setting; cauterization; the utterance or writing of special prayers for curing purposes; exorcism of spirits said to possess the body; and the use of holy water and other sanctified substances such as soil, ash, or sand. Different indigenous healers specialize in one or more of these types of healing.

Herbalism

The preparation and dispensing of herbal medicines form one of the most common forms of indigenous medicine practiced in Ada Bai. Herbal medicines are prepared to be taken as drinks, salves and inhalants. Some of these remedies are accompanied by the recitation of prayers. Others (as in Evil Eye healing) are used in conjunction with other forms of healing. Herbalists may be *debtera*s who have formal training (see below), or they may be illiterate people who claim not to have any training at all. One healer treats all illnesses with the same herbal drink, a mixture of fourteen plants that she collects once each year when she travels to the Tigrayan highlands. After preparing the mixture and letting it sit for six months, a priest comes to her house to bless it. She then administers the medicine in varying amounts depending on each client's particular ailment. She is illiterate, and claims to have been instructed about which plants to use and how to prepare them in a dream that she had thirty years ago.

[4]Indigenous medicine has also been referred to as traditional medicine (and indeed, the Ministry of Health's branch concerned with this type of medicine is known as the Department of Traditional Medicine). Indigenous medicine is seen as preferable because it allows for evolution and change within the corpus of vernacular theory and practice.

Religious Basis of Indigenous Medicine

As with many other kinds of African health care systems, indigenous medicine in Ethiopia is heavily influenced by religious beliefs. Many of the cures that are used are derived from the Ethiopian Orthodox Church. While most of the saints in the church have specific healing practices associated with them, Mikael (for both men and women) and Mariam (for women) are probably most famous for their power to heal. When a person becomes sick, his friends and relatives may say to him, "Mikael must be with you. Mikael will protect you." Likewise, Mariam is said to protect the health of women, especially during childbirth. Even in cases where people seek bio-medical treatment, the eventual outcome of the treatment, whether complete recovery, continued illness or death, is often attributed to the will of the saint.

Tsebel are substances such as water, soil or ash which are blessed in the name of a particular saint.[5] They are used as prophylaxes and treatments for a wide range of illnesses. In order for a *tsebel* to work, the sick person must be a devout believer in its effectiveness. If the *tsebel* fails to cure or protect against illness, the integrity of the patient's belief is challenged rather than the efficiency of the *tsebel*.

One of the most powerful types of healers is the *debtera*, who receives his training (for only men can become *debtera*) from within the church. Whereas most indigenous healers' treatments are orally learned, practiced, and passed on, the *debtera*'s knowledge is derived from a series of texts written for the most part in Ge'ez.[6] These texts and the training that is necessary for their proper use are accessible only to selected men who have already completed their training for the priesthood.[7]

In Ada Bai, there is at least one *debtera*. Like *debtera*s in other places, he is both respected and feared for his incredible powers. In addition to healing, he can also cause a person to become sick and even to die. Because he does not want to be ostracized by the community, and because he is afraid that the state might prevent him from practicing some of the healing practices that he knows (even though they are sanctioned by the Church and in theory at least protected by a 1948 Imperial Proclamation protecting traditional healers), this particular *debtera* says that he does not actively use most of his healing powers. He even tries to keep the fact that he is a *debtera* a secret, though he admits that most people know. He offers his services as bone-setter free of charge, but when people come to him for treatment, he says that he usually advises them to go to other healers and *debtera*s (in Humera town) for help.

Other forms of healing include blood-letting and burning. Blood-letting is widely practiced all over Tigray. Perhaps the best known type of blood-letting involves the creation of incisions in the eyebrows and temples for treatment of eye infections. While this practice is, according to some people, being discontinued in many urban households, there are no indications that returnees have

[5] Many Ethiopian Orthodox Christians define *tsebel* as holy water only. In Ada Bai, however, these other substances are also referred to as *tsebel*.

[6] Young: 1970, xvii.

[7] For an extensive analysis of the ebtera's training and his relation to the Ethiopian Orthodox Church, see Young: 1970.

abandoned it. There is evidence to suggest that displaced people cling tightly to traditional and cultural practices as a way of maintaining their ties to the homeland, from observance of fasting periods to adherence to beliefs about healing.

Indigenous Healers Treat Illnesses not Recognized by Bio-medical Healers

According to local health statistics, the most common illnesses are malaria, respiratory infections, and diarrhoeal diseases. In addition, there are several illnesses that people consider to pose significant health risks that are not recognized by bio-medical doctors. Residents claim that "Evil Eye", or *buda* is one of the most serious threats to the Ada Bai community. "Evil Eye" is said to be carried by individuals who can transform themselves into hyenas at night. The evil eye spirit enters the victim when the person who carries the spirit touches him or her; it then feeds on the victim's body. Death is said to be certain if the spirit is not exorcised promptly.[8]

Other illnesses not specifically recognized by bio-medical health workers are two fevers known as *waz* and *chofer*, thought to be found only in the Humera area. *Waz* is characterized by listlessness, fatigue, and loss of appetite. People say that *waz* is caused by the blood "turning bad." The treatment is the creation of 44 incisions in the symmetrical groups of two and three on various parts of the body. Proof of the bad quality of the blood is said to be the fact that when a vein is cut, the blood comes out black, or as one woman described it, "like Coca-Cola." After the incisions are made, a drink made with a locally available plant known as *waiva (compretum molle)* is given to the patient. Some healers also report that the patient is not supposed to drink cow's milk or eat the meat of a cow or ox for forty days after the incisions are made.

Waz is usually explained by doctors simply as acute fever, but sometimes it is diagnosed as meningitis. When asked whether *waz* was equivalent to either of these diagnoses, one healer who has also been trained in the Western medical system adamantly rejected the idea. "*Waz* is not meningitis," he said. "If you have *waz* and you go to the hospital, they might give you Vitamin B Complex and iron and tell you to rest." Lack of food is said to make people more vulnerable to *waz*.

Chofer is similar to *waz* in that its symptoms involve fever and loss of appetite. In addition, however, the irises of the eyes reportedly turn white while the skin under the eyes and the nails turn green. The sick person's urine looks like hot tea or blood. The treatment for this illness is a series of sixteen burns made in groups of two on each wrist, forearm, elbow, and upper arm. A cross is then burned into the top of the person's head. *Chofer* is commonly diagnosed by hospital doctors as acute fever, and more specifically sometimes as hepatitis. Both *waz* and *chofer* are often associated with malaria, often occurring after the patient has been treated for malaria.

Returnees consider biomedicine to be valuable in the treatment of certain illnesses, but useless in treating others. Because bio-medical doctors do not recognize *waz* and *chofer* as distinct illnesses, people who suffer from the symptoms will usually seek treatment from an indigenous healer first. Only if complications result from the indigenous healer's treatment, or if the symptoms persist will they go to the clinic or hospital for treatment. Doctors at Humera Hospital report that for some illnesses, such as hepatitis, meningitis, or acute fever, most of the patients they treat either report or show signs of having been treated by an indigenous healer first.

[8] For a full description of Evil Eye possession, see Young: 1970, pp. 11-12.

The argument that people choose indigenous healing techniques and specialists because of lack of access to bio-medical health care is not upheld by the returnees' testimonies. One indigenous healer claims that "Only medical treatment can cure meningitis." Another says that medical treatment is probably effective against most illnesses but certainly not against sickness caused by Evil Eye possession.

Recommendations for Integrating Health Care Systems

Presently, there is no interaction at all between the different health care systems. Indigenous healers are afraid that if they are identified to the government they will be forced to stop practicing. One old healer recalled, "During Haile Selassie's time most things (i.e. kinds of indigenous medicine) were legal. When the Derg came the healers were frightened and didn't use it so much. In Tigray during the struggle, the TPLF (Tigrayan People's Liberation Front)
discouraged them from using traditional medicines." As a result, he said, indigenous healers try to keep their knowledge and skills secret from the clinics, hospital, and local political leaders.

Meanwhile, the bio-medical sector's community health workers are refusing to work without payment. With the exception of the traditional birth attendants, therefore, there is no system of bio-medical outreach in the community. The apparent paradox between lack of officially sanctioned health care services and abundance of medical expertise in the community, means that very little of it is recognized and utilized by the government-run health care structure. There is no coordination of efforts, nor is there any attempt by healers from different orientations to work together.

Without very much trouble, indigenous healers could be utilized and integrated into the bio-medical health care system in such a way that the effectiveness of both systems could be enhanced. Five recommendations are proposed:

1) Certify all indigenous healers. Keep records for informational purposes as to who conducts which kind of healing practices, and encourage open discussion about traditional beliefs and practices concerning health.

2) Encourage bio-medical health care workers to refer patients with certain ailments to indigenous healers. For instance, bone-setting is done very effectively by most indigenous healers. Tapeworm is also recognized by bio-medical experts to be effectively treated by *kosso*, a locally available plant.

3)By the same token, encourage indigenous healers to refer difficult or non-improving cases to the clinics or hospitals for further care. Patients are often willing to try a different treatment regime if the kind of treatment they first seek does not cure them.

4)Provide indigenous healers with the same basic training as that received by community health workers, and supply them with chloroquine, certain common antibiotics, and clean dressings for wounds. Since indigenous healers are already located inside the community, and since they know who is sick, they are in a better position to identify and treat people for common, simple-to-treat diseases such as malaria and parasites.

5)Provide healers who perform operations (such as circumcision) with clean instruments and antibiotics to prevent infection. If necessary, provide them with training in the proper use of such items.

Conclusion

Indigenous medicine has been seen for a long time as an impediment to "developed" health care. As is illustrated in the case of the Ada Bai returnee community, however, relatively advanced levels of health care may be accompanied by high rates of utilization of indigenous health care. Each type of service fulfills certain functions within the community, and local residents do not, in most cases, perceive a tension or contradiction between the two systems. Where access to bio-medical health care is limited, indigenous medicine can prove to be an important resource to the community, but even when there are enough drugs and doctors, it appears that indigenous health care has a role to play in the community. By working together, different kinds of healers can help to complement each other.

REFERENCES CITED

Crane, Mary. 1990. "Evaluating Health Care in Saffawa: A Comparison of Two Sources of Refugee Camp Data," unpublished Master's Thesis.

Makonnen Bishaw, unpublished PhD dissertation, University of Southern Illinois at Bloomington.

Young, Alan. 1970. unpublished PhD dissertation, University of Pennsylvania.

Prepared for the UN-EUE
by Laura Hammond

November 1994