Global Scientific JOURNALS

GSJ: Volume 6, Issue 7, July 2018, Online: ISSN 2320-9186
www.globalscientificjournal.com

THE INTERACTION BETWEEN INDIGENOUS AND BIOMEDICAL HEALING SYSTEMS AMONG THE SHINASHA

Abraham Genet
Lecturer
Bahir Dar University
Department of Social Anthropology
Ethiopia
Mob. 0910625217 Email: abrahamgenet2015@gmail.com

Abstract

This study aims at exploring the interaction between the indigenous and biomedical healing systems as well as the professionals working in both healing systems. Drawing on qualitative research approach, the study employed primary and secondary data collection methods. Primary data were gathered through informal conversation, in- depth interviewing of indigenous herbalists and, health extension workers and health officer, focus group discussion with selected community members and herbalists, and systematic observation. Secondary data were collected through critical review of related literature and documents. Both primary and secondary data were organized thematically and were analyzed through systematic interpretation and cross- checking of the different data sources through the use of triangulation to increase the validity and reliability of the findings.

The study found that the Shinasha consider their knowledge of herbal medicine to be the gift of God for them. In the study area, herbal medicinal practitioners are males. The medical ethics of the Shinasha is based on non- commercial (at least in principle) use of medicines which is one point of departure with biomedicine, where treatment is usually exchanged for money. So, herbal medicinal knowledge and healing is considered as a moral profession to help and serve people. The study findings also indicated that the Shinasha practice healthcare and healing for illnesses of natural, supernatural, and personal etiology through popular healthcare practices, the indigenous healing system, and the biomedical healing system. Shifts from one healthcare option to the other and resorts are common among the Shinasha. In the study area, the indigenous and the biomedical healing systems are existing dualistically, but have fewer informal professional interactions, which is more competitive and less cooperative. The coexistence of the indigenous and the biomedical healing systems in the study area generally has a positive contribution in addressing and improving the health of the people.

Key Words and Phrases*: indigenous medicine, herbal medicine, healing system, Shinasha*

1. Introduction

Plants have played a vital role in the prevention and treatment of disease since prehistoric times. People in different parts of the world depend on plant resources for their basic needs and are aware of many useful species occurring in their ecosystem. They have continuously developed their knowledge of indigenous plant uses and plant resource management (Biruktayet, et al, 2010: 3).

Plants are an integral part of life in many indigenous communities[1]. Besides, being the source of food, fodder, fuel, etc., the use of plants as herbal medicines in curing several ailments goes parallel to the human civilization (Bhatia, et al, 2014: 1).

The use of medicinal plants is the most common form of indigenous medicine and medication worldwide. Regulation of herbal medicines is a key means of ensuring safety, efficacy and quality of herbal medicinal products (WHO, 2002: 21). To reduce mortality, morbidity and disability of people, and promote the safety, efficacy, and quality of indigenous medicine, the World Health Organization (WHO, 2002) is providing guidance on regulatory and quality assurance standards, aimed at increasing the availability and affordability of indigenous medicine with an emphasis on access for poor populations. This shows how much indigenous medicine is getting attention from time to time at the global level.

Herbal medicines include herbs, herbal materials, herbal preparations and finished herbal products that contain active ingredients of parts of plants, or other plant materials, or combinations; and indigenous use of herbal medicines refers to the long historical use of these medicines Their use is well established and widely acknowledged to be safe and effective, and may be accepted by national authorities (WHO, 2013:1). According to WHO (2002: 11), 80% of the African population uses some form of indigenous herbal medicine, and worldwide annual

[1] According to Purcell (1998) and Dei (2000), cited in Tebaber, 2015:40), indigenous communities refer to specific categories of people who are categorized under the criteria of ancestral territory, collective cultural configurations, and historical location.

market for these products approaches US $ 60 billion. Indigenous medicine played vital roles in African medical systems. In most parts of

Africa including East Africa, the knowledge and practice of indigenous medicine are based on oral tradition and are mostly shrouded in secrecy. However, it has also been still used as the only source of medical care, especially by societies in rural areas of East Africa where access to modern medical care is highly precarious (Adane, 2014: 1). Ethiopia has a long history of indigenous medical practices and healing systems. The country is very rich in indigenous herbal medicine and medical practices for two fundamental reasons: diversified cultures, and diversified ecological zones. The country is rich in wide varieties of medicinal plants because of its geographical and altitudinal differences (Pankhurst, 2005: 27). Data indicate that up to 80% of the Ethiopian population uses indigenous medicines mainly due to the cultural acceptability of healers, the relatively low cost of medicine, accessibility, and difficulties in accessing modern health facilities (IEFNR, 2005: 127). Also, a study by Teferi (2009) indicates that a significant proportion of the Ethiopian population still depends on indigenous medicine for its healthcare services and most of the indigenous medical preparations are of plant origin. Indigenous medicine served as the major source of healthcare in Ethiopia, especially before biomedicine turns to become another option (Dejene, 2014: 35).

According to the Institution of Ethiopian Food and Nutrition Research (IEFNR, 2005: 128), in Ethiopia, indigenous medical practitioners practice their knowledge and skills in three ways: (1) Preventive practices: several ways of disease prevention as deserting places where the epidemic occurred, sweeping or covering floors with particular plants, detaching oneself from people with contagious diseases, etc. (2) Curative practices: commonly used to treat a variety of diseases by employing substances as recommended or prescribed by skilled local medical practitioners. (3) Surgical practices: include bone-setting, circumcisions, bleeding and cupping, cautery, scarification and tooth extraction, midwifery, etc. Among medical substances, plants are the major source of the Ethiopian indigenous pharmacopeia; leaves, flowers, seeds, barks, roots, and a wide variety of plants are used (Dejene, 2014: 36). Solomon (2005) shows that, in the Ethiopian case, the term herbalist refers to medical specialists who prepared and administered herbal drugs only. According to Dejene (2014), acquiring herbal knowledge was a lengthy

process, requiring prospective healers to undergo a long period of apprenticeship under the mentorship of experienced healers.

The Shinasha, whom this study concerns, are also mentioned by different sources[2] for their long rooted knowledge and practice of indigenous herbal medicine. Pankhurst (2005) argues that, although medical practitioners of the northern and central provinces of Ethiopia had the advantage of recording knowledge/information/ for future generations because of the existence of long history of writing, in the majority of other areas including the Shinasha, indigenous herbal medicine is based on oral transmission of knowledge, which makes study on the indigenous knowledge and herbal healing system of the Shinasha in general and the interaction of indigenous herbalists with the local biomedical workers significantly important.

2. Indigenous Medicine and Biomedicine

Indigenous medicine can be conceptualized as the local health-care knowledge which is unique to a given society (Young 1983, cited in Tebaber, 215: 40). Hammond (1994: 4) defines indigenous medicine as "the use of local herbs and plants 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 holly water and other sanct ified substances such as soil, ash, or sand." Hammond (1994) states t hat indigenous healers specialize in one or more of the above mentioned types of healing. The most comprehensive definition of indigenous medicine was given by WHO (2002). Indigenous medicine refers to:

> *The sum total of 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 mental, physical, and social imbalance, relying exclusively on practical experience and observation handed down from*

[2] Mamush 2011; Mirutse, et al 2007; Zelalem 2011; etc.

> *generation to generation, whether verbally or in written forms (WHO 2002: 1).*

According to WHO (2002), life within indigenous medical sector is defined as the union of body, senses, soul and mind; and health as the blending of physical, mental, moral, social, and spiritual welfare. I considered the importance of all of the above described definitions of indigenous medicine. But, as a working definition for this study, I used the definition given by WHO (2002) because it is more comprehensive. Indigenous medicine is identified also by other alternative names such as 'traditional medicine', 'folk medicine', 'local medicine', etc. In this study, I used "indigenous medicine", rather than t he above terms which sometimes seem to be derogatory.

Biomedicine is defined as a clinical medicine based on the principles of physiology and biochemistry rather than on the art of healing. Thus, biomedicine and biomedical research are closely associated with experimentation and laboratory (Strasser, 2014). Accordingly, biomedicine tries to explain abnormality or pathology in terms of normal biological processes; paradoxically, it also understands the function of the normal body in abnormal environments. But, the difference between the normal and the pathological is a matter of degree, not kind. Socially, biomedicine is considered 'orthodox', scientific', 'Western' medicine.

Biomedicine is a medical science that applies biological and physiological principles to clinical practice. It is also related to many other fields of study in health and biology. The biomedical model of disease ensures that new definitions, practices and controls will emerge to strengthen medicalization (Sulik, 2009).

Biomedicine is a unique way of understanding health and illness, based on the investigation of biological mechanisms the use of the randomized clinical trial, and the identification and quantification of disease risks. Biomedical research rests upon three powerful assumptions: universalism, reductionism, and modelization. The development of biomedicine has been powerfully shaped by state policy (Strasser, 2014). 'Disease', which is objectively measurable and clinical concept, is usually associated with biomedicine.

3. The Study Area

According to the constitution of FDRE (1995), Benishangul-Gumuz is one of the nine national regional states in Ethiopia, which is located in the north western part of the country. According to CSA (2008), the region has three Zones among which Metekel is one and, 20 *Woredas* among which Bulen is one. Bullen Woreda is bordered by Dangur *Woreda* in the north, Mandura *Woreda* in the northeast, Dibate *Woreda* in the east, the Abay River (Blue Nile) on the south (which separates it from the Kamashi Zone), and by Wembera *Woreda* in the west. Its largest settlement is Bulen town which is the administrative centre of the *Woreda* (FEDB of Bullen *Woreda*, 2006). Bulen town is 118km away from the Metekel Zone capital, Gilgel Beles, and 580km away from the Ethiopian capital, Addis Ababa. The *Woreda* lies from 10^0 00` to $11^0$ 07`N latitude and $35^0$45` to $36^0$07'E longitude. The *Woreda* consists of 19 *Kebeles*; Matanabapuri and Bakuji are two of the 19 *Kebeles* (ibid).

With a total area of 2, 857.97 km, Bulen *Woreda* has a total population of 45,523 people; of whom 23,386 (51.4%) are males and 22,137 (48.6) are females; 38,992 (85. 65%) of the population lives in rural areas; the rest of the population lives in urban areas. Bulen *Woreda* has a population density of 10.2 people per square kilometre which is greater than the Metekel Zone average of 8.57 (CSA 2008). Concerning religion, 67.37% of the population practice Ethiopian Orthodox Christianity, 12.68% practice traditional beliefs, 10.16% of the population are Protestant, and 9.68% are Muslim. The five largest ethnic groups found in Bulen *Woreda* are the Shinasha (48%), the Gumuz (33.5%), the Amhara (9.8%), the Oromo (8%), and the Awi (0.5%). All other ethnic groups made up 0.2% of the population. Boro (the language of the Shinasha) is spoken as a first language by 45% of the inhabitants, 33.4% speak Gumuz, 11% Oromiffa, and 10% speak Amharic. The remaining 0.6% spoke other languages *(*ibid). Therefore, the Shinasha make the majority of the *Woreda's* ethnic groups.

The prominent agro-ecological feature of Bulen *Woreda* consists of mainly warm and moist (sub- humid lowland to mid and highland cool sub- humid). The *Woreda* is mostly *Qola*/lowland/ (85%), *Woinadega*/midland/ (10%) and *Dega*/highland/ (5%). Agriculture is the

main stay of the economy of Bulen *Woreda*. The *Woreda* is endowed with huge water resource potential prominently the Abay River (Blue Nile), and the Beles River which can facilitate the development of irrigation (FEDB of Bulen *Woreda,* 2006). The area is also one of the pocket palces of Ethiopia endowed with huge natural forest.

Regarding health infrastructure, according to Bulen *Woreda* Health Office (2007), there are 17 health posts, 2 health centres, and 1 hospital opening soon in Bulen town. According to the Office, the study sites, Matanabapuri and Bakuji *Kebeles,* each have health posts. In addition, in Bakuji there are two privately owned pharmacies.

4. Herbal Medicinal Knowledge and Practice of the Shinasha

There is a favourite saying[3] about the origin of the Shinasha herbal medicine that can be quoted from every ordinary Shinasha. According to their oral tradition, the Shinasha trace their origin to be Canaan, Israel[4]. The key informant (KIH-3)[5], by referring to the oral tradition of the Shinasha, argues that it is from Canaan that the Shinasha moved to Egypt where they further developed their medicinal knowledge; and then come to Ethiopia, and settled in their present day territories. The Shinasha believe that, for them God put wisdom on trees. They consider their herbal medicinal knowledge to be the very gift of God to them.

According to the data gathered and analyzed from all of the indigenous herbalist key informants, the Shinasha herbal medicinal knowledge and practice is composed of vast contents: herbal medicinal knowledge against human illnesses, veterinary medicine, as well as wide range of herbal magical knowledge for diverse purposes. The knowledge and practice of herbal medicine is entirely and deeply entrenched in the cultural system. As Kleinman (1978: 85) argues on "medical systems as cultural systems", among the Shinasha too, we can find that the indigenous

[3] Based on oral tradition of the Shinasha, God gave, for the Amhara book (because the Amhara love and protect his father) so that they administer or govern people; cup for the Oromo so that they prophes using the cup (during coffee making time); white teeth for the Gumuz (because the Gumuz laughed at his naked father); for the Shinasha God put wisdom on trees. By no means is my aim to prove or disprove the sayings. I raised the cases of other people simply because the Shinasha, when tracing the root of their medical knowledge, state them together to indicate their share of gift from God.

[4] Besides the origin of the Shinasha from Canaan based on their oral tradition, linguistic scholars classify the language of the Shinasha among the Omotic language family (Zelalem, 2011: 24).

[5] KIH-3 is a code given to one of the herbalist key informants and, hereafter, the sources of such primary data are cited like this.

medical system is part of the cultural system of the people. A single herbalist usually possesses herbal medicinal knowledge for illnesses (of naturalistic, personalistic, and supernatural etiology), herbal magical knowledge for several purposes, veterinary knowledge, medicine for maintaining natural resources and controlling some aspects of natural events such as rainfall, medicine for ensuring communal survival and protection, and so on. Therefore, the practitioners, while specialists in the extensive use of herbal medicine, they are also generalists in the sense that they use herbs for a wide variety of purposes mentioned above. The types of herbal medicinal knowledge possessed vary from herbalist to herbalist partly because of the low experience sharing trend of herbalists one another. Knowledge transmission is based on oral lengthy apprenticeship, with strict and secretive patterns. In the local language *(Shinashigna) atta /Bori atta and gafa are equivalent terms for* indigenous medicine and healers respectively.

Herbal medical knowledge is preserved and transferred (which is usually from father to a favorite son) from the senior/experienced herbalist to the junior/ prospected one orally. In the study area, it is the males that heir and practice herbal medicine. Daughters are not proposed to heir medical knowledge, because, as the Shinasha practice exogamous marriage, it is believed that if daughters are allowed to possess medical knowledge, they will pass over the knowledge to nonrelatives (members of other clans), which is to their husband. But there are exceptions[6] to exclusion of women on the area of professional indigenous medicine. The selection of the person who heirs medical knowledge is based on critical evaluation of the personality of individuals. Medical knowledge acquisition takes longer period of apprenticeship and practice; and, it is finally officially transferred to the prospected person in a blessing ritual ceremony. After a long period of apprenticeship, in the knowledge transfer ritual, finally, father blesses his son saying, "let everything you touch and pick up by your hand works." Together with the blessing, the father also hands over all the tools and equipment he has been using to cut medicinal plants. After this ritual, the son officially replaces his father and starts to fully and publicly practice his medical knowledge.

[6] Although I found in my study sites that daughters (women) are not allowed to heir herbal medicinal knowledge, in other areas of the Shinasha such as Wombera, I was informed that there was a notable female herbalist.

The scope of the Shinasha indigenous herbal medicine is broad, which includes wide range of herbal- magical arenas. Medicine for the Shinasha is holistic and exists almost in all aspects of the community. The Shinasha herbalists possess herbal medicinal knowledge for illnesses of natural, supernatural, and personal etiology and for other diverse herbal magical purposes.

5. Interaction between Indigenous and Biomedical Healing Systems among the Shinasha

5.1 The Perception of Biomedical Workers and Indigenous Herbalists Towards One Another's Systems of Healing

In- depth interview was conducted with health extension workers from both Matanabapuri and Bakuji *Kebele* health posts. In a question regarding their perception towards indigenous herbal healing and herbalists, they argue that they perceive indigenous herbal healing and herbalists as harmful, sorceries, magical, and primitive. These biomedical workers consider indigenous herbalists as one giving a medicine whose dosage is improper, and hence, causing a serious danger and harm on the person taking the medicine. However, the dosage complaints raised by the users of indigenous herbal medicine are not as exaggerated as that raised by biomedical workers. Health extension workers from Matanabapuri and Bakuji health posts employ the issue of dosage as their leading justification to undermine indigenous herbal medicine and herbalists. But, as I have understood from the data collected from key informant indigenous herbalists, community member FGDs, and key informant health extension workers themselves, their damnation of indigenous herbal medicine and herbalists is based on little or no evidence. Therefore, the perception of health extension workers towards indigenous herbal healing and herbalists is generally negative. One of the key informants from Matanabapuri health post expresses his perception towards indigenous herbal healing and herbalists as follows:

> *My perception towards 'traditional' medicine and herbalists is negative. I do not think that it ('traditional' medicine) is useful. I have never met a person who went to 'traditional' herbalists; and, I have never met 'traditional' herbalists for the purpose of healing. I do not believe that they ('traditional' herbalists) heal. My mind does not accept it. (KIBW[7] - 3, Mata, 27th February 2015).*

[7] KIBW is a code given to biomedical worker key informants.

In an in- depth interview with health extension workers (KIBW-1 and KIBW-2), they say that, "the reason we oppose 'traditional' herbalists is that, for one thing, we consider herbalists as part of 'harmful traditional' practitioners, because we think that their medicine has dangerous side effects. Second, they give a medicine whose dosage is unknown." These health extension workers tend to regard indigenous herbalists including this study's key informants as sorcerers. They label the practice of indigenous healing as 'primitive' and 'dangerous'. As an example, they argue that whenever mothers go to traditional birth attendants (TBAs) for delivery, both mothers and their babies get harmed. Due to this, health extension workers argue that, they teach the community about the harmfulness of 'traditional' healing. At the same time, they encourage people to go to biomedical centres. But, health extension workers say that, they teach such things to the other members of the community, not the herbalists. They are not daring to tell indigenous herbalists about the harmfulness of their medicine and healing, because they say that they fear indigenous herbalists, believing that these herbalists may cause a bad thing or harm on them. Indigenous herbalists are aware of the negative perception of health extension workers towards them. Indigenous herbalists have continued practicing their knowledge in such a hostile institutional environment, because people still come to them without any kind of advertisement or awareness work.

On the other hand, the perception of indigenous herbalists towards biomedicine and health extension workers is the opposite of what health extension workers have towards them. Indigenous herbalists recognize and appreciate the worthy of biomedicine. They themselves and their families go to biomedical centres for treatment when needed. At the same time, indigenous herbalists argue that, biomedicine has weaknesses, and, they know that their healing, besides standing in its own system, is vital in filling the gaps or short- comings of biomedicine. Indigenous herbalists understand that the existence of their healing as well as biomedical healing is important to provide the community healing options, and improve its health.

5.2 The Level and Nature of Interaction between the Indigenous and Biomedical Healing Systems

In the study sites, the level of interaction between the indigenous herbal healing system and the biomedical healing system is generally poor in any criteria. Both healing systems operate parallel, with very little cross- interaction and experience sharing. Medical practitioners of both

healing systems recognize the poor professional interaction they have one another, but each of them provide their own justifications for their poor interaction. Health extension workers say that they do not have professional interactions with indigenous herbalists, nor any kind of co-operation, because they think that indigenous medicine is not good; does not heal; it is harmful; etc. Health extension worker key informants from the health posts also present another reason for not working with indigenous herbalists. They say that, they fear to approach indigenous herbalists, because it is believed that indigenous herbalists hurt a person who offends them; and, health extension workers believe that indigenous herbalists think them as defying their names. Health extension workers also add a further justification for not working with indigenous herbalists. They claim that indigenous herbalists are concealed; keeping their medical knowledge and practice secret, claiming that if publicized, the medicines will be defiled, and another body will also take over their medical knowledge. Due to these obstacles, health extension workers say that, they do not have the interest and plan to work in co-operation with indigenous herbalists. Some of the justifications given by health extension workers for not working in co-operation with indigenous herbalists seem to be true. But, the biomedical centres in which health extension workers belong to, as an institution have never had any attempts to approach indigenous herbalists and try to understand the issues raised as obstacles from the ground.

On the side of indigenous herbalists, they present their own justifications for their poor professional interactions and lack of co-operation with health extension workers. Most of the justifications indigenous herbalists provide are what they argue as the wrong perceptions of health extension workers towards them which have been discussed in the previous sub section. Regarding this, the key informant says:

> *Health extension workers do not consult us. By labelling our medical knowledge and practice as harmful, they teach the community to abandon us and go rather to biomedical centres. They do not ask us 'what knowledge do you have? What illness do you treat?' Only contemning us! Except sometimes, when such kind of research is conducted, no government body intentionally comes and consults us. Government bodies, especially biomedical centres are ignorant of us (KIH-1, Mata, 25th February 2015).*

The other key informant says that health extension workers perceive indigenous healing as unworthy and harmful. He presents his argument as follows:

> *We do not work in co-operation with health extension workers in our locality. We do not have professional interactions. They (health extension workers) say 'let indigenous healing disappear'; whereas, we say 'let it survive.' We believe in and full heartedly use indigenous medicine; our families use it. But, health extension workers teach and mobilize the community no to use indigenous medicine. Whoever publicly speaks to the community saying, 'use indigenous medicine?' (KIH-2, Mata, 22nd February 2015).*

We can understand from the quotes of both indigenous herbalist key informants how much biomedicine is exerting a heavy pressure on indigenous herbal healing and herbalists, as well as on the community who has been accustomed in using indigenous medicine and healing. The powerful, state supported sector of biomedicine together with the notion of science and modernization is undermining and weakening the unsupported sector of indigenous healing. What is going on seems medical imperialism. However, it would be a mistake to suppose that there are no any interactions between the two healing systems. There are fewer interactions between the indigenous and the biomedical healing systems which are informal. But, the nature of the interaction is not two directional; rather it is inclined to one direction, i.e. from indigenous herbalists to health extension workers/biomedical centres. It is common that indigenous herbalists, when patients go to them, send patients to biomedical centres, so that they get diagnosed there. Then, patients either take the biomedically prescribed medicines, or resort back to indigenous herbalists with their diagnostic results. Health extension workers in the study sites are aware of this practice. The key informant (KIBW-1) says: "we do not refer patients and/or diseases to indigenous herbalists. But, we know that there are patients and/or diseases that indigenous herbalists refer to us. Nevertheless, patients, when they come to us, do not disclose as they had gone to indigenous herbalists." The above statement shows not only the one directional nature of the interaction between the two healing systems, but also how much the society is becoming disgusted and unconfident of going to indigenous herbalists and using indigenous medicine.

In general, while the nature of the interaction between the indigenous and the biomedical healing systems is informal and competitive, it has also some cooperative aspects especially on the former side.

5.3 The Dualistic Existence of the Indigenous and Biomedical Healing Systems

The healthcare belief and practice of the Shinasha is now composed of dual medical systems. If we put the popular healthcare practices aside at least for this analysis, and deal with the medical practices that have already established their own systems, we get the two major bodies of medical systems. These are the indigenous healing system and the biomedical healing system. The fact that I deal with the two healing systems does not mean that the popular healing activities are unimportant; they too are vital healthcare and healing mechanisms for the people of the Shinasha. But, for the sake of simplicity, and because popular healing practices are to some extent related with the indigenous healing system, I have chosen to discuss the dualistic existence of the indigenous and biomedical healing systems among the Shinasha.

5.3.1 The Attitude of the Community towards Medical Dualism

For many generations, the Shinasha have been dependent on their own indigenous systems for their healthcare and healing. The advent of biomedicine has changed this trend. According to all of the herbalist key informants and FGD discussants, the Shinasha use of biomedicine is relatively a recent phenomenon. But now, biomedicine has expanded and got the attention of people. As most of the Shinasha live in a warm lowland ecology, many tropical diseases among which malaria is the most common, have been causing troubles. Biomedicine is found to be efficient for controlling and treating malaria and other diseases and epidemics. Therefore, biomedicine undeniably helped to decrease morbidity and mortality and, significantly improved people's health. Still, the role of the indigenous healing system is unreplaceable, although some of its graces have been taken by biomedicine. People generally recognize and appreciate both the indigenous healing system and the biomedical healing system. But, as a fashion, many people nowadays tend to use biomedicine. However, the indigenous healing system is deeply rooted in the society; people also resort back to indigenous medicine and indigenous herbalists for many illnesses of all etiology. Illness experiences of the different etiologies make the society to be critical of the dualistic existence of healthcare systems, rather than perceiving the one healthcare system as essentially better than the other. There are occasions that even biomedical workers[8] themselves as well as their families go to indigenous herbalists and get treated by indigenous herbal medicine. A sick person wishes to have options of treatment. In general, the Shinasha look

[8] The health extension worker key informant (KIBW-1, Bakuji, 26th February 2015) told me that her young child had a severe amoebiasis case in which she could not be treated by biomedicine. The key informant say that, her young child was finally cured by indigenous herbal medicine which disappeared the amoebiasis

positively the dualistic existence of the indigenous and the biomedical healing systems in their locality. Their positive attitude is pragmatic, because the dualistic existence of the indigenous and the biomedical healing systems offer obvious options and benefits, as we shall see in the next sub section.

5.3.2 Advantages of Dualistic Medical Existence

Analysing and summing up the data collected through in- depth interviewing of key informants (both indigenous herbalists and health extension workers), informal interviews, FGDs, and systematic observation, the advantages of the dualistic existence of the indigenous and biomedical healing systems among the Shinasha are summarised as follows. The first and the fundamental advantage is regarding illness etiology and treatment options. As we have seen before, according to the medical belief and practice of the Shinasha, illnesses result from natural, supernatural, and personal origins. Biomedicine is effective in treating and controlling certain diseases of naturalistic etiology such as malaria. Indigenous medicine, in addition to effectively curing diseases of naturalistic etiology such as amoebiasis, is not only preferable but a resort for many of the folk illnesses (illnesses of personal and supernatural etiology). Biomedicine does not accept and cannot treat illnesses of personal and supernatural etiology. For instance, can biomedicine treat a person believed to be victim of evil eye? Certainly not. Likewise, indigenous herbalists have no training and modern equipments to diagnose internal body organs, what a biomedical specialist can easily do with the help of ultrasound and x-ray equipment. There are many other illnesses which indigenous herbalists treat but biomedicine cannot and vice versa. Whether illnesses come and invade people or people unintentionally get caught by illnesses, it is not the choice of people to be affected by whatever kind of illness. Therefore, whatever illness kind comes, the availability of several options of treatment is vital. Whether people seek treatment through indigenous healing or by biomedicine, the final goal is to do away with the problems and restore health. Therefore, the existence of both options of treatment is very important for the community.

The second advantage is physical accessibility. The availability of both indigenous herbalists and biomedical centres reduces the physical distance people travel to get treatment. People may go to the physically nearest treatment place, whether they go to indigenous herbalists or to biomedical centres. Indigenous herbalists are dispersed throughout the community and may be easily

available. Whereas, biomedical centres are planted at certain places, except for mobile vaccination programmes. This does not mean that indigenous herbalists are always more accessible than biomedical centres. Indeed, for people living in urban areas, it may be much more difficult to access an indigenous herbalist living in remote rural area than finding a biomedical centre.

The third advantage is reducing crowdedness by dispersing people to different places of treatment. Both the indigenous healing system and biomedical centres take their own share of people seeking treatment. This decreases crowd to either of the healing systems. Think of what it would look like if all people were seeking treatment from biomedical centres; or imagine if everyone would be going to the homes of indigenous herbalists for treatment. The existence of medical dualism reduces the over crowd and density of people on either side of the healing systems.

The fourth advantage is a matter of cost. According to the indigenous medical tradition of the Shinasha, people can get treatment in a minimum cost without compromising their basic needs. However, nowadays, there are conditions that the cost of biomedicine is better to escape the inflations of indigenous healing as a result of the commercialization of indigenous medicines.

Last but not least, the survival of the indigenous healing as a system is important for the maintenance of other herbal- magical and veterinary medicines, because the Shinasha herbalists are medical generalists.

5.3.3 Trends of Medical Dualism

The expansion of biomedical centres and biomedicine among the Shinasha has brought significant changes in the healthcare belief and practice of the community. The healthcare and healing systems of the people increased and took the form of dual character. In this regard, the advent of biomedicine brought important changes in the health of people. The problem is, as biomedicine expands and gets the attention of people, it is undermining and threatening the indigenous healing. Biomedicine is expanding at the expense of the indigenous healing system. Biomedicine is the cause of medical dualism as well as one of the factors undermining indigenous medicine and healing. Biomedicine has the support of the government. By policy it is the national healthcare system of Ethiopia. The indigenous healing, although it is developed

within the community, is based largely on the effort of individual practitioners/herbalists. It is not practically supported by the government in any aspect, even if the health policy of the country gives it recognition. What asset does the indigenous healing system has is its cultural acceptance among the community. But this is the time that globalization is subsuming local cultures and practices in to the Western culture. From the critical medical anthropology perspective/political economy of health, the threat of the Shinasha indigenous herbal healing system is part of this 'modernization' and 'Westernization' process. In line with Ethiopia's current condition of development, the Shinasha are now a developing society. Although the country is developing, it still is not adequately utilizing local cultural values including indigenous knowledge for its development. The country is experiencing economical and socio-cultural changes. The country's medical polit ics is in favour of biomedicine. The Shinasha are part of these national phenomena; they are undergoing economical and socio- cultural changes, and these changes include aspects of medicine and healthcare system. As a result of such global and national conditions, currently, biomedicine is heavily influencing the Shinasha indigenous healing system.

The community, although increasingly favouring biomedicine partly because of the contemporary political economy of health, do not want its indigenous healing disappear. Indigenous herbalist key informants and focus group discussants of all FGDs argue that the existence of the indigenous healing system is very important for them. The beliefs and practices of indigenous healing are part of their culture. Health extension workers are also members of the Shinasha community. They developed a negative perception of indigenous healing mainly because of the influence of their profession and, because as institutional workers they have to be loyal to the ideology of biomedicine. When coming to the real life phenomena, some of the health extension workers themselves and their families have had experiences of using indigenous medicine.

As discussed in the previous sub section, although the indigenous healing system and the biomedical healing system are operating dualistically among the Shinasha, the professional interaction and co-operation between the two healing systems is poor. Health extension workers in the health posts say that they do not bother about the work of the indigenous healing system

and indigenous herbalists. Well, indigenous herbalists loose nothing whether health extension workers bother about them or not, could they stop their discrimination against them.

6. Concluding Remarks

The study findings show that herbal medicinal knowledge and healing practice of the Shinasha is based entirely on and closely related with the culture of the people. Moreover, the study shows the extent to which medical systems, such as the Shinasha medical system, encompass wider aspects of the community. The findings also imply that in the current trend of globalization, to understand the indigenous health beliefs and practices of the community with pluralistic medical systems such as the Shinasha, there needs to assess the indigenous health beliefs and practices in relation to the other medical systems, especially in relation to biomedicine.

Although the dualistic existence of the indigenous and biomedical healing systems is not much appreciated and acknowledged by the latter side, on the ground, the dualistic existence of the two medical systems is found to be complementary and providing healing choices and options for the community. Although the indigenous healing system and the biomedical healing system are existing among the community dualistically, the existence is not in a win- win strategy. Biomedicine is dominating and undermining indigenous healing and indigenous herbalists. Therefore, if the medical trend continues like this, indigenous healing is most likely to be endangered, and probably, medical dualism may be only rhetorical of the Shinasha.

References

Abebe Anno[9]. 2012. *The Luba Basa Institution: The Challenge on Shinasha Identity?* Science, Technology and Arts Research Journal Article, Department of History and Heritage Management, College of *Social* Sciences, Wollega University.

Adane Kassie. 2014. *A History of Traditional Medicine in East Africa.* Innovare Journal of Social Sciences, Vol 2, Issue 4. Addis Ababa University.

Baer, H. 2001. *Biomedicine and Alternative Healing Systems in North America: Issues of Class, Ethnicity and Gender.* Madison: University of Wisconsin Press.

Balcha Abera. 2014. *Medicinal Plants Used in Traditional Medicine by Oromo People, Ghimbi District, Southwest Ethiopia.* Journal of Ethnobiology and Ethnomedicine. BioMed Central Journal.

Ballal, M., Salih, N., and Abdel, M. 2014. *Ethno-botany of Natural Forests of Nuba Mountains, South Kordofan State, Sudan.* Journal of Forest Products & Industries, Khartoum, Sudan.

Bhatia, H., Sharma, Y., Manhas, R, and Kumar, K. 2014. *Ethno Medicinal Plants Used by the Villagers of District Udhampur, J&K, India.* Journal of Ethno pharmacology 151 1005–1018, India.

Birgit, N. 1988. *Traditional Wisdom and Modern Development. A case Study of Traditional Peri-natal Knowledge among Elderly Women in Southern Shewa, Ethiopia.* Institute of International Education, University of Stockholm Akademitryck AB, Edsbruk and Taby.

Biruktayet Assefa, Gerhard Glatzel, and Christine Buchmann. 2010. *Ethnomedicinal Uses of Hagenia Abyssinica Among Rural Communities of Ethiopia.* Journal of Ethnobiology and Ethnomedicine:

Birx, J. 2011. *21st Century Anthropology A Reference Handbook Volume 1 and 2.* Sage Publications, New York.

Boro Shinasha Development Association Report. 2007.

Brown, H. 2014. *Material Proximities and Hotspots: Toward an Anthropology of Viral Hemorrhagic Fevers.* http://onlinelibrary.wiley.com/doi/10.1111/maq.12092/full. Medical Anthropology Quarterly published by Wiley Periodicals, Inc. on behalf of American Anthropological Association. Accessed: 30 May 2015.

Bulen *Woreda* Education Office Report. 2007.

Bulen *Woreda* Health Office Report. 2007.

Bulen *Woreda* Public Communication, Culture Tourism and Sport Office Report. 2007.

Chapin, A. 2011. *Medical Anthropology.* Medical Anthropology Quarterly, Vol 14 Issue 3. American Anthropological Association.

Claudia, S. 2008. *The Role of Indigenous Peoples in Biodiversity Conservation: The Natural but Often Forgotten Partners.* The World Bank, Washington, D.C.

Constitution of the Federal Democratic Republic of Ethiopia 21 August 1995. http://www.refworld.org/docid/3ae6b5a84.html. Accessed: 27 May 2015.

Cotton, C. 1996. *Ethno botany*: *Principles and Applications*. John Wiley and Sons Ltd. Chichester, England.

Diederichs, N. 2006. *Commercializing Medicinal Plants: A Southern African Guide*. Sun Press, Stellenbosch.

Dejene Teshome. 2014. *An Overview of the Role of Traditional Medicine in Ethiopia.* Andhra University, India. http://www.abhinavjournal.com, downloaded 5 January, 2015.

Ember, C. and Ember, M. 2004. *Health and Illness in the World's Cultures: Encyclopedia of Medical Anthropology.* Kluwer Acadamic / Prenum Publishers, New York.

[9] I put first name, followed by father name for Ethiopian authors, and second name for non Ethiopian authors.

Etana Tolasa. 2007. *Use and Conservation of Traditional Medicinal Plants by Indigenous People in Gimbi Woreda, Western Wellega.* Unpublished Thesis Submitted to the School of Graduate Studies, Addis Ababa University in Partial Fulfilment of the Requirements for the Degree of Master of Biology in Botanical Science, Addis Ababa.

Ethiopian Mapping Agency (2009), Map of Benishangul Gumuz Regional State.

Ethiopian Institution of Food and Nutrition Research. 2005.

Fabrega, H. 1990. *An Ethnomedical Perspective of Medical Ethics.* The Journal of Medicine and Philosophy, Kluwer Acadamic Publishers, Netherlnds.

Farmer, P. 2003. *Pathologies of Power, Health, Human Rights, and the New War on the Poor*. University of California Press Berkley, Los Angeles, London.

Getachew Addis. 2002. *Perceptions and Practices of Modern and Traditional Health Practitioners about Traditional Medicine in Shirka District, Arsi Zone.* Ethiopian Journal of Health Development, 16(1).

Gidey Yirga. 2010. *Assessment of Traditional Medicinal Plants in Endrta District, South-eastern Tigray, Northern Ethiopia.* African Journal of Plant Science Vol. 4.

Good, B. 1994. *Medicine, Rationality, and Experience. An Anthropological Perspective.* Cambridge University Press.

Gray, D. 2004. *Doing Research in the Real World.* SAGE Publications Ltd, London.

Hammond, L. 1994. *The Need for Integrating Indigenous and Biomedical Healthcare Systems: Case Study from Ada Bai Returnee Settlement.* For the UN Emergencies Unit for Ethiopia.

Hoareau, L. and DaSilva, E. 1999. *Medicinal plants: A re-emerging Health Aid.* Universidad Católica de Valparaíso, Chile

Howard, W. 1986. *Micropolitics of Medicine: Theoretical Issues. Medical Anthropology.* Quarterly Article first published online American Anthropological Association. 13 APR 2011 DOI: 10.1111/j.1937-6219.1986.tb01059. Accessed: 29 May 2015.

Kebede Kassaye, Amberbir A., Getachew B., & Mussema Y. 2006. *A historical Overview of Traditional Medicine Practices and Policy in Ethiopia.* The Ethiopian Journal of Health Development, 20 (2). Addis Ababa, Ethiopia.

Kleinman, A. 1978. *Concepts and a Model for the Comparisons of Medical Systems as Cultural Systems.* In Soc. and Med. 12: 85- 93, Pergamon Press Ltd, UK

Kleinman, A. 1980. *Patients and Healers in the Context of Culture*. Berkeley: University of California Press.

Kleinman, A. 1988. *Social Origins of Distress and Disease: Depression, Neurasthenia, and Pain in Modern China*. New Haven, CT. Yale Univ. Press.

Konadu, K. 2007. *Indigenous Medicine and African Society.* New York & London. Routledge.

Leigh, E. 2014. *Definition of Medical Anthropology.* University of California.

Lock, M. and Scheper- Hughes, N. 1990. *A critical- interpretive Approach in Medical Anthropology: Rituals and Routines of Discipline and Dissent.* In T.M. Johnson and C. Sargent (Eds.), Medical Anthropology: A Handbook of Theory and Method. New York, Greenwood Press.

Mamush Gudeta. 2011. *Use and Conservation of Traditional Medicinal Plants by Boro-Shinashas in Bullen District.* A senior Essay in Partial Fulfilment for the Requirement of Bachelor Science (B.sc) Degree in Heritage Conservation, Department of Heritage Conservation, Mekelle University, unpublished work.

Martin, G. 1995. *Ethnobotany*: *A Method Manual.* Chapman and Hall, London.

_____. 2013. *Medical Pluralism in Addis Ababa.*

Metekel Zone Administration Council. 2014.

Ministry of Health (MoH). 1995. *Health Sector Strategy.* Ministry of Health, Ethiopia, Addis Ababa. Ethiopia.

Mirutse Giday, Tilahun Tekelehaymanot, Abebe Animut, and Yalemtsehay Mekonen. 2007. *Medicinal Plants of the Shinasha, Agew-Awi and Amhara Peoples of Northwest Ethiopia.* Aklilu Lemma Institute of Pathobiology, Journal of Ethno-pharmacology.

Morgan, L. 2009. *Dependency Theory in the Political Economy of Health: An Anthropological Critique.* Department of Anthropology, University of California, Berkeley.
National Census Population and Housing Report. 2008. Benishangul Gumuz Region Report.
National Census Population and Housing Report. 2008. Bullen *Woreda* Reprt.
National Census Population and Housing Report. 2008. Metekel Zone Report.
Nazrul, I. 2005. *Pluralism, Parallel Medical Practices and the Question of Tension: the Philippines Experience.* Department of Sociology, University of Hong Kong.
Nichter, M. and Lock, M. 2004. *New Horizons in Medical Anthropology, Essays in Honour of Charles Leslie.* Tylor and Francies e- Library, Routledge.
Ochwang, D., Kimwele, C., Oduma, J., Gathumbi, P., Kiama M. 2013. *Medicinal Plants Used in Treatment and Management of Cancer in Kakamega County, Kenya.* Journal of Ethnopharmacology Department of Veterinary Anatomy and Physiology, University of Nairobi.
Norman, S. 1963. *Medical Anthropology.* Harvard School of Public Health. http://www.jstor.org/stable/2949170. Accessed: 28/05/2015.
Pankhurst , R. 2005. *Traditional Ethiopian Knowledge of Medicine and Surgery; An introduction to Sources; Indigenous Knowledge Systems in Ethiopia.* Proceedings of the First National Workshop of the Ethiopia Chapter of OSSREA, Addis Ababa.
Pawluch, D., Shaffi, W., and Miall, C. 2005. *Doing Ethnography: Studying Everyday Life.* Canadian Scholars' Press Inc. Canada.
Purcell, W. 1998. *Indigenous Knowledge and Applied Anthropology: Questions of Definition & Directions.* Human Organization, 57 (3): 258-272.
Raskin, D. 2007. *Out of Africa: A Tale of Gorillas, Heart Disease... and a Swamp Plant*, BioScience. Kampala, Uganda.
Russel, B. 2006. *Research Methods in Anthropology, Qualitative and Quantitative Approaches.* Fourth edition. AltaMira press, UK.
Scheper- Hughes, N. and Lock, M. 1987. *The Mindful Body*: *A prolegomenon to Future Work in Medical Anthropology.* Medical Anthropology Quarterly, 1, 6- 41.
Singer, M. and Baer, H. 1995. *Critical Medical Anthropology*. Amityville, New York: Baywood Publishing Company, Inc.
Solomon Getahun and Asssefa Balcha. 2005. *Indigenous Healing Practices in Ethiopia. I ndigenous Knowledge Systems in Ethiopia.* Proceedings of the First National Workshop of the Ethiopia Chapter of OSSREA, Addis Ababa.
Strasser, B. 2014. *Biomedicine: Meanings, assumptions and Possible Futures*. University of Geneva and Yale University.
Sulik, G. 2009. *Managing Biomedical Uncertainity: the Technoscientific Illness Identity.* Sociology of Health and Illness, Vol 30, No. 7. Blackwell Publishing Ltd.
Tebaber Chanie. 2015. *Indigenous Medicine: Cultural and Environmental Values of Medicinal Plants among the Konso People in Southwestern Ethiopia.* Unpublished Dissertation Submitted to the Department of Social Anthropology, Addis Ababa University.
Teferi Flate, Teferi Gedif, Kaleb Asres, and Tsigie Gebre Mariam. 2009. *Ethnomedical Survey of Berta Ethnic Group, Assosa zone, Benishangul Gumuz Regional State, MidWest Ethiopia*. Journal of Ethnobiology and Ethnomedicine, Addis Ababa.
Tilburt, J. and Kaptchuk, T. 2014. *Herbal Medicine Research and Global Health: An Ethical Analysis.* Bulletin of the World Health Organization.
Tsega Endalew. 2004. *Luba Basa and Harma Hodha: Traditional Mechanisms of Conflict Resolution in Metekkel, Ethiopia.* Asien-Afrika-Institut, Universität Hamburg, Germany.
World Health Organization. 2000. *General Guidelines for Methodologies on Research and Evaluation of Traditional Medicines.* Essential Medicines and Health Products Information Portal, Geneva.
World Health Organization. 2014. *Herbal Medicines Research and Global Health: An Ethical Analysis.* Bulletin of the World Health Organization.

World Health Organization. 2000. *International Classification of Disease: Clinical Modification.* 5th, Millennium edition U.S Department of Health and Human Services.

World Health Organization. 2001. *Legal Status of Traditional Medicine and Complementary and Alternative Medicine.* A World Wide Review. Geneva.

World Health Organization. 2011. *The World Medicines Situation and Traditional Medicines: Global Situation, Issues and Challenges.* Geneva.

World Health Organization. 2002. *Traditional Medicine Strategy 2002- 2005.* Geneva.

World Health Organization. 2013. *Traditional Medicine Strategy 2014- 2023.* Geneva.

Young, A. 1983. *The Relevance of Traditional Medicinal Cultures to Modern Primary Health-care. Social Science and Medicine*. US National Library of Medicine, National Institute of Health.

Zelalem Leyew. 2011. *Wild Plant Nomenclature and Traditional Botanical Knowledge among Three Ethnolingiustic Groups in Northwestern Ethiopia.* Organization for Social Science Research in Eastern and Southern Africa (OSSREA), Addis Ababa.