ADDIS ABABA UNIVERSITY
COLLEGE OF SOCIAL SCIENCES
DEPARTMENT OF SOCIAL ANTHROPOLOGY

INDIGENOUS KNOWLEDGE OF HERBAL MEDICINE AND HEALING PRACTICE AMONG THE GAMO PEOPLE: THE CASE OF DORZE *DERE*, SOUTHERN ETHIOPIA

BY: WAGAYE WADE

Thesis Submitted to the School of Graduate Studies of Addis Ababa University in Partial Fulfillment of the Requirements for the Degree of Master of Art in Social Anthropology

November 2016

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This thesis entitled "Indigenous Knowledge of Herbal Medicine and Healing Practice among the Gamo People: The Case of Dorze *Dere*, Southern Ethiopia" is submitted by Wagaye Wade in fulfillment of the requirements for the Degree of Master of Art in Social Anthropology. The thesis complies with the regulations of the University and meets the accepted standards.

Approved by the Examining Committee:

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List of Acronyms

CSA	Central Statistics Agency
EMs	Explanatory models
FGDs	Focus Group Discussions
IHM	Indigenous Herbal Medicine
IK	Indigenous knowledge
KI	Key informant
KIBW	Key informant biomedical worker
KIC	Key informant from the community
KICTW	Key informant culture and tourism worker
KIH	Key informant herbalist
SNNPRS	Southern Nations, Nationalities and Peoples' Regional State
USD	United States Dollars
WHO	World Health Organization
WIPO	World Intellectual Property Organization

List of Glossary

Abasha dhale	A phrase equivalent to indigenous medicine
Ayle	Ex-slave
Buluko	A big white traditional clothes made by local weaver. Its end is res colored.
Dana	Local drink in Gamo prepared from barley and wheat
Degela	Marginalized social groups mainly engaged in tannery
Dere	Small autonomous political unit that survived until the incorporation of the Gamo highlands into the Ethiopian empire
Dhale	Drug
Gabba	Local name of cropping season ranging from February to July
Gadha	Equivalent to lowland from which the herbalists collect the medicinal plants
Geze	Equivalent to highland from which the herbalists collect the medicinal plants
Gome	Taboo, refers to transgression of traditional rules or *woga* in Gamo society
Hargge/Sako	A term equivalent to disease/illness in Dorze
Idir	A voluntary association in which members help each other when relative die
Ikub	A voluntary association of money saving with rotating credit.
Kumeth	Refers to fullness of local drink which is manifestation of good wish
Mala	Free citizens who are not tanners, potters and slaves.
Mana	Marginalized social groups mainly engaged in pottery
Shemppo	A term comparable to life
Shemppo asha	Local name given to herbalists among the Dorze, equivalent to life sever.
Silla	Local name of cropping season ranging from August to January
Xoossa	Local name of God

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Abstract

The oral nature of indigenous herbal medicinal knowledge and practice poses a challenge that the knowledge is at risk of extinction after some generations unless otherwise documented. The aim of the present study was to investigate and document the indigenous knowledge of herbal medicine and healing practice among the Gamo people in Dorze *dere*, southern Ethiopia. Secondary data were reviewed for conceptual framework. The primary data were gathered through in-depth interview, focus group discussion and observation. Fieldwork was conducted between February and March, 2016. The data were thematically organized and analyzed through systematic interpretation. The findings of this study revealed that herbal medicinal practitioners in Dorze were both males and females. The indigenous knowledge is acquired either from the herbalist parent or from other places by providing gifts. The knowledge is transferred through orally either to the family members or trusted person that heir herbal medicinal knowledge based on good personality and dedication to serve the community. Medicinal plant collection, drug preparation, preservation, and prescription are directed by the local culture in which the efficacy of medicines is believed to be the result of the natural content of the plants. The herbal medicine and healing is broad in scope in the study area which is practiced for healthcare and healing for illnesses of natural, supernatural, and personal etiology. Both the indigenous herbal medicine and the biomedical healing systems exist together and shifts from one healthcare option to the other and resorts are common among the community. There was no interaction between herbalists and the biomedical workers. In general, indigenous herbal medicine in Dorze occupies major place as part of their cultural beliefs and practices.

Keywords/phrases: Dorze, Gamo people, healing, indigenous herbal medicine, indigenous knowledge

Chapter One

1. Introduction

1.1. Background

Anthropology has included research regarding health and diseases from its earliest days. However, it was systematized into the area of specialization known as "medical anthropology" only within the past thirty seven years (Ember and Ember, 2004: 3). As a result, during the last three decades, anthropologists have increasingly turned their attention towards the problems of health and diseases of the people they studied. This sub-discipline is engaged in carrying out research in the field of health and its abuse, definition of health and diseases, ethno medicine, ethno physiology, doctor-patient relationship, preventive medicine (Guruprasad *et al.*, 2013).

According to Ember and Ember (2004: 10), medical anthropology can be defined as "a branch of anthropology that studies all aspects of health-related phenomena (health, illness, and health care); considers cultural systems as well as the effects of local and worldwide social and political environments". It can also be defined as "the branch of anthropological research studying the factors that cause, maintain or contribute to disease or illness and the strategies and practices that different human communities have developed in order to respond to disease and illness" (Singer and Susser, 1997: 5). It represents the general conceptual frame of ethno-medical studies (Barnard and Spencer, 2002: 540). So, medical anthropology is generally understood as the study of social and cultural dimensions of health, ill health and medicine.

Medical anthropologists generally see “illness” as a culturally structured, personal experience of being unwell which entails the experience of suffering. Disease, on the other hand, is a clinically measurable lesion or anatomical or physiological irregularity. Both illness and disease spur people to seek medical treatment. The main goal of most people seeking medical treatment is to have their suffering removed (Ember and Ember, 2004: 3). Although, how societies view health and the therapeutic techniques to deal with illness vary considerably from one society to another (Howard, 1986: 388), the use of herbal medicines as effective remedies for the prevention and treatment of multiple health conditions by almost every known culture for centuries.

Herbal medicine is a natural remedy derived from herbs to treat sickness (Falodun, 2010). Historically, many herbs have been used to provide human medicines for diseases that challenge people. Although Western medical practices seem to have questioned or even denied the efficacy of many indigenous herbal medicines (IHM), plants undoubtedly continue to play a key role in the well-being of indigenous communities. The World Health Organization (WHO) estimated that one quarter of all medical prescriptions are based on plant derivatives or plant-derived synthetic derivatives and 80% of the world‘s population continue to rely on medicines derived from herbs (WHO, 2013). Thus, despite the dramatic advances of conventional medicine, it is clear that herbal medicine continues to possess a high level of significance in many social settings.

Several species of plants are used in the indigenous health care system to treat numerous mental and physical disorders in Ethiopia. The wide spread use of indigenous medicine both in urban and rural population in Ethiopia could be attributed to cultural acceptability, efficacy against certain type of diseases, physical accessibility and economic affordability as compared to modern medicine. Ethiopian indigenous medical system is characterized by variation and is shaped by the ecological diversities of the country, socio-cultural background of the different ethnic groups as well as historical developments, which are related to migration, introduction of foreign culture and religion (Dawit and Ahadu, 1993; Vecchiato, 1993).

1.2. Statement of the Problem

Ethiopia has a long history of indigenous medical practices and healing systems. The country is very rich in IHM and medical practices because of diversified cultures and ecological zones. The Gamo people in Dorze *dere* of Chencha *woreda* to which this study concerns have an experience and practice of IHM as it is in other parts of the country. However, the oral nature of indigenous herbal medicinal knowledge and practice poses a challenge that the knowledge is at risk of extinction after some generations unless otherwise documented. In addition, the limited indigenous knowledge on usage of medicinal plants are getting lost due to rural-urban migration, marginalization due to the introduction of modern medicine, loss of natural habitats and changes in life style (Tilahun and Mirutse, 2007). This makes study of indigenous knowledge of herbal medicine essential in Ethiopia in general and among the Gamo people in particular.

Although there have been some organized ethno-botanical and ethno-medicinal studies conducted in Ethiopia (Gidey *et al.*, 2011; Matthew *et al.*, 2013; Balcha, 2014; Petros *et al.*, 2014), no attempt has been made to collect and preserve the indigenous knowledge of herbal medicinal practices in Gamo area. Therefore, in view of these, documentation of the indigenous uses of medicinal plants is an urgent matter and important to preserve the knowledge. This study is intended to do this accomplishments focusing on the following questions.

- ✓ How does indigenous knowledge of herbal medicine transferred from generation to generation?
- ✓ How do the indigenous herbalists prepare, preserve, prescribe and administer the drugs.
- ✓ What are the major diseases that the herbalists treat and how do they heal by using herbs?
- ✓ How is the interaction between the herbalists and the biomedical health professionals?

1.3. Objectives of the Study

1.3.1. General Objective

- ❖ To investigate, analyze, and describe the indigenous knowledge of herbal medicine and healing practice among the Gamo people in Dorze *dere* of Chencha *woreda*[1], Southern Ethiopia.

[1] *Woreda* is an Amharic term, which represents the Ethiopian government administrative body below Zonal administration, equivalent to district.

1.3.2. Specific Objectives

- To describe the indigenous herbal medicinal knowledge acquisition and transfer in Dorze.
- To describe medicinal plant collection, drug preparation and healing system in the study area.
- To explain the interplay between the herbalists and the biomedical health professionals.

1.4. Research Methods and Data Sources

1.4.1. Study Design

In research, there are two types of research methods, namely: quantitative and qualitative approaches. The quantitative is a positivist approach whereas the qualitative is an interpretative approach. Most of the time, anthropologists prefer to use qualitative methodology so as to get detail and reliable data from their study participants (Bernard, 2006: 24). Therefore, to do this, they go out and stay in the field to collect the data; they stay in the field to make second socialization with the study community; they watch and listen, they take notes, bring it to home, and thematically organize and analyze data. Hence, I have chosen qualitative methodology in order to explore the views, perspectives, beliefs and practices of study participants. I also employed an ethnographic approach which requires extended fieldwork and a carful observation and interaction among members of the study community.

1.4.2. Study Participants

The study participants were the Gamo people living in the Dorze *dere* of Chencha *woreda*, Gamo Gofa Zone. Particularly, the participants were herbalists who are engaged in IHM and the healing system, clients or patients, health professionals, culture and truism officers, *kebele*[2] leader, and selected community members. Elders and youngsters from both sexes who are living in Dorze *dere* were included based on the sampling techniques described below.

1.4.3. Sampling techniques

Key informants (KI) were herbalists, individuals from the community, workers in biomedical health center, and the culture and tourism office (see the profiles of the KI in Annex II). The herbalists were identified based on the information obtained from *kebele* leaders. Clients or patients who visit the herbalist for medication were included. The focus group discussants were herbalists, selected individuals from the community, biomedical health center workers, and the culture and tourism office. The community members were selected using snowball sampling method. This technique relies on referrals from initial subjects to generate additional subjects. In snowball sampling, the researcher was starting the sampling process by contacting a few individuals for inclusion in the sample. This people have been then asked for names of additional people who might be willing to be part of the research project. The process was used to select the local community until satisfactory information was obtained (Ruane 2005: 117).

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[2] *Kebele* is an Amharic term that refers the lower level of administration unit in Ethiopia.

A total of 34 individuals: 7 local herbalists and 27 selected study participants who are residing and working in the study area were included. I had chosen 34 informants by considering the resource available to conduct this study. Four of the participants were the clients/patients and 10 were local elder and youngster who reside in Dorze. Other participants were 8 biomedical health workers and 5 culture and tourism officers. The participants were selected based on age, profession, experience, social status, sex and acceptance among the society.

1.4.4. Data Collection Methods

1.4.4.1. In-Depth Interview

The first method used to collect primary data in this study was in-depth interview. The method was employed to collect data from local herbalists' who were experienced in IHM. I conducted these interviews with the key informant herbalists (KIH) and their clients. I have also interviewed the key informants from the community (KIC), the key informant biomedical worker (KIBW) and key informant culture and tourism worker (KICTW) (Annex II). The interview was conducted in Amharic and Gamo language (Gamogna) depending on the preference and ability of the participant. The interview was conducted on face-to face basis in order to prove more about the issue and observe the reaction of the participants over certain issues under interview.

Interview is a very important tool to dig out detailed information of once perception, experience and impression about certain issues (Dawson 2002: 13). Therefore, the interview guide questioners were developed based on the findings of the preliminary interviews with the herbalists (Annex I). Through this method, I collected data in relation to herbal medicine and healing system, and the interaction between indigenous herbalist and health professionals. The interviews were recorded except under a few instances when the informants express their inconvenience with the recording. I took notes of their responses on my notebook under such conditions.

1.4.4.2. Observation

Observation is not simply a question of looking; rather, it is a complex combination of sensation and perception (Gray, 2004: 238). It helps the researcher to yield information which people are in general unwilling or unable to provide and helpful to discover complex interactions in natural social settings (Russel, 2006). Data gathered through observation is also valuable in determining whom to recruit as study participant and how best to recruit them (Mack *et al* 2005: 16). It is one of the appropriate methods to gather valuable information in anthropological studies. Thus, observation is used as instrument of data gathering.

This method was chosen because data pertaining to some aspects of herbal healing could be extracted better through careful observation. I observed some of the herbalist practices such as disease identification, dosage determination and drug prescription. Data obtained through this method helped me to cross- check the validity of data gained through interview. I also observed the interaction between the herbalist and clients in terms of healing practice. However, my observation was limited to the extent of the mentioned practices and interactions because in most cases the drugs were pre-prepared secretly and the healers were not willing to show details.

1.4.4.3. Focus Group Discussion

Focus group discussion (FGD) was also used to collect the primary data. The reason behind undertaking FGD is due to its importance "in the elicitation of wide variety of different views in relation to a particular issue" (Bryman 2004: 348). According to Bryman (2004), conducting FGD help the researcher to develop an understanding about why people think the way they do. In addition, members of the focus group will bring ideas forward and the interactions found in group dynamics are closer to the real life process of "sense making" and acquiring understanding (Bryman 2004). Moreover, it is essential to substantiate the data obtained through other techniques.

I faced two challenges in implementing FGDs in this research. One was the herbalists were far apart from each another to avail themselves for discussion in groups. Secondly, the inhabitants were too busy as the research was conducted during the harvesting season. With this challenge in mind, I organized the discussion for herbalists at one of the herbalist's compound where other herbalists were relatively nearby. The discussion with community elders was held around their compound as they were gathered during the dusk. Similar session was organized with youngsters while they were harvesting the wheat near to the village. The FGD of biomedical workers, and the culture and tourism officers was conducted at the office without any challenge.

I had organized five FGDs. These were FGD-1 (Culture and tourism workers), FGD-2 (Biomedical health workers), FGD-3 (Community elders), FGD-4 (Community youngsters) and FGD-5 (herbalists) (see the profiles of the discussants in Annex III).

Participants/members of each FGD consists individuals of both sexes and different age groups of similar background.

1.4.5. Sources of Secondary Data

According to Kothari (2004: 113) the secondary data source can be obtained from publications of the central or local state governments, publications of foreign governments or international bodies and their subsidiary organizations, technical and trade journals, books, magazines and newspapers, reports and other published sources. To reveal the contribution of IHM, I reviewed those related secondary sources. In the process, I attempted to define key terms and give emphasis to the literature on the ideas of health and illness. In addition, the ideas from secondary sources served for conceptual framework and indicated the gap for further research in the context of Ethiopia.

1.4.6. Data Analysis

The data obtained through the above techniques were analyzed qualitatively to answer the research questions. The responses of key informants and focus group discussion were transcribed carefully. My skill of local language was helped me in the process of transcription. Before the actual analysis, the collected data were sorted and categorized in accordance to their source and type. The collected data were transcribed, compiled and further elaborated into meaningful and patterned information soon after the completion of that particular data collection session. Finally, the whole data were analyzed in a thematically organized way by pursuing to the original descriptions of the fieldnote so as to infer meanings and arrive at conclusions. The themes were discussed with respect of literature and the research finding.

1.4.7. Ethical Consideration

Ethical consideration of the study participants and the host community is obvious and mandatory. Therefore, I had conducted this study keeping all ethical standards of a research. The study was reviewed and approved by Department of Social Anthropology, Addis Ababa University. Permission was obtained from zonal and *woreda* administration. I had built rapport, consider and respect the rules and norms of the study community so as to avoid suspicion. The selection of study participants was based on their consent after clearly informing them their right to withdraw if they feel discomfort. During report writing, I refrained myself from using derogative terminologies and ethnocentrism. The photographs of the study participants who gave consent were disclosed in this paper. Otherwise, confidentiality was kept for others.

1.5. Significance and Scope of the Study

The findings of this study provided a brief, reliable and up-to-date account on the role of IHM in healing various illnesses in the study area. In addition, it gave useful information on other social, cultural, and economic practices of the society at large. Since there is lack of professional writings on IHM and healing system among Gamo people, the current study is believed to contribute at least few of those indigent areas of the issue through provoking those potential researchers and providing them with basic and preliminary information on subject under study. The study could also serve as a valuable reference document as an input for policy makers.

The study was delimited to the investigation of the indigenous knowledge of herbal medicine and the healing system among Gamo people focusing on Dorze *dere* which is located in Chencha *woreda*. The study focused on both dichronic and synchronic aspect to see the dynamism through time on indigenous knowledge of herbal medicine and the healing practice.

1.6. Limitation of the Study

To begin with the issue of language as most researchers did, there was no language barrier between me and the study community. However, there might be slight difference that may affect exact translation of words. Besides, there were some factors that might challenge the fieldwork and data collection. Some of these are: infrastructural problem and time constraint among others.

1.7. Fieldwork Experience

As most anthropologists did, I have travelled from Addis Ababa to Chencha *woreda* of southern Ethiopia for this research. After preparing myself for fieldwork, I started the journey from Addis to Arba Minch, and then to Chencha *woreda*. I have travelled about 520 kms. During my field stay, I was hosted at the house of my field assistance from February 10 to March 25, 2016. The study area, Dorze, is near to my birth place, Ochollo. My skill of local language helped me during data collection and transcription. I have built rapport with my study participants to avoid suspicion.

In this research I faced the following challenges during the fieldwork. First, since the research was conducted during the harvesting season, the herbalists and the community dwellers were busy. As a result I was obligated to go up to their farmland. Second, according to the herbalists, patients/clients come their home at midnight or early in the morning; as a result I could found few clients when treated by herbalists. But I have contacted and interviewed the healed individuals.

I never forget the response Mr. Akalu[3] (pseudo name of KIH-3) for the question that I asked, how do you know the type of the illness? He said that "I differentiate the type of the illness by observing signs and symptoms, using biomedical clinical data, or I let the patient to smell the drug of some illness". For instance he said, and asked me to smell one of drugs. Following my smelling and lack of symptom, he said "you are free from evil eye". But I was tensioned until I depart.

I realized that fieldwork has its own challenges because it needs energy time and money. Since the topography of the study area is full of ups and downs, it needs energy. On the other hand, fieldwork research enables the researcher to make second socialization with the study community.

The other challenge was I have a kid who was one years old when I started my fieldwork. I left him in Addis Ababa with his father. In the field I was always thinking about him and calling frequently to check his status. Above all, I have completed my fieldwork successfully. So, it gives me pleasure to see the final thesis.

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[3] Mr. Akalu is the pseudo name of the KIH-3 and, hereafter, the sources of KIH-3 data are cited by this name. For more information, see annex II.

1.8. Organization of the Thesis

This thesis is organized into seven chapters. The first chapter deals with background of the study, statement of the problem, objectives of the study, research methodology and data collection tools and procedures. The second chapter is about the literature pertinent to the research topic and conceptual framework. It also presents empirical studies in the context of Ethiopia. The third gives brief and general information about the study area and the community understudy.

The fourth chapter discusses the main findings in relation to indigenous knowledge of herbal medicine among the Dorze people. It describes the processes of knowledge acquisition and transfer, herbal medicinal knowledge sharing, interaction of herbalists with the patients and community. The fifth chapter deals with the process and practice of healing system. It gives due attention to the medicinal plant identification and collection, drug preparation, preservation, illness identification, prescription and the cultural ethics of healing. Chapter sixth discusses the health care alternatives and factors influencing decision-making and health seeking behavior of the people. It also explains the interaction between the herbalists and the health workers; and the perception that indigenous herbalists and biomedical workers have towards one another's healing systems; and the attitude of the community towards the dualistic existence of health systems. The last chapter presents the conclusion and summary of the work.

Chapter Two

2. Review of Literature and Conceptual Framework

This section reviews the existing literatures related to the research question under study. It begins with explaining the conceptual framework of indigenous knowledge and herbal medicine. It presents a brief account on the different types of health care system and major theoretical schools of thought in medical anthropology. At the end, the empirical studies related to herbal medicine are reviewed.

2.1. Definition of Key Terms and Concepts

2.1.1. Indigenous Knowledge

The literature on indigenous knowledge (IK) does not provide a single definition of the concept. This is in part due to the differences in background and perspectives of the authors, ranging from social anthropology to agricultural engineering. Nevertheless, the various definitions also have some common traits. According to Warren (1991) the concept IK is the local knowledge that is unique to a given culture or society. IK contrasts with the international knowledge system generated by universities, research institutions and private firms. It is the basis for local-level decision making in agriculture, health care, food preparation, education, natural-resource management, and a host of other activities in rural communities (Warren, 1991). Barua also described IK as “Neither static nor frozen. Rather it is socially dynamic and culturally appropriate as it practiced in the local environment” (Barua, 2009: 63).

According to Maurial (1999), IK is the people‘s cognitive and wise legacy. He further categorizes IK into three bases: First, IK is a result of the everyday interactions among indigenous families and communities. This knowledge is immersed in the whole culture and it is recreated through generations in the daily oral stories, symbols, songs, riddles, and sayings constructed in local languages to reflect their daily agrarian work in the land, the curative powers of their local plants as well as the celebration of special events. The most important thing about IK is that it is alive in indigenous peoples‘culture, but the distinction between indigenous and western knowledge is that IK is neither archived nor stored in the laboratories and is not separated from political and everyday life of the indigenous people. The implication of this is that it makes indigenous people the actors of their own knowledge and not passive repositories of a knowledge that is separated from their everyday life (Maurial, 1999).

Secondly, IK is holistic in the sense that ideas and practices are one. There is no division among-disciplines of knowledge. What Western knowledge may call *Religion, Law, Economics,* and *Arts* are united within a whole entity of worldview. This is expressed through oral and written tradition especially through indigenous peoples‘ mythical narrations and symbolic works. Such exposition presents local people as theorists of their lived experience. Unlike Western classroom, where theorizing of live experience remains the privilege of those in the academia, the IK is rooted and grounded in the local people‘s everyday practices. The local people theorize through their daily interaction with one another. This is why IK is experientially based and relies on the subjective experience and the inner workings of the self to make sense and meanings to social interactions. Thus, IK is holistic and relational (Maurial, 1999).

Finally, IK, according to Maurial (1999), is transmitted through oral tradition in societies that are agrapha. By definition, agrapha are a word used in Hispanic Anthropology to refer to societies that did not invent or incorporate originally written expressions in their culture. These societies maintained a complex oral tradition repeated daily from parents to children and elders to youngsters. Through oral tradition, indigenous people transmit their holistic culture through proverbs, songs, riddles, storytelling, fables, myths and health practices to foster a relationship among themselves, and between themselves and nature (Maurial, 1999). In this study, I have used definition of Warren (1991) as operational definition because it is more comprehensive.

Due to European colonization, many cultural believes, the living style of African people such as social, economic, cultural, political, ecological, spiritual aspects were degraded and marginalized IK in Africa. Consequently, the importance of IK in Africa was overlooked and its recognition was impeded because of problems related with poverty, economy and lack of education (Kapoor and Shizha, 2010: 4).

Recognizing indigenous forms of creativity and innovation as protectable intellectual property is essential to protect indigenous medicines and biodiversity-related knowledge against misappropriation, and enable indigenous peoples and local communities to control and benefit collectively from their commercial abuse. Two types of intellectual property protection are being sought. The first is defensive protection that aims to stop people outside the community from illegally acquiring intellectual property rights over IK. The second is positive protection which granting of rights that empowers communities to promote their IK, control its use and benefit from its commercial exploitation. So, certification in both types may play a role (WIPO, 2012).

2.1.2. Herbal Medicine

According to WHO, herbal medicine is defined as "plant derived material or preparations with therapeutic or other human health benefits, which contain either raw or processed ingredients from one or more plants" (WHO, 2005: 1). It is also referred to as plant medicines, phytomedicines, green medicines, plant drugs and forest health products among others (Osemene, 2011). The parts of plants that are used for medical purposes include leaves, roots, flowers, seeds, resin, root, bark, inner bark (cambium), berries or other portions of the plant (WHO, 2004: 4). Herbal medicines have been widely utilized as effective remedies for the prevention and treatment of multiple health conditions for centuries by almost every known culture. Plants have been used for medicinal purposes since time immemorial. The first documented records of herbal medicine use date back 5,000 years in China. Similarly, India's Ayurvedic medicine tradition is thought to be more than 5,000 years old and herbal medicines remain an essential component of its practice (Garodia *et al.*, 2007). Today, certain countries including Ethiopia still depend on herbal medicines to address their healthcare needs.

Most herbalists (refers to a specialist skilled in the knowledge of medicinal plants) had supernatural revelations on the type of plants and their therapeutic components. Due to the growing demands by the conventional medicine, herbal medicine has taken a new level where scientific analysis is introduced to improve the healing capacities of these plant medicines. Herbal Medicine as used in this proposal, simply refers to medicines that are purely derived from plants either scientifically analyzed or not but in contrast with conventional medicine.

Taking the above mentioned conceptions of IK and herbal medicine into consideration, IK of herbal medicine thus, refers to the knowledge pertaining to the identification, preparation, extraction and administration of herbal medicines for the purpose of preventing and treating disease/illness and various abnormalities of physical, mental as well as social forms (Solomon and Assefa, 2005: 15).

2.1.3. Healing System

Healing is a complex process that starts with a patient's experience of something being wrong and proceeds to some form of diagnosis and then possibly treatment. Cultural ideas and practices are fundamental in the healing process and societies vary enormously in the ways that the healing process proceeds (Ember and Ember, 2004). Indigenous healing is an ancient, intact, complex holistic healthcare system practiced by indigenous people worldwide that is profound and more deeply rooted and complex than is commonly understood (Struthers *et al.*, 2004). Even though the same beliefs related to healing are held, the methods of diagnosis, methodology, and treatment vary greatly from society to society and from healer to healer; and may be simple or complex (Avery, 1991; Vogel, 1970 as cited in Struthers *et al.*, 2004). Herbalist-healers were the largest group of specialists who occupied the pre-biomedical medical setting.

2.2. Concept of Health, Disease and Illness

Illness and disease were the major factor which resulted sickness throughout the world. As a result diseases and illness were challenging those people who are economically poor. As the area of specialization, medical anthropologists turned their attention to understand the relationship between human health and their culture holistically. They consider all aspects of health related issues such as health, causes illness and disease, and strategies that different societies developed to solve health problems. Anthropologists generally see ‘health’ as a broad construct, consisting of physical, psychological, and social well- being, including role functionality (Ember and Ember, 2004: 3). Such a definition works much better cross-culturally than one that links health only to “disease” which, technically, means simply a clinically measurable lesion or anatomical or physiological irregularity. A supportive meaning is also developed by Baer. According to Baer, health is not merely the absence of disease and infirmity but complete physical, mental, and social well-being (Baer, 1997: 334).

Medical anthropologists differentiate between disease and illness. Disease is generally defined as a pathological or physiological disorder, infection or malfunction of the body. On the other hand, illness is the sufferer experience which is a culturally constructed concept of how people conceive of a particular physical state as being deviant from the normal state (Baer, 1997: 334). For Ember and Ember, disease is a clinically measurable lesion or anatomical or physiological irregularity, whereas illness (Ember and Ember, 2004: 3) is explained as:

> *“Illness” can refer to a variety of conditions cross-culturally. In some cultures, it is limited to somatic experiences; in others it includes mental dysfunction; in others it includes suffering due to misfortune, too. That is, some medical systems deal with human struggles related to love, work, finances, etc. Social, somatic, emotional, and cognitive troubles often are not separated at all but quite intertwined and even fused together.*

According to Foster 1998 as cited in Dejene 2013, the causation theory consist conception of health and the causes of disease and illness. He also distinguished the difference between personalistic and naturalistic system. The personalistic explanation of illness is a condition in which illness is purposefully caused by supernatural forces or by human beings like sorcery and witchcraft. On the other hand, naturalistic system explains disease causation in impersonal and more systematic terms (Dejene, 2013: 1).

2.3. Medical System and Pluralism

Medical pluralism can be defined as the use of more than one medical system or the use of both conventional and complementary and alternative medicine for health and illness (Wade *et al.*, 2008). Numerous medical anthropologists have articulated various methods that distinguish the occurrence of medical pluralism in complex societies. As cited in Ember and Ember (2004), Dunn (1976) delineates three types of medical systems: (1) local medical systems, (2) regional medical systems, and (3) the cosmopolitan medical system, based upon their cultural ecological settings. According to Dunn (1976) the three systems are stated as:

> *Local medical systems are folk or indigenous medical systems in foraging, horticultural or pastoral societies, or peasant communities in state societies. Regional medical systems are systems distributed over a relatively large area, such as Ayurveda and Unani medicine in India and Sri Lanka and traditional Chinese medicine. Cosmopolitan medicine refers to the world-wide system commonly referred to as Western medicine, regular medicine, allopathic medicine, scientific medicine, or biomedicine. Complex societies generally contain all three of these systems. In modern industrial or post-industrial societies, biomedicine, the dominant system, tends to exist in a competitive relationship with other systems such as chiropractic, naturopathy, Christian*

> *Science, evangelical faith healing, and various folk medical systems. It often seeks either to annihilate these systems or to restrict their scope of practice. In some instance, biomedicine seeks to absorb or co-opt them, particularly if the latter achieve increasing legitimacy.*

Although it is not easy to exactly discriminate between the three overlapping sectors in health care systems, scholars created a widely used model that delineates them. According to the scholars, the popular health care sector is mainly undertaken by the patient themselves or by their families members. In this sector different treatment options were used such as taking special diets, usage of medicinal herbs, doing some exercise, taking rest, bathing and massage. The folk sector, on the other hand, includes different healers who engaged in various curative activities. These include shamans, mediums, magicians, herbalists, bonesetters, and midwives. This subsector includes the practitioners and bureaucratic structures, such as clinics, hospitals, and associations, which are associated with both biomedicine and professionalized heterodox medical systems, such as Ayurvedic and Unani medicine in South Asia, herbalism and acupuncture in the People's Republic of China, and homeopathy, osteopathy, chiropractic, and naturopathy in Britain (Chrisman and Kleinman, 1983 as cited in Ember and Ember, 2004).

In Ethiopia, indigenous medicine was the exclusive source of health care for the majority of people until recently. It comprises knowledge systems that developed over generations within various societies before the era of modern medicine. The WHO defines indigenous medicine as "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 illness" (WHO, 2005: 1). Of the various systems, the use of herbs is a core part of all systems of indigenous medicine. In different literatures the term indigenous medicine is used interchangeably with terms like, 'traditional medicine', 'local medicine', and 'folk medicine'. So, I prefer to use the term indigenous medicine for convenient description.

Biomedicine is the dominant medical system in Western countries today with the bio part highlighting the biological emphasis of this professional medical system, particularly the focus on specific diseases and cures for those diseases. Natural causes such as germs are reflected in disease but there is relatively little emphasis placed on the person in the larger social and cultural system (Ember and Ember, 2004). There has been increasing expansion and coverage of biomedicine in Ethiopia through public health care policies and programs.

2.4. Theoretical Framework

The first major theoretical approach to understanding health systems in medical anthropology emphasizes the importance of the environment in shaping health problems and how they spread. The second perspective focuses on health beliefs and practices, cultural values, and social roles. The third points to the need to look at structural factors (political, economic, media) which affects the medical beliefs and practices of the local people. The fourth highlights symbols and meaning in people's expression of suffering and healing practices. The last will give brief account on how the combination of the local cultural values and the larger socio- economic and political dimensions influence and shape the health beliefs and practices

2.4.1. Medical Ecological Perspective

Medical anthropologists study human health in varied environmental and cultural contexts. As an approach in medical anthropology, medical ecology emphasizes the environmental context of health (McElroy and Townsend, 2009: 7). According to them medical ecology is concerned with basic questions:

> *How do people survive in this environment? How do they cope with hunger and disease? What resources help them deal with problems affecting their health? Who controls these resources? Are resources restricted by ethnic and class boundaries? Is the population growing, and how rapidly will it exceed its resources if growth is not checked?*

Answers to these questions reflect relationships among community, environment, and health. Therefore, the vulnerability and exposure to specific type of disease within a given societal group is related with environmental factors. Medical anthropologists using an ecological perspective to understand disease patterns view human populations as biological as well as cultural entities.

Adaptation is a key concept in medical ecology. It explains the changes, modifications, and variations that increase the chances of survival, reproductive success, and general wellbeing in an environment. Alland, was one of the first to apply the concept of adaptation to medical anthropology. Humans adapt through genetic change, physiological responses, cultural knowledge and practices, and individual coping mechanisms. Therefore, the basic premise in this approach is "health is a function of environmental adaptation, and disease indicates disequilibrium". The other premise is that "the evolution of disease parallels human biological and cultural evolution". The risks faced by foraging peoples differ from those of agricultural groups and industrial societies, and the epidemiological profile of each subsistence type is a function of human relations with the environment and with other species in the ecosystem, especially food sources, domesticated animals, and pathogens (Alland, 1970).

2.4.2. Ethno-Medicine

According to Quinlan, ethno-medicine is "the area of anthropology that studies different societies' notion of health and illness, including how people think and how people act about wellbeing and healing" (Quinlan, 2011). It is also refers to the study of indigenous medical practice which is concerned with the cultural interpretation of health, diseases and illness and also addresses the health care seeking process and healing practices (Krippner, 2003). Ethno-medicine is a complex multi-disciplinary practice that includes different elements in the healing process. This comprises the use of plants, spirituality and the natural environment for many years (Lowe *et al.*, 2000). It is used to analyse the topic of medical ethics pertaining to the healer's relations with clients, with other healers, and with the group or society (Levinson and Ember, 1996: 4).

A basic concept in ethno-medicine is "explanatory model" which is introduced by Arthur Kleinman (1980). Explanatory models (EMs) are notions about the causes of illness, diagnostic criteria, and treatment options. In a clinical encounter, the EMs held by practitioners, patients, and family often differs. The ensuing communication and negotiation of decisions for managing illness lead to the cultural "construction" of illness. To the extent that disparity among EMs continues because of cultural, ethnic, or class differences, communication remains problematic.

2.4.3. Critical Medical Perspective

Critical medical anthropology is a branch of medical anthropology that blends critical theory and ground-level ethnographic approaches in the consideration of the political economy of health, and the effect of social inequality on people's health. It is perspective that emphasizes that social and political factor (for example: poverty, social inequality, discrimination, structural violence) are important elements in understanding and treating health and disease (Ember and Ember, 2004).

Turner (1987) stated that political economy is an approach which focuses “socio-economic inequality in power and wealth which in turns significantly affects the health status and access to health care facilities” (Turner, 1987 cited in Zerihun, 2005). Therefore, economy plays a vital role to have an access to health care system so as to decrease and reduce morbidity and mortality rate in a given society. Political economy of health which is influenced by Marxist theory and dependency theory was mainly analysis the impact of global economic systems particularly capitalism on local and national health. Indigenous medicines are economically affordable than modern medicine. Hence, everyone can access it easily. However, by the introduction of western medicine, indigenous medicine are highly dominated and marginalized because of that reason people inclined to modern medicine. Therefore, these conditions lead to high level exploitation of resources/money in developing countries.

2.4.4. The Interpretive Approach

Cultures throughout the world use different systems of meaning to describe and respond to illness. Anthropologists who study these differences with symbolic meaning employ the interpretivist approach to medical anthropology. This approach looks at illness from an emic perspective attempting to understand health and disease relative to a particular culture. The interpretive approach, which emerged with Arthur Kleinman's foundational work (1980), departs from an epistemological stand that differs from earlier approaches such as the ecological and cognitive. The concept of 'explanatory models' of illness proposed by Kleinman (1978: 187) to elicit what he referred to as the 'native's point of view', introduced a radical change of perspective in the understanding of the relation between the cultural domain and the domain of disease.

The interpretive activities according to Good involve interaction of biology, social practices and culturally constituted frames of meanings, through which clinical realities are constructed" (Good, 1994: 54). According to Baer (1997), interpretive medical anthropology has verified how various biomedical subspecialties reach different conclusions about the same clinical episode. The interpretive tradition examines the construction of interpretations in different social contexts. That is: "how meaning and interpretive practices interact with social, psychological, and physiological processes to produce distinctive forms of illness and illness trajectories" (Good, 1994: 54).

Critical views of the interpretive approach – which later resulted into the formulation of the 'critical approach' – pointed to a central flaw i.e., the lack of attention to the role of asymmetrical power relations in the construction of the same clinical realities which the critical perspective has contributed to disclose. Indeed, those realities constituted through interpretation and representational processes have largely been treated as consensual by the interpretive approach, while usually, in reality, they are not (Kleinman, 1988: 43).

2.4.5. Critical-Interpretive Approach

The critical approach in medical anthropology integrates the macro perspective of the political economy approach, without losing sight of individual experiences and agency. This double focus is central to the analysis of migrants' illness experiences. The approach of social suffering continues the line of analysis proposed by the critical approach, integrating into its analysis a wider range of forms of human suffering including experiences of emotional distress (Kleinman, 1988: 40).

According to Erickson and Murphy (2001: 482), the task of a critical- interpretive medical anthropology is:

> *First,* to *describe the variety of metaphorical conceptions (conscious and unconscious) about the body and associated narratives and then to show the social, political and individual uses to which these conceptions are applied in practice. When using such an approach, medical knowledge is not conceived of as an autonomous body but as rooted in and continually modified by practice and social and political change. Medical knowledge is of course, also constrained (but not determined) by the structure and functioning of the human body. A medical anthropologist therefore attempts to explore the notion of "embodied personhood".*

Erickson and Murphy argue that the body is identified in three ways: (1) ‘The Individual Body’ or body self, and the vulnerability of the body as it is experienced in health and ‘sickness’; (2) ‘The Social Body’ which represents the state of health of nature, society, and culture itself. It is considered that if the body is healthy it is a model of “organic wholeness”; if it is ‘sick’ it is a model of disharmony, conflict, and disintegration. (3) ‘The Body Politic' which represents the regulation, surveillance, and control of both the individual and collective body in “reproduction and sexuality, work, leisure, and ‘sickness” (Erickson and Murphy, 2001: 482).

2.5. The Global Distribution

Herbal medicines have been recognized by the WHO as the most popular form of indigenous medicine, and thus, highly profitable in the international medicine market. They have contributed immensely to humans’ effort against diseases and sustenance of health. WHO (2003) estimates that the global market for herbal medicines currently stands at over 60 billion United States Dollars (USD) annually and is growing steadily. For instance, annual revenues in Western Europe were estimated at 5 billion USD in 2003-2004, in China the revenue was estimated at 14 billion USD in 2005, and in Brazil it was 160 million USD in 2007 (Oreagba and Oshikoya, 2011). In African, for countries such as Ghana, Mali, Nigeria and Zambia, the first line of treatment for 60% of children with high fever due to malaria is the use of herbal medicines at home (WHO, 2003).

Herbal medicines are by far less concentrated, less toxic and are used in much lower doses than orthodox medicine which in its concentrated drug formulations are designed to target and reverse specific pathologies in the minimum of time (Osemene, 2011). In addition, the increasing widespread use of indigenous medicine has prompted the WHO to promote its integration into the national health care systems of some countries and to encourage the development of national policy and regulations as essential indicators of the level of integration of such medicine into a national health care system (Oreagba and Oshikoya, 2011).

Ethiopia is endowed with diverse natural resources due to significant geographical diversity, which favored the formation of different habitat and vegetation zones. The country is also home to a diverse mix of ethnic, cultural and linguistic groups. This diverse combination of social and cultural backgrounds contributed much to the existence of rich IK, including managing and using medicinal plants against human ailments. Medicinal plants have been used as a source of medicine in Ethiopia for a long time. Studies reported that a significant proportion of the Ethiopian population still depends on indigenous medicine for its health care services (Dawit and Ahadu, 1993; Gedif and Hahn, 2003).

2.6. Challenges of Herbal Medicine

Despite being widely used in Africa, indigenous medicine has been viewed with a lot of doubt by conventional health practitioners and the practice faces some challenges. The first challenge of herbalist is that the African medicinal plant resources may be doomed to extinction by overexploitation resulting from excessive commercialization, habitat destruction and other natural and man-made destructive influences unless energetic conservation measures are taken to ensure their continued availability. This can be done through the establishment of medicinal plant gardens and farms (Abebe, 2001). The second challenge is related with the lack of information in indigenous medicine herbal-based treatments regarding the composition of the remedy in many cases. Herbs are natural products and their chemical composition varies depending on several factors, such as plant species, chemical types, the anatomical part of the plant used as well as the storage, sun, humidity, type of ground, time of harvest and geographic area (Chavan, *et al.,* 2006). The other serious problems are related to the preservation and dosage measurement in developing countries (Erah, 2002).

Although indigenous medicine plays an important role in Ethiopia, the healing practice and practitioners were neither integrated in the national policy of health nor got support from the government. However, in 1942 formal recognition to indigenous medicine was given under proclamation NO.27/1992 which demanded the registration of indigenous medical practitioners in the country. (Dejene, 2013: 170).

2.7. Related Empirical Studies in Ethiopia

The use of medicinal plants for treatment for humans and animals are practiced from time immemorial. These plants are collected mainly from forest and pasture ranges. Herbal products are globally accepted and marketed at a high rate. Ethiopia has a large unexploited potential to develop the herbal medicine and the healing system to a large scale industry (Yadav, 2013).

The studies conducted on the medicinal plants in Ethiopia are limited when compared with the multiethnic cultural diversity and the diverse flora of Ethiopia. This is supported by Zelalem (2011). He argues, though IHM have long been known to the larger public, as elsewhere in Africa, the culture and language specific knowledge of herbal medicine has not been well explored and documented scientifically. Most of the studies are ethno-botany, initiated to document the medicinal plants in the natural vegetation and home gardens, and some are ethno-medicinal (Gedif and Hahn, 2003; Mirutse *et al.,* 2007; Tilahun and Mirutse, 2007; Lulekal *et al.,* 2008; Fisseha *et al.,* 2009; Teferi *et al.,* 2009; Biruktayet *et al.,* 2010; Mamush, 2011; Zelalem, 2011; Gidey *et al.,* 2011; Matthew *et al.,* 2013; Balcha, 2014; Petros *et al.,* 2014).

With respect to anthropological empirical studies on IK of herbal medicine and healing system, very little study was conducted. One is MA thesis conducted by Abraham, entitled "*Indigenous Herbal Medicinal Knowledge and Healing System among the Shinasha: The case of Bullen Woreda of Benishangul Gumuz region, Ethiopia*" (Abraham, 2015). This study was intended to provide an ethnographic account regarding knowledge and healing system of the Shinasha. According to Abraham (2015), herbal healing practice of the Shinasha is based on and closely related with the culture of the people.

Another anthropological empirical studies is PhD dissertation entitled "*Indigenous Medicine: Cultural and Environmental Values of Medicinal Plants among the Konso People in Southern Ethiopia*" conducted by Tebaber (2015). This study was aimed to gather indigenous medicinal knowledge and practices used by the Konso people and investigate the status of medicinal plants and their management in the study area. According to Tebaber (2015), a number of health problems are possibly treated by indigenous medicinal plants in the study area.

Dejene (2013) also conducted a PhD dissertation on *"Persistence and Change in the Practice of Medical Pluralism in Addis Ababa"*. His focus was to look into the nature of medical pluralism in Addis Ababa. This study reveals that there has been a growing diversity in the practice of medical pluralism based on different assumptions of health, illness and healing in the study area despite the absence of impartial health policy. According to Dejene (2013), the most commonly organized indigenous medicines in the study area were IHM and faith healing.

From this point, it is clear that empirical anthropological research on the IHM in Ethiopia is now growing. Generally, because it is clear that there are no adequate empirical anthropological studies on indigenous herbal medicinal knowledge and healing system in the country.

Chapter Three

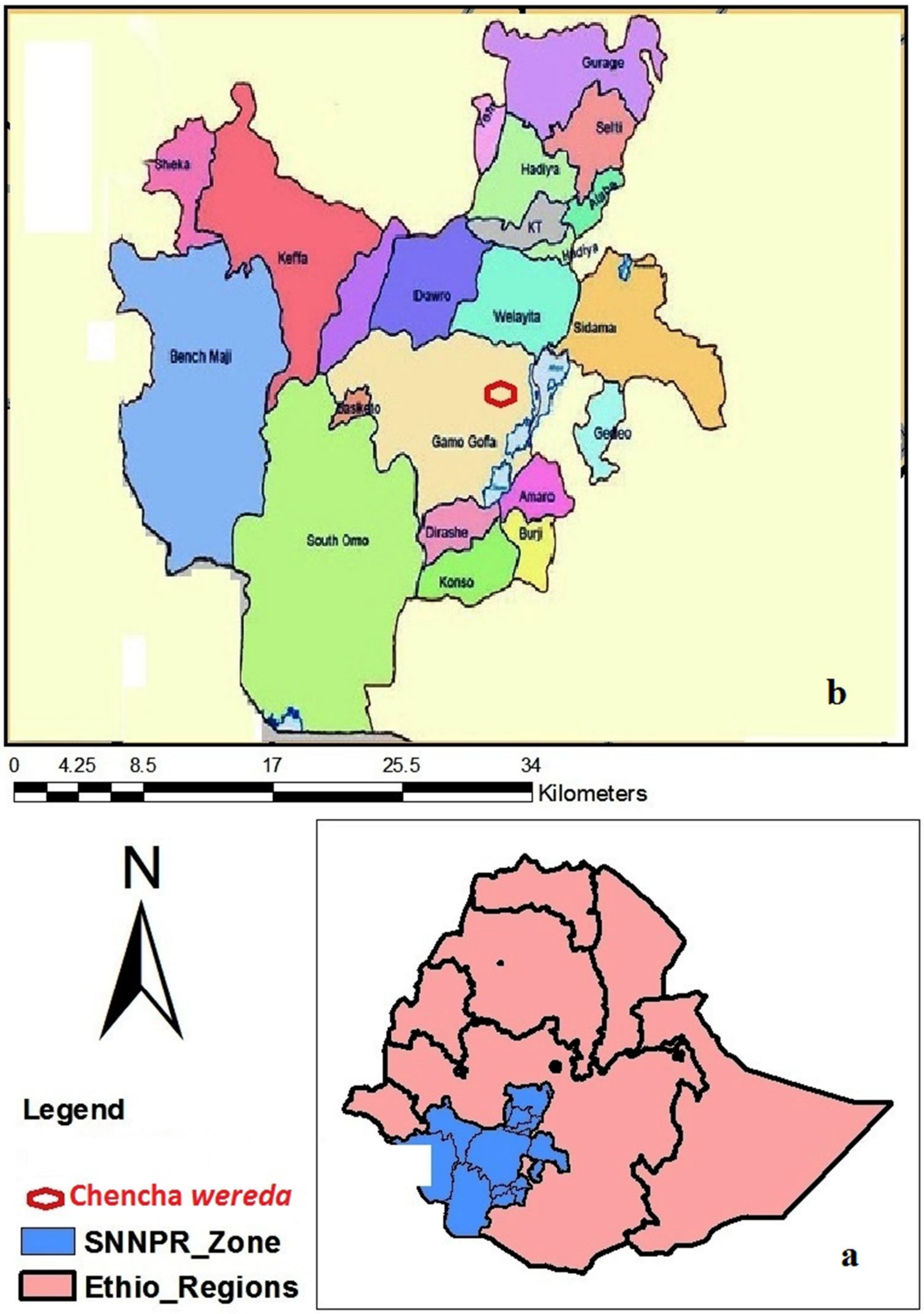
3. Description of the Study Area and the People

This chapter describes the general setting in which the study has been conducted. It provides a general background about geographical setting and population of the Gamo highlands and then highlights the Gamo Gofa Zone and Chencha *woreda* where the research area is located. It also provides brief information on the socio-cultural setting and the economic activity of the study area.

3.1. The Geographical Setting and Population

The study area, Dorze, is located in Gamo highlands. The Gamo highlands are perched high above the African Rift Valley in Southwestern Ethiopia. The Gamo highland is situated in Gamo Gofa Zone, which is one of the administrative Zones of Southern Nations, Nationalities and Peoples' Regional State (SNNPRS). The highlands are the southernmost extension of the northwestern block of Ethiopian highlands. The landscape rises up to 3962 meters above sea level and is roughly 62 miles long and 18 miles wide. The varied landscapes are characterized by series of ups and downs; altitudinal change is common within a few kilometers distance (Chencha *Woreda* Agriculture Office, 2010).

Gamo Gofa Zone is named for the Gamo and Gofa peoples, whose homelands lie in this Zone. The Zone is bordered on the south by the Dirashe special *woreda*, on the southwest by South Omo and the Basketo special *woreda*, on the northwest by Konta special *woreda*, on the north by Dawro and Wolayita zones, on the northeast by the Lake Abaya which separates it from the Oromia Region, and on the southeast by the Amaro special *woreda* (Map 1). The administrative center of Gamo Gofa is Arba Minch which is located 505 kms south of Addis Ababa.



Map 1. Location of the study area: (a) Map of Ethiopia showing SNNPRS; (b) Map of SNNPRS showing Chencha *woreda*. **Source:** Ethiopian Mapping Agency (2016).

Gamo Gofa Zone has a total population of 1,593,104, of whom 793,322 are men and 799,782 women. The Zone has covered an area of 18,010.99 square kilometers (CSA, 2007: 9). It has a population density of 144.68 per square km. While 157,446 or 9.88% are urban inhabitants, a further 480 or 0.03% are pastoralists. According to CSA, Gamo is a largest ethnic group (64.61%) which is followed by Gofa ethnic groups (22.08%). The remaining ethnic groups account 13.31% of the total population. In this zone Gamogna language is spoken as the first language followed by Gofagna. The remaining ethnic groups speak other language (CSA, 2007:9).

Chencha is one of the *woredas* in the Gamo Gofa Zone in which the study area is located. It is bordered on the north by Kucha and Boreda, on the south by Arba Minch Zuria, on the east by Mirab Abaya and on the west by Dita *woredas*. It is situated between 1300 and 3250 meters above sea level. The *woreda* has 5 urban and 45 rural *kebeles*. Chencha is also the name of the *woreda* town located 37 kms north from the Zonal town, Arba Minch; and about 520 kms away from the capital, Addis Ababa (Chencha *Woreda* Justice and Security Office, 2012).

Based on the 2007 census conducted by the CSA, the Chencha *woreda* has a total population of 111, 686 of whom 51, 310 are men and 60, 376 women (CSA, 2007). The majority of the inhabitants are adherents of the Ethiopian Orthodox Christianity (62.19%) followed by members of the protestant Church. The largest ethnic group reported in the *woreda* was the Gamo people (98.7%) the rest ethnic groups made up 1.3% of the population. Gamogna is spoken as first language (CSA, 2007).

Dorze *dere* is located in the Chencha *woreda*. It is situated along the Arba Minch-Chencha road which divides the *dere* into two parts. Dorze is dvided into 12 *kebeles.* These are Amarana Bodo, Ayra, Belle, Godiye, Dorze 01, Doshike, Hayzo, Hirpho, Hollo’o- Laka, Maldo, Metsona Gara Dita, and Tegecha. Dorze 01 is a small town with a total population of 4141 among which 2057 were males. This was the highest population number among the 12 *kebeles*. On the other hand, Ayra *kebele* is least populated about 811 of which 321 were males (Table 1) (Chencha *Woreda* Agriculture Office, 2010). Of these 12 *kebeles,* the pilot *kebeles* of this study were 01 *kebele,* Amarana Bodo, Metsona Gara Dita, and Hollo’o-Laka (Annex II).

Table 1. Name of *kebeles* and number of population in Dorze *dere*

Sirial No.	**Kebeles**	**2007**			**2008**		
		Male	**Female**	**Total**	**Male**	**Female**	**Total**
1	Amarana Bodo	539	677	1216	555	694	1249
2	Ayra	321	490	811	330	504	834
3	Belle	1352	1451	2803	1391	1493	2884
4	Godiye	561	955	1516	577	983	1560
5	Dorze 01	2057	2084	4141	2156	2186	4340
6	Doshike	429	580	1009	441	597	1038
7	Hayzo	491	410	901	505	597	1102
8	Hirpho	578	880	1458	595	906	1501
9	Hollo’o- Laka	480	844	1324	494	868	1362
10	Maldo	612	897	1509	630	923	1553
11	Metsona Gara Dita	502	734	1236	517	735	1252
12	Tegecha	653	714	1367	672	735	1407

Source: Chencha *Woreda* Agriculture Office, 2010

3.2. The Socio Cultural Situation

3.2.1. The Gamo People

The term Gamo is a name used to refer the people who speak the Gamogna. The name "Gamo" literally means “lion”, which refers to their legacy (Hirut, 2013). Gamo is one of the ethnic groups with a total population of 1 044 589 and accounts for 1.5% of the total population of Ethiopia (CSA, 2007: 153). They inhabit various *woredas* of the Gamo Gofa Zone, namely, Arbaminch-Zuria, Chencha, Bonke, Kucha, Kamba, Zala, Boredda, Mirab-Abaya, Dita and Dara Malo. Today members of the Gamo ethnic group reside in the Gamo Gofa Zone, which is their homeland, and in other urban centers of the country including the capital, Addis Ababa.

3.2.2. Cultural Setting

Although the Gamo share cultural similarity with the neighbor ethnic groups, it has unique culture and value systems. The basic elements of social culture are the same throughout the Gamo community (Getaneh, 2006: 12). The administrative system is carried out by the institution called *dubusha* (assemblies). The *dubushas* are chaired over by the political leaders called *halaqas* and *hudugas*. The patriarchal ideology is another common feature of the Gamo people. Men dominance is common; men own and inherit key resources such as land and houses. Decent is also reckoned through male line. Women have very low socio-economic status and depend on their husbands and son (Olmstead, 1997: 31 as cited in Getaneh, 2006). The most important values of the Gamo ethnic group are communal life, resilience in the face of different natural hazards, a propensity to be hardworking, truthfulness (Yishak and Gumbo, 2014).

Gamo communities are organized into exogamous patrilineal clans and marriage is virilocal. Although exogamy is the dominant marriage pattern, endogamy within each community exercised in a great extent (Getaneh, 2006: 12). The Gamo wedding ceremony is arranged through a mediation process overseen by the elders, known as *Chimma*. If a man wants to be married to someone, he sends his family representatives to the parents of his fiancée to being the negotiations. The elders, sent for mediation, will be allowed to enter the house of the girl's parents on their third trip and fix the date of marriage together (Yishak and Gumbo, 2014).

Another important value of the Gamo ethnic group is *gome* or taboo. Gome is the transgression of traditional rule locally named as *woga*. It is a misfortune which afflicts a person for the transgression of a traditional rule. It is believed that an infraction of *gome* would breing misfortunes such as illness, drought, infertility, poverty and death (Getaneh, 2006: 12).

The staple diets of the Gamo people are prepared from different kinds of cereals and bi-products of a false banana, called *enset.* The *enset* products are named as *unchaa (idaraa), itima* (*bulaa*), c*hadhe* and *utsare*. The traditional food called *shendera (moyde)* and *qinche* are made of flour, milk, yeast and butter and usually served as breakfast. The Gamo people also prepare different foods such as *uketsa, kashka*, and *petela* (*posose*) from maize and wheat flour. There are also some ritual foods. They have a special drink known as *borde,* made from barley and maize flour.

Although there are similarities with other Gamo societies, the study people (Dorze) have some unique socio-cultural features. One of them is their traditional house. A Dorze hut is made up of hard wood poles, woven bamboo, *enset* and other natural materials. The hat has a unique and beautiful structure. It is sometimes called “a house with a nose” because of its nose like projection at the front face (Picture 1) (Getaneh, 2006: 30). Inside the main hut, there is a fire place, a seating area and bedrooms. Smaller huts can include guest houses, a workshop, a kitchen and even cattle shed. They are also famous for their cotton woven cloths which take the lion share of their economy. One of the biggest ceremonies in the country, Meskel, is also a unique and colorful annual festival which attracts many people from other Gamo *deres*, people from other parts of Ethiopia and tourists from abroad to visit and celebrate.

Picture 1. Traditional house (*woga ketha*) of the Dorze. Photo by: Wagaye. Feb, 2016

3.2.3. Social Categories

Social categorization is the process of classifying people into groups based on similar characteristics such as nationality, age, occupation, diagnosis, or some other trait (Krueger, and DiDonato, 2008). Based on their occupation and position in the society, there are three different social groups in Gamo community. These are the *mala* (free citizens); the *ayle* (ex-slaves); and the artisans (*mana* and *degela*, i.e. tanners and potters) (Freeman, 1999: 58). The *mala* possess higher rank in the social structure. As a result they have better access to resources and the right to own land.

Unlike the past time, the *ayle* social group is not marginalized currently. They had get chance to be independent especially during the Derg regime. However, they are not able to be *dere* officials or traditional leaders but participate in assemblies. The artisans are still marginalized social groups and are considered as ‘impure’. They had land to build their houses and could cultivate the land around the compound. They are accused of eating meat of animals that die before being slaughtered. They were not considered as citizens and are not allowed to participate in traditional meetings (Getaneh, 2006: 14).

There are firmly established rules of taboo with regard to the relationship between the *mala* and other social groups. Each social category is endogamous groups. Hence, it is taboo for the *mala* to establish marriage with the artisans. However, there are some rare cases of transgression of the traditional rule and decide to marry the marginalized groups, though there fate is alienation from the family. The Gamo people believe that it is seriously taboo for artisans to own and cultivate farmland (Olmstead, 1973: 224 as cited in Getaneh, 2006). The artisans had separate burial land and it is taboo for *mala* to participate in funeral ceremony of *degela* and *mana.* It is also taboo for *mala* to eat meat of animals slaughtered by *degela* and *mana.*

3.3. Economic Activity

Agriculture is the mainstay of the economy of the Gamo communities. The variation in altitude allows the cultivation of different types of crops in the highland. Cereals, pulses and tubers of various types are cultivated at different altitude. The major food crops cultivated are *enset*, wheat and barley. Maize and sorghum are also common in the lower altitude (Freeman, 1999: 20). The pulses (bean and chickpeas, pea, lentils) and tubers (potato and sweat potato) are also cultivated in the highland. The highland fruit, apples, is common now days in Chencha and other *woredas*. However, productivity is very low because of small land holdings, poor fertility of the soil due to severe erosion (World Vision, 1997 as cited in Getaneh, 2006).

There are two cropping season in a year, which are locally known as *silla* and *gabba* seasons. *Silla* crops are planted in August and harvested in January, while the *gabba* crops are planted in February and harvested in July. In the *dega* region *silla* crop is the most important as it enable to cultivate various crops. The *gabba* crop consists mainly of barley and the yields are usually low (Belete, 2006: 15).

A considerable number of the Gamo highlanders are also engaged in certain off-farm activities. The common off-farm activities are weaving, trading and daily labor. For example, 27 % of the total population of Chencha *woreda,* in which Dorze is located, is engaged in off-farm activates. Weaving is the major off-farm activity and about 60% of the people who engaged themselves in off-farm activates are weavers (World vision, 1997: 41 as cited in Getaneh, 2006). Although some sources indicate that the number of weavers among the Gamo communities has been increasing from time to time, Dorze people dominate weaving (Getaneh, 2006: 12). It is the Dorze people who are renowned for their weaving tradition and skills throughout Ethiopia (Mathiszig, 2014). There is a saying in Ochollo *dere* which strengthen the above statement *“hariray harppa ges Bodoy”* which literally means “weaving is the major asset to *Bodo*”.

In relation with the weaving activity, life of the Dorze is associated with rural-urban migration. This is because products of weaving such as *na’tsala*, *kuta*, *gaabe* and *buluko* are most profitably sold in urban centers. As a result, most weavers migrate to and live in Addis Ababa settled mainly at Shuro Meda (Olmstead 1974: 4 as cited in Getaneh, 2006). Figures indicate that the spatial mobility of the Dorze is dominated by male migration. According to the 1994 census, there were 39,401 Dorze migrants in Addis Ababa. Of the total migrants, 63.6% were males and 36.4% were females (CSA, 1994). Getaneh (2006: 15), citing the 1994 Population and Housing Census, indicated the impact of out migration on the spatial and sex distribution of the Dorze.

Chapter Four

4. Indigenous Herbal Medicinal Knowledge among the Dorze

This chapter presents the indigenous herbal medicinal knowledge acquisition and transfer among the Dorze people. In spite of the availability of biomedicine, indigenous herbalists exist and the healing practices are common in the study area. Therefore, I describe the IK acquisition and transmission, and sharing of the practices among the herbalists in this chapter.

4.1. Knowledge Acquisition and Transfer

According to the data gathered and analyzed from the KIHs and FGD-5, the medicinal knowledge, practice, and healing system of the Dorze are well adapted to socio-cultural and environmental conditions. The knowledge and practice of IHM is well adapted in the study area, accepted by the society and still serving the community. As Kleinman (1978: 85) argues in "medical systems as cultural systems", the indigenous medical system is part of the cultural system of the Dorze people. However, nowadays due to the existence of the biomedical health care system some people and the youngsters prefer the later health care system than the former.

4.1.1. Knowledge Acquisition

All the KIHs in Dorze do not claim the same source for their medicinal knowledge. Their sources, methods of acquiring the knowledge or progression of the knowledge are different. Some herbalists had acquired the healing knowledge and skill from their herbalist parent. For example, Mrs. Marta (pseudo name of KIH-6) mentioned that "I inherited the medicinal knowledge from my herbalist father. In addition to the medicinal knowledge, he also gave me the residence". Mrs. Damenech (the name of KIH-1) shared this idea that they acquired the herbal knowledge from their herbalist parents. This was also supported by Mr. Kebede (the name of KIH-4).

Mr. Akalu acquired the medicinal knowledge and practice from non-relative herbalist resides at Gofa. He stated that "I never inherited the medicinal knowledge from my parents because they do not know the practice. But I learned from Gofa area where I went for weaving". According to him learning the knowledge is not a simple task. It needs sacrifices, payment and even gifts like delivering *buluko.* He also stated that "following the provision of *buluko*, the healer showed me the medicinal plants, the drug preparation and administration. Then, I took these medicinal plants to Dorze and planted them in the backyard. I always thank the healer because the cost of *buluko* during that time was 40 or 50 Birr but the knowledge is forever and I am benefited and become a known healer not only in Dorze *dere* but also Chencha and Arba Minch". Mrs. Almaz (pseudo name of KIH-2) and Mr. Mangasha (the name of KIH-7) have also acquired the healing knowledge and ability from Shelle and Gresse, respectively, where they went for farming and weaving.

Mrs. Beyenech (pseudo name of KIH-5) argued that her herbal medicinal knowledge is a gift from God. She also claims that God provides her with the knowledge. She mentioned that her family had no knowledge of herbal medicine and practice. But her children frequently suffered with illnesses and she was afraid to take them to indigenous medical healers again and again. She also mentioned that:

I have prayed and begged my xossaa (God) to reveal those medicinal plants. Then, xossi told me to go to lowland area (bazo) and ordered to collect the herbs around me. Then, I have collected all and took to home. When I test them, some were bitter but others were sour. Finally, I have mixed them and grind using mortar and pestle and boiled. Then, I first drunk for myself and gave for my ill son. Finally, he becomes healthy. Subsequently, I become known healer in the community by the help of God.

From the above quote one can understand that for Mrs.Beyenech the medicinal knowledge is gift of God. This is because she neither inherited from her parents nor learned from non-relative herbalist.

4.1.2. Knowledge Transfer

Among the Dorze people, indigenous herbal medicinal knowledge is acquired, maintained and transferred via oral and practice. Most herbalists prefer to convey their knowledge verbally either to their family members or trusted person. According to the interview with herbalists and FGD-5[4], learning the practice and skill requires willingness, continued practice and recalling ability to differentiate various medicinal plants. This is in agreement with the situation among the Shinasha as reported by Abraham (2015). This continued practicing of herbal medicine preparation, preservation, and administration activities are in part simplified by the fact that, for the practitioners' herbal medicine is part of their life.

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[4] FGD-5 is a code given to the focus group discussion held with herbalists; hereafter, primary data gathered and analyzed from all other focus group discussions and discussants are cited like this. For more information refer annex III.

The indigenous herbalists who were involved in this study were adult and elderly (Picture 2). There are some reasons behind this fact. First, they want to maintain the existing indigenous trend. This trend was that their parents transferred the knowledge when they get old. As a result, most of the herbalists in the area prefer to keep this trend and plan to transmit their knowledge when they get aged. This does not mean that the son/daughter of the herbalist learn the knowledge and skill in short period of time rather they learn throughout the time. However, they formally replace the herbalist father/mother when they get too old or may be after they die.

Picture 2. Mr. Mangasha, an elder indigenous herbalist. Photo by Wagaye; Feb., 2016

According to the Mr. Kebede:

> *My father showed me those medicinal plants and its processing many years back. Consequently, he allows me to sell the prepared drugs in his absence. However, he did not allow me to replace him and sell the drugs in his presence. Hence, I want to maintain this practice and transfer the medicinal knowledge when I get old because I inherited when my father gets too old at about 117 years old. Following his death, I officially started and applied the knowledge and began to serve the society and get income.*

Second, mastering the knowledge and skill takes many years as the knowledge is transferred through orally. This idea was supported by Mrs. Damenech, a female herbalist of about 55 years of age. She lives in Dorze 01 *kebele*. She stated that "learning medicinal knowledge and practice is not simple. It took a longer time for me to learn the knowledge and skills from my herbalist father and to become a known healer in the community". Third, the herbalists want to maintain their prestige and respect in the community as well as to secure their income, although the income is minimal.

Selection of the heir of the indigenous herbal medicinal knowledge was based on culturally accepted criteria. According to Mrs. Beyenech, the person who is proposed to heir the medical knowledge is one who is patient and committed to serve the community. Most KIHs witnessed that the one who inherit the knowledge should not going to harm or revenge others by his virtue of possession of herbal knowledge. Honesty and trustworthy personality were greatly valued. The KHI-6 mentioned that "I inherited the medicinal knowledge because I honestly served my herbalist father". This means I served my herbalist father without any reservation i.e.I provide food, drinks and any other things that interestes him. She also stated that "I will inherit the medicinal knowledge to family members who respects me; "*tambboni tukke ushiray na'ei koyroki"* which literally means "my son/daughter who provide and serve me tobacco and coffee took the first place". Mostly, the herbalist tends to transfer the indigenous medicinal knowledge to a person who respectes them and has good attitude towards the practice.

In the context of Dorze, indigenous herbal knowledge is usually transferred from herbalist parent to a preferred son/daughter or may be outside family member. In most cases, there is no sex-based bias. They equally share the medicinal knowledge to both of their son or daughter who fulfills the above mentioned criteria. The number of KIHs involved in this study supports this fact. For instance, from the total of seven KIHs, four were females (Picture 3). This was in contrary to the situation among Shinasha where daughters are not selected to heir medical knowledge (Abraham, 2015). According to most of the KIHs, there is no *gome* when a parent transfers his/her knowledge to his daughter because it is an issue of *"shemppo asho"* which means "lifesaving practice". Mr. Kebede also said that "I am happy to transfer my medicinal knowledge to my son or daughter who is honest, truthful and trustworthy individual". In contrast, Mr. Mangasha does not want to transfer his medicinal knowledge to daughters. The main reason is that the females will take the knowledge out of the family member when they get married. Therefore, he said "how can I transfer my knowledge to daughters. It is right and appropriate to inherit to male". In addition, Mr. Mangasha believes that medicinal knowledge is a resource. As aresult he wants to inherit for male children.

Picture 3. Mrs.Damenech, female indigenous herbalist. Photo by Wagaye; Feb., 2016

Most of the time, herbalists prefer to transmit their knowledge to their family members. However, whenever the herbalist does not have a son/daughter or if the herbalist's son/daughter does not attract his/her attention, he/she may transfer the knowledge to one of his/her relatives' son/daughter. For instance, relative of Mrs. Marta told his willingness to inherit the medicinal knowledge from his aunt. Mrs. Marta also confirmed her willingness to transmit the knowledge to her brother's son.

In Dorze there is no specifically endowed clan with herbal medicinal knowledge. As it has been mentioned, the herbalists acquired their medicinal knowledge through different means that were from different clan. According to Mrs.Damenech there is no specifically gifted clan, but the one who is selected by God will know the healing practice. In Dorze medicinal knowledge tradition there is also no ritual activity performed or scarified during knowledge transfer. For example, Mrs.Damenech stated that "when I inherit medicinal knowledge and skills from my father, there is no ritual conducted because it is not worship. But it is based on willingness of the individual". Mr. Kebede shares this idea as:

> *There is no ritual ceremony when I inherit the medicinal knowledge. But my father blessed me and advised me to not harm the community. He also counseled me to not take much money because it is your local people that perform your burial ceremony. So, please, welcome all people that need you and your medicine, he said.*

4.1.3. Challenges in knowledge transfer

Most of the KIHs mentioned the existence of some challenges in relation to knowledge acquisition and transfer. First, the son/daughter of most herbalists is not living together with the herbalist parents. They live in urban area engaged in the weaving economy. Following this Mrs.Damenech stated that "for the future, who will inherit my knowledge? I don't know because four of boys are not with me. One of them living in Addis Ababa and the rest are at Arba Minch". Mr. Kebede also shares this idea. He stated that "my children migrated to urban areas. I am left with my last son who is only seven years old. In the future, I will show him the medicinal knowledge and weaving, if he wants. Othwrwise, if he becomes academically excellent, he will advance my medicinal knowledge scientifically". According to Mrs. Marta, for the future "I want to transfer the medicinal knowledge to my son or daughter. But the problem is we are not living together. They are living in Addis Ababa. If this will continue, probably I will transfer to my brother's son". Migration from rural to the capitals, especially Addis Ababa, is very common in Dorze. This situation made knowledge acquisition and transfer outside the family members.

Second, children of herbalists were not willing to inherit the knowledge by considering the practice as a "primitive" or manifestation of uncivilization. For instance, Mr. Akalu's daughter mentioned that "I do not want to inherit the medicinal knowledge because it is backward practice".

As a result of globalization, African countries are rapidly losing their cultural identity and therefore their ability to interact with other cultures on an equal and autonomous basis, borrowing from other cultures only those aspects that meet its requirements and needs (Ibrahim, 2013). Likewise, the youngsters in African including Ethiopia have denied accepting the IHM by considering the practice as "traditional" and "primitive". Yet, no attempt was made to solve the problem. In addition, individuals and groups seek to annex the global into their own practices of the modern, and that consumption of the mass media worldwide provoke resistance and in general agency. Hence, it seems good to include IK in the curriculum of modern education so that the young people would have positive attitude to the practice.

In Dorze, a person is not obligated to inherit the medicinal knowledge. There is no *gome* if a son or daughter is not willing to inherit the knowledge. Even after inheriting the knowledge, if the person has no willingness to work on, he or she can stop. According to Mrs.Damenech, it is up to me to work or not. So, there is no *gome* and it is not mandatory but still I am serving the community. Mrs. Almaz also said that "the practice is not a worship hence there is no *gome* if I stop the practice or fail to transfer the knowledge prospective heir". Other KIHs also share this idea.

4.2. Herbal Medicinal Knowledge Sharing

The type and depth of herbal medicinal knowledge possessed by the herbalist vary from one herbalist to another. According to the interview with the KIHs and FGD-5, "they do not share their knowledge to each other". Among the FGD-5 discussants, two discussants said that "they are neighbor and know each other but they do not share what they know and practice to each other and other herbalists". Another discussant stated that "how can I share my knowledge to others, I am working independently and do not refer any case to other herbalists living in Dorze".

A single herbalist usually possesses herbal medicinal knowledge for several illnesses (naturalistic, personalistic, and supernatural etiology). Although they did not share their medicinal knowledge, they refer cases or illness to one another. Regarding this notion, Mrs. Marta said that:

> *I have experienced in treating illness such as higisha (evil eye), guso (diarrhea) and bolbo (Cutaneous leishmaniasis). However, when cases like woliwush hargge (hepatitis), galba hargge (skin diseases), madunts (wound), pura (swelling) and acha hargge (tooth illness) came to me, I usually refer to* Mr. *Mangasha*[5]*, he is more experienced in those illnesses than me.*

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[5] Mr. Mangasha is about 85 years of age and known herbalist in Dorze *dere* (See appendix II)

The relationship among the herbalists was not based on medicinal knowledge sharing. Rather the relationship was based on referring the patient to more experienced herbalist. Mr. Mangasha shared the idea of Mrs. Marta and stated that "*hinasoko* (we do not hesitate to treat the refered patients) because we are serving the same community. In addition, we are neighbors and participate in different social activity. Hence, I took her as sister and she took me as a brother". However, we make our experience and specialization secrete because the indigenous herbal knowledge is our own business which helps to maintain our prestige and generate income. As a result, there was no knowledge sharing within the herbalists living in Dorze and the nearby *deres*. But they do refer the patients to other herbalists based on their experience. They treat patients came from other places, like Ochollo, Chencha, Shama and other neighbor *deres'*.

4.3. Interaction with the Patients

It has been mentioned that the interaction between the herbalist and patient is positive and friendly. One of the depictions of this is that herbalists treat the patients at their home, at the home of the patient and even at work places. Mr. Akalu said that "I have no problem; I serve the patient at any place. Sometimes they took me to their home by a car or a motor bicycle or even by bare foot depending on the distance of the client's home". Unlike the biomedical workers, herbalists serve the client at any convenient places. So, there is no bureaucratic condition. Based on the data obtained from observation, the patients expressed their problems freely and friendly. Before starting the healing process, herbalists warmly welcome and greet the patient when arrive to home. Sometimes, even, they invite the client's coffee and food before the treatment. I saw this practice at Mr. Akalu and Mrs. Beyenech's home.The herbalists also check-up the status of the patients either by going to the patient's home or asking family members. For instance, one of FGD-3 discussant mentioned that "I always thank Mr. Akalu because he repeatedly visited my home to check the health status of my son after treatment".

Regarding the healing of social groups all the KIHs said that there is no discrimination in serving different social categories. They mentioned that they accept and serve different social groups that are the *mala*, *ayle* and *artisans*. They also stated that they serve and treat all social groups *shakoy baawa* (without discrimination) because all are human beings. However, Mr. Mangasha discriminates between the different social groups. He mentioned that:

> *I do not treat some social groups especially the tanners. The reason is that the tanners (degela) have their own herbalist healers. If they come to my home, I order them to go back". However, I tolerate to treat the ayle (ex-slaves) because this time they exist as a social group though they are not marginalized as they were before and it is not recommended to say somebody "ayle". I remembered an individual who paid 800 Birr in dubusha for saying ayle. So, I treat them because they are not marginalized as they were before.*

According to Mrs. Almaz, there are people who do not support her engagement in herbal healing by considering the practice as 'primitive' activity. She stated that "my neighbors and friends oppose the provision of healing to some social groups especially to *degela* by saying *degela qanthe woza oyqay* literally means *how can you handle tanners problem*". But she said that, “I do not like to discriminate between different social groups because life is the same for all groups”.

Except Mr. Mangasha, most herbalists share the saying “*shemppoy isinoko”* which literally means “life is the same for all groups”. Mr. Akalu mentioned that “I treat different social groups without discrimination because *tsosi medhira shempo dene aysi boro* which literally means *all are creature of God, so why I discriminate*”. Mrs. Damenech also stated that “I equally serve and treat *mala*, *ayle* and *degela* because *shemppoy isinoko*”. Mr. Kebede has similar believed. He mentioned that “I accept patients with different background and serve equally. *Ayleki*, *degelaki gara shakike* which literally means *I do not discriminate by saying this is ex-slave and that is tanner*”. Mrs. Beyenech also shared this idea and mentioned that “In the process of healing, I accept and treat different social groups. I do not take money from the marginalized social groups because there participation and contribution during my burial ceremony is enough”. Most of the FGD-3 discussants confirmed this idea as the herbalists accept different social groups and treat equally.

4.4. Interaction with the Community

Like any other member of the community, herbalists have normal social relationship with other community groups. They engage themselves in *ikub*, *idir* and other social associations. For example, Mr. Kebede is a member of a weaving association. Herbalists also participate in other social commitments in solving social problems like conflict. Herbalists were known and respected in the community. They have friendly relationship with community members and share what they have to a neighborhood in need. The experience of Mrs. Beyenech explains her good interaction with the community.

Currently I am not healthy and went to Arba Minch Hospital by referral and my leg was removed due to cancer. Then large number of the community members came to the hospital and visited me and expressed their deep feeling by saying 'nu shempo ashizayre nena sakopo' which literally means 'our life saver do not get sick'. So, this is great support and belongings hence I have benefited by serving the community.

One of the FGD-3 discussant who is neighbor of Mrs. Almaz has mentioned her friend relationship with Mrs. Almaz. She stated that "Mrs. Almaz has a good relation with us. She participates in different social activities like *iqub*, *idir* and we enjoy coffee together so our relationship is sisterly". The FGD-2 discussants also support this idea and explained the good relation of herbalists with the community.

Although the herbalists hide the medicinal knowledge, they perform the healing practice openly. Mr. Akalu and Mr. Kebede stated that we hide our medicinal knowledge to maintain our prestige in the community and to secure our income. All of the KIHs stated that we work for the wellbeing of the community but not to harm. Mr. Akalu stated that "I am working the healing practice openly. Even I went to Chencha and Arba Mich when patient family calls me. Sometimes they even took me by car or motor bicycle".

Chapter Five

5. The Processes and Practice of Healing System

This chapter describes the processes and practice of indigenous herbal healing system in Dorze. The chapter together with the previous chapter gives major point on IK of herbal medicine and healing system in the study area. The major focuses of this chapter are medicinal plant collection, drug preparation and preservation, mechanisms of illness identification, dosage determination and drug prescription, healing cost and expectation of herbalists.

IHM in Dorze occupies a major place as part of their cultural beliefs and practices. The practice is highly intertwined in the community even after the introduction of modern biomedicine. People still use the indigenous medicine. The Dorze herbal medicinal knowledge and practice range from use of herbal medicine against human illnesses and veterinary disease. Herbalists heal different health problems related with natural, personal and supernatural cases by their herbal medicine. There are also known bone healers and indigenous birth attendants (midwifery) in the study community though these areas are beyond the scope of this research.

5.1. Medicinal Plant Collection

The issues related to medicinal plant collection, drug preparation and preservation were gained through in-depth interview with herbalists. Herbalists collect the medicinal plants from different areas. They collect from *bazo* (lowland), *geze* (highlands), from their own garden or buying from others garden. According to herbalists, medicinal plants are also available in backyards between the *enset* plants mainly during raining seasons. But it is rarely available during the dry season. The places where the herbalists collect medicinal plants might vary from one herbalist to another. For example, Mr. Akalu usually collects the medicinal plants from *bazo* and his backyard; whereas Mr. Kebede collects from *geze* and his neighbors' backyard. This variation is expected because each herbalist practices the medicine independently.

The method of medicinal plants collection was also varied from herbalist to herbalist. Mr. Kebede stated that "I collect medicinal plants from others garden by asking them and they gave me because they know who I am. If that is not the case, I may buy from another area". Mrs. Marta also said that "now I am aged and get tired, hence I order trusted individuals to bring medicinal plants because it is far from my homestead. Sometimes, I also buy from other people". Although herbalists buy plants from other people, they keep the secret in that they do not tell them which part of the plant is used for drug preparation. In addition, they do not tell them which plant is used for what purpose. Moreover, the herbalists do not show them the preparation technique. Another KIH, Mrs. Beyenech, also stated that "currently I am not healthy. As a result the wife of my son brings the plants from the available places".

Most of herbalists collect the medicinal plants early in the morning to keep the collected plant from sun burn. Although they collect the plants early in the morning, they have no special day to collect medicinal plants. For instance, Mr. Akalu collects the medicinal plants from *bazo* in any convenient day. However, in Shinasha there are religiously and culturally selected days (Wednesday and Friday) to cut and collect those medicinal plants. These days were selected because there is believe that if medicinal herbs cut on these days, they became effective and curable (Abraham, 2015: 52). According to the medicinal herbalists of Dorze, what makes the plant a medicine is its natural content. So, there is no special procedure or believe during collection and preparation of medicinal plants. The herbalists also claim that if the medicinal plants grow only in a certain season, they collect during the growing season and keep them. What they do is they collect the plants, dry and grind, and store in a sealed containers for utilization in a time when the plants are not available.

The parts of plants that are used for medicinal purpose are leaves, roots, seeds, barks and fruits. In Dorze herbalist's context there is no special instruments used for cutting medicinal plants. Usually they cut and collect the medicinal plants by hands with out using special instrument as most of the plants are herbal. However, Mrs. Damenech mentioned that "I used instrument like knives and *qaxole* to cut the areal and underground part of the medicinal plants".

5.2. Drug Preparation and Storage

After the collection of the plants from different ecological zones, they prepare the drug in the form of solid, liquid and powder and sometimes mixed with honey for different types of illnesses. It has been mentioned by most of the herbalists that they prepare the drugs either earlier in the absence of patients or at the moment based on their problems. Except Mrs. Damenech and Mrs. Almaz, all the KIHs prepare some drugs earlier in the absence of patients and store in different containers. They also prepare drugs for some disease at the moment when patients arrive at their home. For example, drug for diarrheal disease is prepared in the presence of clients since the drug is liquid form. However, Mrs. Damenech and Mrs. Almaz do not prepare drugs earlier. Damenech stated that “I prepare the drug at moment when patients are in need or I tell the client to come near in near future”. Similarly, Mrs. Almaz stated that “I do not prepare the drug earlier. I prepare when patients come at home or I appoint them for the near time if the drugs are not available for collecting the medicinal plants”.

Based on the observational data, the drugs are stored in plastic containers such as, polyteens and bottles (Picture 4). They were stored in locked boxes until the client comes. In addition, they keep drugs for emergency cases. For example, drug for *higisha* and *wugat* is always prepared and reserved. Because these diseases are serious and need emergency treatment otherwise they kill the patients.

Picture 4. Plastic containers used by herbalists to store the drugs. Photo by Wagaye; Feb., 2016

Herbalists prepare and store the herbal drugs at their home. Sometime they keep in their pockets. According to Mr. Kebede

> *I keep the drug at my home as well as in my pocket using plastic containers. I do not separate the drug from my pocket because I am not sure where and when the patients arrive. For instance, some clients come to home during mid-night; others my contact while I am walking; some others even consult me at Bodo market.*

Regarding expire date of the prepared drugs, Mr. Akalu and Mr. Kebede stated that expire date of the drug depends on the type and form of the drugs. There are some drugs that can stay for a year without being expired. For instance, drugs prepared in the form of powder could stay longer time than other types. We herbalist differentiate the freshly prepared drugs from expired drugs by looking and smelling as the expired drugs have different appearance and smells.

5.3. Mechanisms of Illness Identification

According to FGD-4 discussants, diseases such as typhoid and typhus are better treated at clinic where as illnesses such as hepatitis and hemorrhoids are better treated at indigenous medicine. Herbalists identify the illness of the patient in different ways. According to Dejene (2013: 1) every medical system constitutes three basic components, namely: theory of etiology, a system of diagnosis, and techniques of appropriate therapy. In every society there is cultural explanation regarding causes of illness, sign and symptoms and techniques of appropriate treatment. As Kleiman (1980) the medical believes and practices which he call “explanatory modes” are shared between herbalists and patients. This ideology also works in the society of Dorze.

From interpretive approach health and illness are understood from emic perspective. In addition, based on the concept of ‘explanatory model’ of illness proposed by Kleinman (1978:187); herbalists have their own cultural explanation about the case of the illness. Mrs. Almaz mentioned her own cultural explanation regarding the cause of illness of one of the patient’s mother. She had explained that:

> *Once up on a time a woman arrived to my home with her ill child. Then she asked me to treat her son. I immediately identified the illness looking the signs that the child showed. I have collected the medicinal plants from my garden and prepared the drug. Then I gave it to the child to drink. Followed this, his mother asked me the type of the illness, then I said it is kafo hargge (Ye wof Beshita) because the sign and symptom clearly indicative. Your son is shouting like bird and his face seems green due to change in the color of the blood. After consecutive treatment and follow up the, child become well and cured.*

Following this, the researcher and the field assistant go to the home of this family to check whether it is true or not. We could not find the parents of the child for consecutive two days. Then we went to their farming plot but we could not find them there. On the third day, we met the mother of the son on the street when she came back from her farming. Then we asked her whether the case talked by Mrs. Almaz was true or not. Then she responded that the story was right, as the herbalist. The mother of the son told us that her child is getting healthy, after the treatment.

The indigenous herbalists of Dorze *dere* identify the illnesses of the clients by observing the signs and symptoms of the patients, allowing the patient to smell the drugs, by smoking the drugs, asking the patient whether he or she go to biomedical center, if that is the case the herbalist use the clinical information to identify the illnesses. As a result of similar cultural background between the herbalists and the patients, there is clear clinical communication and they understand each other. Hence there is no communication barrier between them and the Clients gets possible treatment. Mrs. Damenech stated that "I identify the type of the illness by observing sign and symptoms of the patients". Mr. Akalu also stated that "I identify the illness type by observation or based on the patient's explanation of symptoms". According to him there are patients who have clinical data. For example, some patients tell the clinical result like *wuliwush hargays* (hepatitis), *kintarote hargays* (hemorrhoids) and *kantse hargays* (abdominal pain). The other KIH, Mrs. Marta, mentioned that "in addition to signs and symptoms that the patient tells, I let the patient to smell the drugs and smoke the drug on fire so that patient gives symptom of some diseases". The other herbalists also share the above idea in identification of illnesses.

5.4. Types of Illness Heal by Herbalists

As Kleiman (1978:91) argues "in small scale, preliterate society medical system tend to serve more general (non-medical) functions than in more developed and differentiated societies". This argument was also works in the context of Dorze medical system as it solves problems related with natural, personal and super natural etiologies as well as animal diseases. Table 2 contains lists of illnesses for which the Dorze herbalists possess herbal medicinal knowledge.

Table 2. List of diseases/illnesses heal by indigenous herbalists in Dorze *dere*

Serial no.	**Types of Illness heal by herbalists**		
	Local name	**Amharic name**	**English name**
1	*Wuliwusha hargge*	*Ye-gubet beshita*	Hepatitis
2	*Gusso*	*Tekimat*	diarrheal diseases
3	*Bolbo*	*Shair/Kenchir*	Cutaneous leishmaniasis
4	*Kosso*	*Kosso*	Teniasis
5	*Shekere / bazo hargge*	*Woba*	Malaria
6	*Naqarsa*	*Samba nekersa*	Tuberculosis
7	*Hupe bito*	*Ras mitat*	Headache
8	*Acha hargge*	*Ye-tirs himem*	Tooth illness
9	*Kintarote*	*Kintarot*	Hemorrhoids
10	*Yusho hargge*	*Azurit*	-
11	*Galba hargge*	*Ye-koda beshita*	Skin diseases
12	*Asa ayfe*	*Ye-sew ayne*	
13	*Madunth*	*Kusul*	Wound
14	*Kachech*	*Ye-entil mabet*	Tonsillitis
15	*Higisha (asa kana)*	*Buda*	Evil eye
16	*Mehe Hargge*	*Ye-ensisat beshita*	Animal disease
18	*Shosha maata*	*-Ye Tat kusil*	-

5.5. Dosage Determination and Drug Prescription

After identifying of the illness, the herbalist administer the drug which is either prepared earlier or at the moment. The herbalists have mentioned that determination of the dosage of the drugs depend on the type of illness, the age and the physical status of the patients. According to the herbalists dosage is determined by indigenous methods which have been under use for generations and descended down together with the medicinal knowledge and skills. They also mentioned that drugs taken in liquid forms are measured by tea cups, coffee cups or water glasses.

According to herbalists, there are illnesses to which the drugs are taken once and there are also illnesses to which the drugs administered for three consecutive days. However, the dosage determination of the drug of the same disease may vary from herbalist to herbalist. For example, Mr. Mangasha uses water glass to determine the dosage depending on the type of illness, the age and the physical status of the patients. On the other hand, Mrs. Beyenech stated that "I use water glass for adults but coffee cup for children to determine the dosage. I also administer the drugs for three consecutive days in the case of adults". Most of the KIHs said that orally taken drugs are usually determined by coffee cup depending on the above mentioned factors.

Herbalists provide the drug to the patient by blessing them like "*nessi dhale ootho*" which means "may the drug cure you" and "*Xoossi mado*" which means "may God cure you". In addition, herbalists order the patient to take nutritional foods for better function of the drugs. As mentioned before, most of the time herbalists treat the patients and administer the drug at their home. For example, Mr. Akalu mentioned that "I prescribe and order to use the drugs at my home. But sometime based on patient's health status, I prescribe to use the drugs at his/her home for consecutive days as prescribed". Other KIHs also share this idea. However, Mrs. Damenech stated that "I prescribe to use orally taken drugs at my home because the patient may fail to use the drugs as prescribed. Hence in order to avoid risks as a result of dosage, I provide at my home".

After using the drugs as prescribed, the patient come-back to the herbalists home most commonly in the fourth day either to acknowledge or provide money and other gifts if he/she get cured. In case if the patient is not get cured, he/she may consult the herbalist further treatment. Most of the herbalists did not refer cases to clinic because they believe that most patients who take their medication were cured by their own drug. However, Mrs. Almaz refers cases which are beyond her experience.

Discussion with representatives of culture and tourism office (FGD-1) and biomedical health workers (FGD-2) as well as in-depth interview held with youngsters had complained the dosage of the indigenous herbalists. According to them, the over dosage seriously harmed the patients and caused death. Nevertheless, herbalists strictly rejected the idea of over dosage raised by discussants and interviewers. The herbalists said that, “we have long years’ experience but we have not seen injured or dead clients. Thanks to God!” However, Mr. Kebede remembered one case happened with his herbalist sister. He said that “the patient was baby. He was seriously ill and got faint after taking the drug. Then my herbalist sister was disturbed and decided to stop the work. Otherwise I never heard such a serious dosage complain from our clients”. Although herbalists do not quantify dosage like modern medicine, they determine properly and prescribe by the medical believes and practice of indigenous herbal healing.

5.6. Cost of Healing

According to interview with KIHs and FGD-5, indigenous herbalists provide medication to the Dorze community and patients who came from another area with minimal cost. The main reason behind the least payment for the service they provide might be explained in two different ways. The first is that the herbalist parents may order the successor herbalist to not take much money and to not say pay this much, as the case of Mr. Kebede. The second reason might be related with their respect to the community. The herbalists believe that their local community is the one that take care whenever they face challenges and the one who perform their burial ceremony.

The herbalists said that they do not ask money or do not say pay this much for the treatment they provide. Mrs. Almaz said that "I never say pay this much because *"Xoosi tana eratetha bira qantxunta mela erisides. aysi bira qanxiso? Paxida asi bes tuke uya gidi guutha santime immes, izoka oycha ekike"*. This literally mean "God gifted me the knowledge without any payment, so why I ask money? The healed client may give some money; even I never ask that payment". Mrs. Beyenech, Mrs. Marta and Mr. Mangasha also shared this idea and said we are here to serve the community and we never ask them to pay money. Mrs. Marta also stated that "I do not sell the drug because it is not transaction item, but it is to save life".

Mr. Mangasha said that, "I never ask money from my clients because there are patients who have potential to afford and there are also poor patients who do not. My mind also does not accept it". Mrs. Beyenech stated that "I do not sell the drugs but after satisfied with the treatment the patient provide some money, However, I never, want to take money from marginalized social groups. Because, "*tani hayqiko guge ho'othizaysi gidana"* which literally means "attendance and contribution during my burial ceremony will be enough". Even there are clients who pay nothing after get cure".

Then I asked, what is your profit for your service? Most of the herbalists reported that spiritual and moral satisfaction is our profit. However, the KIHs said that the patient may give some money like 2, 5, 10 or 20 Birr and rarely little more. Sometimes the clients may invite local drink known as *dana* or provide clothes, shoe and others, in return for satisfaction. But, these things are done by the full interest of the person who used the medication and nothing is a must. This condition is similar with the situation in Shinasha (Abraham, 2015: 60). Most of the cured clients said that "if we visit health centers, we are expected to pay more than what we are providing. So, we are very happy they say". Nevertheless, the herbalist confirmed that, they do not take money from poor clients of their own community. They say their blessing is enough.

Mrs. Almaz also supported the above idea. She said that "after treatment, patients may come back either for blessing, provide money or "*kumetha dana*"[6] (a calabash filled local beer) by saying *"ye'a yesa kumeth ootho"* which literally means "may God make your life full". In Gamo culture providing *kumeth dana* is an important thing that strengthens social relationship. For example, in holydays like *meskel*, relatives may provide full local and alcoholic drink to their relatives by expressing best wish. This relation maintained and continued throughout the time which strengthens their social relationship. Therefore, according to symbolic/interpretive medical anthropology, providing *kumetha dana* by the client is the symbol and manifestation of good wish. It is, for example, exhibition of whishing fullness of grain store and other things for the healer.

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[6]It refers to local drink (*dana*) filled in a calabash; it has a symbolic meaning; people use it for blessing and during ritual performed to resolve conflicts, bring about reconciliation, and cleans pollution caused by transgression of *gome*

On the other hand, two of the herbalists, Mr. Akalu and Mr. Kebede, sell the drugs for clients who came from another place. For example, clients who came from Arba Minch, Hawassa, Addis Ababa and other places were expected to pay. Unlike the Shinasha where selling medicine is strictly forbidden and associated with healing ability of the drug (Abraham, 2015: 59), selling the drug has no cultural and ethical value. Nevertheless, for the clients of Dorze community, they never sell the drug. According to Mr. Kebede, the reason of selling the drugs for outsiders is to compensate the buying cost of some medicinal plants and the provision of the service. They sell it with minimum cost for the patients who came from another area. Mr. Kebede also explained that there is some customer who come from Arba Minch and buy the drug and sell in other places. For instance, he stated “my brother is living at Arba Minch. He come and collects the drugs that I prepared and sells it to his customers living in Arba Minch and other places”.

Most of FGD-3 discussants mentioned that indigenous medicine is cost effective than biomedicine. Unlike indigenous herbalists of Shinasha, the herbalists of Dorze were not complained by the community for selling the drug with high price. Therefore, selling of drug is not a critical problem in Dorze indigenous healers.

The income generated from healing does not cover the livelihood of herbalists in Dorze, because they serve the community for free or with minimal cost. So, the herbalist cannot make a living and support his family from such materials and money obtained from clients, which is unreliable and inconsistent source of income. Therefore, the herbalists are engage in other activities, most often in weaving, farming and petty trading (Picture 5). All of the KIH accept this fact; and, all of them argue that they cannot sustain their family by the income they get from herbal medicine and healing. During my field stay, I have observed the life style of KIHs. They live under low economic status. From the seven herbalists, three herbalists live in roofed house, while the remaining was live in hut. This might show that the income made from healing work is minimal.

Picture 5. Mr. Kebede, a herbalist engaged in weaving. Photo by the field assistant; Feb., 2016

5.7. Expectation of herbalists

Most of the herbalists have mentioned that their expectation behind herbal medical service to the community is mainly to gain reward from their God. The herbalists also stated that our intention related with their blessing rather than money. Moreover, herbalists mentioned that their expectation is related with gaining social reward from the community during their funeral ceremony. One example is during burial ceremony community sing a unique song for herbalists. The unique songs that community sings for male and female herbalists are indicated in Table 3.

Table 3. Unique songs that the community sing for herbalists during burial ceremony

Songs for male herbalist	
Local term	**English equivalent**
shempho asha giri soriza	Our life saver
Doctore doctore	Our doctor
Hakimezo hakimezo	Our nurse
Shemppo ashizayso	Our lif saver
Nunayita adezo	Father of our children
Nu adezo	Our Father
Daha adezo	Father of Poor
Song for female herbalist	
shempho asha giri soriza	Our life saver
Doctoro doctoro	Our doctor
Hakimo hakimo	Our nurse
Nayita ayido	Mother of our children
Doctoro doctoro	Our doctor
Daha ayido	Mother of Poor
Nu-Shemppo ashizayiro	Our lif saver

Participating and attending burial ceremony give higher value for the individual in Gamo community. Similarly, making colorful burial ceremony is prestige for the deceased one. Hence herbalists were respected in their life time and they want to maintain this trend with warm and colorful burial ceremony.

In addition to the above mentioned expectations, the KIHs also underlined the contribution of the community when the herbalists get sick or sad. The experience of Mrs. Beyenech was a good example when she was sick.

Chapter Six

6. Indigenous and Biomedical Health Care System in Dorze

This chapter presents health care alternatives in the study area. It also gives due attention to the factors that affect decision making to choose the health care systems. In addition, trends on management of illness and patterns of resort are briefly highlighted based on data from interview and FGDs.

6.1. Health Care Alternatives

As Kleinman (1978) stated that the health care system of contemporary and societies in the past can be classified into three except for those relatively few societies which lack professional practitioners. (i) popular sector, (ii) indigenous/folk healing system and (iii) biomedical healing system. Kleinman's classification of health care system also works in Dorze community.

The popular sector of health care system is mainly undertaken at home, family and community level. In this sector the health and healing activities were performed by the patient themselves or family member of the patients. This can be done, for example, by eating special diets, doing exercises and taking rest. According to FGD-3 conducted with community elders, women play a considerable role in healing activities at home level. They prepare nutritional foods and mix medicinal spices such as white onion, ginger, among others, for various illnesses.

According to FGD-3 and 4, before going to indigenous herbalists or biomedical health care system women treat family members at home for less serious illnesses such as, headache, common cold abdominal pain, and wound. These illnesses were treated by locally available materials of medicinal importance such as *tire bula, magantsa, nech shinkurt* (garlic), *feto* and *anka unkulo*.

Indigenous health care and healing system is mainly undertaken by herbalists. According to FGD-3 discussants, before the arrival of biomedicine health care system, indigenous healing system play a significant role in healing various illnesses related with natural, personal and supernatural etiologies. Most of the discussants still use the herbal medicine and say that *"bahile dhaliche pathes aseka haykope ashes"* which literally means "indigenous drugs are curable and save human from death". However, one of the discussant disclosed his preference of the biomedical health care system than the indigenous one for him and his family. Another, 86 years old discussants of FGD-3 mentioned that "I used the indigenous medicine many years ago because there was no health center during that time. However, nowadays, I prefer to go to the health center rather than indigenous herbalists because of its availability and better diagnosis". Discussants of FGD-3 also mentioned that "I and my family member did not used indigenous medicine because of its side effect. In addition, the health center workers teach the community to attend the health center rather than the indigenous healers in different meetings".

According to Mrs. Berhane (the name of KICTW) and FGD-1 discussants, IHM exists in Chencha *woreda* in general for long time and serving the people as health care alternative even if the dosage was in question. They also mentioned that there are trained herbalists who had collaboration with pharmacists. The herbalists working in Tolola *Kebel*e are good examples. They prepare the drug based on scientific guide manual and sell the drugs in Chencha, Arba Minch and Addis Ababa and are more benefited. However, the majority of herbalists in the *woreda* are indigenous herbalists. Hence, according to the dicussants, there is need of awareness creation for herbalists to practice their medicinal knowledge in open manner to be more benefited. According to the discussants, it is better to maintain and preserve the practice because it is impossible that each and every thing will come after scientific proof. The discussants also mentioned that indigenous medicine is treatable to those diseases that biomedicine fails to treat such as *wuliwusha* (hepatitis), *kintarote* (hemorrhoids) and *higisha* (evil eye).

Biomedical health care system is another health care alternative in the community. The comparision between the indigenous and biomedical healing system is shown in Table 4. There is one health care center which was established in 2010 and health extension workers also serve the community in each *kebele* of Dorze. According to FGDs, before the establishment of biomedical health care system in the study area indigenous medicine play significant role. Currently, most patients prefer to visit biomedical health care system because of awareness created by government bodies. These health workers encourage the patients to visit health care center by labeling the indigenous healing as backward practice. Most of discussants mentioned that using biomedicine is considered as manifestation of civilization. This might be taken as a challenge for the existence and continuity of the indigenous medicine and healing system.

Table 4. Comparison between the Indigenous and Biomedical healing systems

Points of comparison	**Indigenous healing systems**	**Biomedicine healing systems**
Scope	More general, includes healing humans and animal.	More specialized, specific to human or animal
Healing setting	In a familiar natural and sociocultural environment.	In an institutional, formal, and bureaucratized environment.
Practitioner- patient interaction	Less sense of power, friendly relations, free feeling.	With sense of power on the side of the practitioner, bureaucratic and less free feeling.
Dosage determination	Determined by indigenous methods which have been under use for generation	Determined based on experimental test
Cost of healing	Inexpensive and based on the interest of the patient	Expensive as compared to indigenous and payment is must except for some cases
Inheritor selection	Selected based on culturally accepted criteria such as honest, trustworthy, etc…	Based on level of formal education

Holy water (*tsebel*) was also used by some discussants as an alternative to the three health care systems. This is a faith based healing mainly practiced by adherents of the Ethiopian Orthodox Church. One of FGD-4 discussant mentioned that “I prefer to use *tsebel* when I get sick because I believe in it”.

6.2. Decision to Choose Health Care Systems

There are several factors that affect decision making to choice a health care system. One is type and severity of the illness. Most of the FGD-3 discussants stated that for naturalistic (diseases caused by germs) type of disease they want to visit biomedical health care system. For example, diseases like typhoid, typhus, malaria and others are preferably treated at biomedical health care system. However, there are some illnesses of non-natural etiology for which indigenous medicine gives a better and complete cure. Notable among these is the case of *higisha* (evil eye). As all of the KIHs and participants of FGDs said, biomedicine does not give cure for *higisha*. But, herbalist healers help to cure the illness. The same is true for *wuliwusha, asa ayfe* and *miche* (skin eruption). The severity of illness also influences choice of a health care system. Illnesses which are considered simple may be dealt at the popular sector. However, when they face severe illnesses that do not give time, most people prefer to go to biomedical centers.

The second factor that affect decision making as to which healthcare system to go is faith and attitude towards healthcare alternatives. According to FGD-2 and 3 discussants, faith is a main factor that influence people's decision making. One of the discussants of FGD-2 remembered the case of one client that *"Bakela angete lay asire kusile dinolignal"* which literally means "via tight bean on my neck, my wound was cured". Hence, there are still patients who adhere to indigenous healing than biomedicine.

Another factor that affect decision making is dissatisfactions with treatment by biomedicine. Some patients were treated with biomedicine before indigenous medicine. Those with earlier consultation of a physician dropped their follow up when they fail to observe progress in their health status. According to Mr. Gelaye (the name of KIC-1) and Mr. Zenebe (the name of KIC-2), and Mrs. Berhane, family members or neighbors advise the patients to resort the treatment to indigenous medicine. Such decisions mostly come after dissatisfactions or failed in treatment with biomedical health care system.

In the context of Dorze, cost is another factor that affects decisiom making in health system choice. There are clients who prefer to visit indigenous medicine. According to them, the reason behind is the healing cost. One of the discussant of FGD-3 mentioned that Mr. Mangasha has treated my daughter without any payment. This idea was strengthened by the song of the community following the death of herbalist as *daha adezo* and *daha ayido* for male and female herbalist, respectively (Table 3). Therefore, indigenous healing is the first choice for those who cannot afford to get treatment at biomedical centers.

Educational background of the patient's family can also affects decision making as to which health care system to go. According to FGD-4, a family who had better formal educational background mostly tends to decide to go to biomedical centers. However, whenever treatment becomes unsuccessful, resorting to indigenous medicine is common. The above discussed factors influence the decision making processes in a way that several factors interplay one another.

6.3. Management of Illness and Patterns of Resort

According to FGD with community members, illness is managed through three health care systems i.e. popular (at home level), indigenous herbal and biomedical health care systems. According to most of the discussants, the biomedical health care system is the first choose of most of members when they get sick. It is believed that if somebody dies at hospital or health care center, it is considered as prestige. If somebody dies, people firstly ask "*awar haykire*?" means "where she/he died"? If the person died in a health care center, most of the time people do not blame the family member of the deceased. This is partly because using biomedical health care is regarded as the right thing and also considered as manifestation of civilization and prestige.

Management of illness is not one directional. The patient can shift from popular to indigenous herbal and then biomedical health care systems or vice versa. Otherwise, it may end or get treatment in one of those health care systems. Patients resort from biomedical health care system to herbal healing or vice versa when they become dissatisfied with one of treatment options. Patients resort to indigenous herbal healing system when they are dissatisfied with biomedical health care system especially for illness of personal and supernatural etiologies. However, there are cases that herbal healing becomes effective in treating natural diseases than biomedicine.

Mr. Zenebe mentioned his illness history with respect to effectiveness of indigenous medicine as follows:

> *I am forty seven years old. I have started to experience wuliwusha or kafo hargge (hepetites) illnesses around twenty five years old. During that time I went to health care center and they told me the type of the illness; following this they provided me a drug. But for a long period, I have suffered from the illness without any improvement. I also go to health care center for the second time. There was also no change. Then I went to* indigenous *healer and I told for the herbalist my case as wuliwusha then he gave me his drug which was orally drunk for three consecutive days which was very strong. Then after, I totally get cure from my illness. Therefore, I can say that wuliwusha is better treated in* indigenous *health care system than the biomedicine*. indigenous *medicine is the only drug that*

> *terminates the illness. In my life time, I have never seen an individual with wuliwusha illness cured at hospital. I spent much money and time for none effective treatment of hepatitis in biomedicine.*

Similar case was mentioned by one of the discussants of culture and tourism worker. He mentioned that

> *I am one of the benefited individual from* IHM. *I have treated from wuliwusha illness by using the* indigenous *drug. But before that I went to biomedical health care system for a longer time. When I lack treatment, then I shifted to use* indigenous *medicine and I have totally cured. So, I am witnessed that* indigenous *medicine treats what biomedicine has failed to cure.*

Another FGD-1 discussant was a herbalist who inherited the knowledge from his father. He was preparing the indigenous medicine at home for his own family, relatives and friends. He said that "personally I have cured around four patients who failed to be cured in biomedicine".

Mr. Gelaye is *kebele* leader. He has remembered his hemorrhoids illness history. He mentioned that:

> *I have visited hospital repeatedly. But I was not get cured. As a result, I and my friend with the same illness history went to a* indigenous *healer. The herbalist identified the problem and gave us a herbal drug. We took the drug as prescribed. Finally, we get cured from the illness. So, hemorrhoid is better treated by* IHM *than biomedicine. From this day onward, we gave a nick name for this herbalist*

healer. His name is Mr. Shedo, but we called him as "Doctor Shedo" to respect his practice.

From the above quote one can understand that IHM treats what biomedical health care professionals' fails to treat. As a result most of the cured patients believe this efficacy and respect the practice.

6.4. The Perception towards one Another

According to one discussant of FGD-2 discussants, as a biomedical worker I have positive perception towards indigenous healing practice. One of the discussants mentioned that "I do not oppose the IHM because it serves as source of drugs of modern medicine. Therefore, I suggest that it is better if the practice is supported by science especially to determine the dosage because indigenous medicine treats what modern medicine fails to treat". Another discussant strengthens this idea saying that indigenous medicine should be encouraged because it is the base for modern medicine. They prepare the drug by mixing leaves and roots of plants. But the problem is the dosage. Another FGD-2 discussant also mentioned that "there are illnesses that do not still get treated by biomedical health care system. Nonetheless, the indigenous medicine cures such illnesses. So, it is better if it get scientific proof".

According to the interview held with Mr. Gashaye (the name of KIBW), it is also possible to understand his perception. To the question that the researcher raised, he described his perception towards indigenous herbalists and their practice. His perception was positive. He said that "personally, I appreciate the effort of indigenous herbalists. Even scientists pass through many trials and errors to be a scientist".

The FGD-2 discussants mentioned that herbalist's have normal social relationship with the Dorze community. One of the discussant stated that "they have regular social relationship like any person. They communicate, enjoy and participate in different social activities although they make their knowledge secrete". Most discussants also support indigenous medicine as it has potential for many source of drug for those diseases which have no treatment at the biomedical system.

Most of the herbalists have positive perception towards the biomedical health care system. However, there are herbalists who blame biomedical workers because they do not visit and consult them. In addition, Damenech stated that biomedical workers teach the community as *"abasha hakimeso betopite abasha dhaleka ekopite"* which literally means "do not go to indigenous herbalists and do not use their drugs". FGD discussants and KIC mentioned that biomedical workers teach them to stop use of indigenous medicine. The daughter of Mr. Mangasha stated that "biomedical health workers recommend my father to stop the practice by explaining the possible risks that can happen as a consequence of over dosage". Hence, from critical medical anthropological point of view, organized and government supported biomedicine is putting pressure on indigenous herbalists and their practice.

6.5. The Nature and Level of Interaction

According to the data gathered from KIHs and Dorze health center workers, there was no interaction between herbalists and biomedical health workers. Both health care systems work independently without any interaction. The reason behind is that biomedical workers consider herbalists as non-educated and labeled their practice as harmful in terms of the dosage of the drugs.

Dorze health center workers have also stated there is no interaction with local herbalists. According to Mr. Gashaye, the main reason for the lack of interaction between herbalists and biomedical workers is knowledge gap between the two practitioners. He said that “we have no knowledge about the herbal medicine and the herbalists do not have knowledge about the biomedical health care. As a result, we do not collaborate. So it is we educated individuals, government and non-governmental organizations to share experience and advance their practice”. Another factor that became obstacle for their interaction was herbalists keep their medicinal knowledge secret. According to FGD-2 discussants the reason for making their knowledge secret was it is a means maintaining their prestige in the community and earns money although minimal. Therefore, they even did not allow their heir to formally replace unless they get aged.

Following the medicinal knowledge secrecy, biomedical workers suggested that in countries like China, indigenous and biomedical health care system collaborate. So, it is better if this trend become applicable in Ethiopia. According to the FGD-2 discussants, although the country health policy gives recognition to indigenous medicine, it was not practical on the ground. This shows that Ethiopia has not properly using IK of herbal medicine for development activities. This is because the herbalists were undermined and dominated by biomedicine. As a result, herbalists are working by their own effort. According to the discussants, if they get recognition and incentive from the government to work in collaboration with the biomedical sector, the issues of over dosage and knowledge secrecy would be resolved.

Mr. Gashaye appreciated the ability of herbalists to treat emergency cases like bleeding by preparing their own drug to clot the bleeding. "In our case what we call it as emergency case. So, it is better when their knowledge is supported by science to know the dosage and its side effect". As a result, they recommend that if the government support and promote their practice, herbalist will not make their medicinal knowledge secret. One of the discussant stated that "we have no interaction and we did not support the indigenous herbalists. It is better if the government pay due attention to them and give them recognition".

Mr. Zenebe is a teacher at Dorze high school and has mentioned his belief on indigenous medicine and healing as follows:

> *I believe in* indigenous *medicine because I had been treated and get cured from wuliwusha. So, it is better if they get training and advance the practice in the future. It is better if pharmacists collaborate with herbalists to prepare the drug in the form of tablet drug. To do this, the government has support and motivates the herbalists by providing incentives and recognizes their work. Hence, recognition is needed. There is a trend in Gojjam area that pharmacists come to herbalists home to buy their product which is in the form of powder. Then, they determined the dosage together. In this process the herbalists as well as pharmacists where benefited. So, I recommend if this trend adopt in the context of Dorze.*

This quotation reveals that Mr. Zenebe was one of the clients' who benefited from herbal medicine. It is also indicated that his wish towards the improvement of the healing practice was great.

Chapter Seven

7. Summary and Conclusion

The indigenous herbal medicinal knowledge is acquired either form the herbalist parent or non-relative herbalist residing outside Dorze. The herbal medicinal practitioners are both males and females who are adults and elders. The knowledge is maintained and transferred from generation to generation through orally. The person who heirs herbal medicinal knowledge was selected either from the family members or outside family based on honesty, trustworthy and patience as well as commitment to serve the community. There was no specifically endowed clan with herbal medicinal knowledge and no ritual activity performed during knowledge transfer. Although the type and depth of herbal medicinal knowledge possessed by the herbalist vary from one herbalist to another, they do not share their knowledge to each other. The interaction among the healers, the patient and the community is positive and friendly.

Medicinal plant collection, preparation, preservation and administration was carried out by the herbalist based on medical believes and practices. Herbalists collect the medicinal plants from different ecological zones such as *bazo*, *geze*, backyards between the *enset* plants mainly during raining seasons, or sometimes buy from the others compound. Although, the method of medicinal plants collection was varied from herbalist to herbalist, most herbalists collect the plants early in the morning. Leaves, roots, seeds, barks and fruits are parts of the medicinal plants used for medicinal purpose. The drugs were prepared in the form of solid, liquid and powder and sometimes mixed with honey for different types of illnesses. In the study area, herbalists identify illnesses through the medical believes and practice of the indigenous medical culture and by using biomedical clinical data. Healing cost was based on the interest of the person who takes the medication and was very minimal. As a result, the payment does not cover the livelihood of herbalists and their family. Therefore, the herbalists were engage in other activities, most frequently in weaving, farming and petty trading.

There are three health care alternatives in Dorze, namely the popular sector, indigenous herbal healing and biomedical healing system. Several factors could influence the decision making process of people for treatment seeking. The patient might start treatment from indigenous to biomedicine or vice versa. The patient can end or get treatment with one of those health care systems. If the clients fail to get cure, shifts from one healthcare system to the other and resorts are common phenomena. There is no professional interaction between the two health care systems. The perception towards biomedical professionals and herbalists was mixed, both optimistic and adverse. Most biomedical professionals appreciate the effort of indigenous herbalists. However, they raise the question of dosage and they oppose the practice as it does not follow scientific procedures. As a result they teach the community to visit biomedical health center. On the other hand, the herbalists respect the modern medicine, but they blame the biomedical workers for their advice of the people to stop treatment at indigenous medicine. In general, the two health care systems exist in Dorze *dere* and serving the community with the biomedicine being dominating and undermining the indigenous herbal system.

In general, what could be understood from this study is the IHM is co-existed with biomedical health care system and still serves the community in the study area. In the course of the study, I come to understand that the IHM and healing system in Dorze is facing challenges. These are the oral transfer of medical knowledge, problems of knowledge transfer as a result of changes in lifestyle, migration and settlement pattern of people, dosage determination, and the labeling of indigenous herbal healing as ‘harmful’ and ‘primitive’. Hence, further studies are needed on IHM to demonstrate its potential role and to solve the observed challenges.

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Annex I: Field Research Guiding Questions: English Version

Addis Ababa University, College of Social Sciences

Department of Social Anthropology

Study on Indigenous Knowledge of Herbal Medicine

(1) Guiding Questions of In-depth Interview

Introduction: The purpose of this interview is to collect data on IK of herbal medicine and healing practice among the Gamo people: the case of Dorze *dere* in Chencha *woreda*, southern Ethiopia. The data of this study was used for the fulfillment of requirements for Master of Art Degree in Social Anthropology. Therefore, the data you gave will be used only for this anthropological study. You are kindly requested to participate in the interview in which confidentiality of information is strictly protected and valued. I also kindly request you, so that I can record your voices, since it is difficult to write all of your responses while interviewing.

Thank you!

፩. Interview Questions for Indigenous **Herbalists**

Part 1: Personal Data

1. Age________2. Sex ___________3. Religion _____________ 4. Marital status____________

5. Educational background________6. Occupation____________7. Source of income________

8. Residential *Kebele* /sub-*Kebele*/_____________9. Length of stay in the area_____________

10. Place of interview____________________ 11. Interviewer's Name ___________________

12. Date of interview_______________ Starting Time: ___________ Finishing Time: ________

Part 2: Interview Questions

2.1. Questions Related to the Herbal Medicinal Knowledge

1. From where and whom did you acquire your knowledge of herbal medicine and healing?
2. How did you learn and how did you master your herbal medicinal knowledge?
3. How do you practice herbal medicine and healing? Secretly or open? Why?
4. How do you transfer your herbal medicinal knowledge? To whom? Why?
5. Do you share and exchange herbal medicinal knowledge with other herbalists? If so, how?

2.2. Questions related with Herbal Medicinal Drug Preparation

1. From where do you get medicinal plants? Who provides to you?
2. Is there any special time to collect (cut) medicinal plants?
3. What tools do you use to cut and collect medicinal plants? Why do you use such tools?
4. Which plant parts do you use for medicinal purpose? roots? leaves? barks? stems? seeds? flowers? Combination of one with another? Other plant parts?
5. How do you prepare those plant parts for medicinal purpose?
6. In what form do the drugs prepared? Powder? Liquid? Solid? Ointment? Other else?
7. Where do you keep the prepared drugs? What containers do you use to store?
8. Does the drugs have expire date? If so, do you discard the expired drugs?

2.3. Questions Related with Illness Identification and Healing

1. What are the illnesses that you heal using the herbal medicine?
2. Does all the listed illnesses get cured using the drugs? Or it varies from illness to illness?

3. If your answer is yes, which illnesses totally get cure? Which illnesses partly cure? Which illnesses challenges?
4. How do you come to know your patients' health problem? By the information patients provide? By observation? By a certain method of examination/testing/? If so, how? Other means?
5. When and where you provide treatment to the patients? Are you working on a full time or part time basis?

2.4. Questions Related with Medical Prescription and Administration

1. How do you determine the dosage? What materials you use to measure the amount of the drug?
2. Are there problems encountered as a result of over dosage? If so, what are the problems encountered?
3. How do you prescribe the drugs to use? Drink? Polish? Tight? Other else?
4. What are the complements that are usually ordered as additives with the medicines?
5. For how long do the drugs prescribed?
6. Do you make patient follow up and check up? If yes, how?
7. For emerging diseases, do you find new drugs?
8. How is the treatment cost? Is there variation in cost of the drugs? Do you make improvement on payment?
9. Do you make a living or support your livelihood from your profession?

2.5 .Questions Related with Interaction between Herbalists and Biomedical Workers

1. How is your interaction with biomedical health officers and health extension workers?

2. If so, do you share knowledge and experience from them?
3. What are the problems (if any) that hinder the IHM and healing system in Dorze?
4. How do you see the continuation of the Dorze indigenous herbal medicinal knowledge and healing system? Safe or endangered?

    - In terms of knowledge transfer?
    - In terms of the society's use of IHM and healing?
5. What do you think are the solutions to solve the above mentioned problems?

፱. Interview Guide for the Health Center Worker

Part 1: Personal Data

1. Age____________ 2. Sex_______ 3. Religion________ 4. Marital status_____________

5. Educational background____________ 6. Occupation_________7. Income ___________

8. Place of residence_______________________ 9. Length of stay in the area____________

10. Place of interview___________________ 11. Interviewer's Name _________________

12. Date of interview:______________ Starting Time: __________ Finishing Time: ______

Part 2: Interview Questions

1. What look the interactions likes between herbalists and biomedical healing systems?
2. Is there professional interaction between the two healing systems in your locality? If yes, what is the relation?
3. Are there cases/diseases/ that you refer or recommend to indigenous herbal healers? If yes, what illnesses?
4. Do you know /think/ that indigenous herbal healers refer cases/diseases/ to you? If yes, what illnesses?

5. Is there any problem that hinder the interaction between the herbalists and the biomedical healthcare system?
6. What do you think should be done to improve the professional interaction and dualistic co-existence between the two healing systems?

፫. Interview Guide for the Community Members

Part 1: Personal Data

1. Age____________ 2. Sex_______ 3. Religion________ 4. Marital status_____________

5. Educational background____________ 6. Occupation_________7. Income ___________

8. Place of residence_______________________ 9. Length of stay in the area____________

10. Place of interview___________________ 11. Interviewer’s Name _________________

12. Date of interview:______________ Starting Time: __________ Finishing Time: ______

Part 2: Interview Questions

1. To care your health, what types of health care systems are available in your area?
2. What do you do when you fell ill? Where you go? Why?
3. Do you use IHM? For what type of diseases? Why? When? How?
4. Is there any condition that you use both health care systems? Why? How?

፬. Interview Guide for the Culture and Tourism Workers

Part 1: Personal Data

1. Age____________ 2. Sex_______ 3. Religion________ 4. Marital status_____________

5. Educational background____________ 6. Occupation_________7. Income ___________

8. Place of residence_______________________ 9. Length of stay in the area____________

10. Place of interview___________________ 11. Interviewer’s Name _________________

12. Date of interview:______________ Starting Time: __________ Finishing Time: ______

Part 2: Interview Questions

1. How long since the IHM is known in the *woreda*?
2. How did you see the contribution IHM in serving the people as health care alternative?
3. Does the IHM have caused any problem?
4. Are there promotion works from your office for indigenous hebalists?
5. What do you think is neccassary to preserve and maintaine IHM?

(II) Focus Group Discussion Guide

Introduction: The purpose of this focus group discussion guide is to collect data on IK of herbal medicine and healing practice among the Gamo people: the case of Dorze *dere* in Chencha *woreda*, southern Ethiopia. The data will be used for the fulfillment of Master of Art in Social Anthropology. Therefore, the data you gave will be used only for this anthropological study. You are kindly requested to participate in the FGD in which confidentiality of information is strictly protected and valued. I also kindly request you, so that I can record your voices, since it is difficult to write all of your responses while interviewing.

Thank you!

፩. Focus Group Discussion Guide for the Indigenous Herbalists

Part 1: Personal Data

1. Age_________ 2. Sex_________ 3. Religion_________ 4. Marital status_____________

5. Educational background___________ 6. Occupation_________ 7. Income ___________

8. Residential *Kebele*/sub-*Kebele*/ _________9. Length of stay in the area______________

10. Place of the focus group discussion___________11. Facilitator's Name______________

12. Date of the focus group discussion: ______ Starting Time: _____Finishing Time:____

Part 2: Focus Group Discussion Guiding Questions

1. What looks your interaction like with the biomedical health officers in your locality?
2. Do you work in cooperation with the biomedical health officers in your locality? If so, on what matters do you cooperate?
3. What do you think are the problems on the side of the biomedical healing system that hinder mutual cooperation between the two health systems?
4. What do you think are the problems on your side that hinder mutual cooperation between the two health systems?
5. Do you think that the co-existence of the indigenous herbal healing and the biomedical healing systems is important in your locality? If so, how?

፪. Focus Group Discussion Guide for Biomedical Workers

Part 1: Personal Data

1. Age_________ 2. Sex_________ 3. Religion_________ 4. Marital status_____________

5. Educational background___________ 6. Occupation_________ 7. Income ___________

8. Residential *Kebele/*sub-*Kebele/* _________9. Length of stay in the area______________

10. Place of the focus group discussion___________11. Facilitator’s Name______________

12. Date of the focus group discussion: ______ Starting Time: _____Finishing Time:____

Part 2: Focus Group Discussion Guiding Questions

1. How do you see the IHM with respect to the biomedical health care in your locality?
2. Do you work in cooperation with the IHM in your locality? If so, on what matters do you cooperate?
3. Do you recommend the patients to use IHM? If so, which illnesses?

4. Dose the IHM has role in solving societal problem and alleviate your burden?
5. Do you think that the indigenous herbal healing system and the biomedical healing system are dually serving the society?
6. Do you plan to work in collaboration with IHM? In what cases?
7. What are the problems that hinder mutual cooperation between the two healing systems? What are the solutions?
8. What are the problems that hinder mutual cooperation between the two healing systems from the herbalists side? What are the solutions?

፫. Focus Group Discussion Guide for the Selected Community Members

Part 1: Personal Data

1. Age_________ 2. Sex_________ 3. Religion_________ 4. Marital status_____________

5. Educational background___________ 6. Occupation_________ 7. Income ___________

8. Residential *Kebele/*sub-*Kebele/* _________9. Length of stay in the area______________

10. Place of the focus group discussion___________11. Facilitator's Name______________

12. Date of the focus group discussion: ______ Starting Time: _____Finishing Time:____

Part 2: Focus Group Discussion Guiding Questions

1. What is your choice of treatment at the time you are confronted with illness? Home remedies? Indigenous herbal healers? Biomedical healthcare centers? Why do you choose/prioritize/ the one?
2. For what types of illnesses you usually go to indigenous herbal healers? For what types of illnesses you take home medicines? For what types of illnesses you visit biomedical centers?
3. How do you see the efficacy of IHM and the healing system in curing illnesses?

4. Which illnesses are better cured at indigenous herbal healers?
5. Which illnesses are better cured biomedical healthcare centers
6. Do you combine medicines of home remedies, herbal medicines given by healers, and biomedical medicines one another? If so, in what situations? How?

ō̱. Focus Group Discussion Guide for the Culture and Tourism Workers

Part 1: Personal Data

1. Age____________ 2. Sex_______ 3. Religion________ 4. Marital status_____________

5. Educational background____________ 6. Occupation_________7. Income ___________

8. Place of residence_______________________ 9. Length of stay in the area____________

10. Place of interview___________________ 11. Interviewer's Name _________________

12. Date of interview:______________ Starting Time: __________ Finishing Time: ______

Part 2: Focus Group Discussion Guiding Questions

1. How did you see the interaction between your office and indigenous herbalists?
2. What are advantages and dis advantages of indigenous medicine?
3. Are there promotion works from your office for indigenous hebalists?
4. What do you think is neccassary to preserve and maintaine IHM?

Annex II: Socio-demographic Profile of Key Informants

2.1. Profile of Key Informants Herbalists

Name of KIH	Age	Sex	Level of education	Occupation	Religion	Marital status	Place of interview	Date of interview	Remark
Mrs. Damenech (KIH-1)	55	F	Can read and write	Herbalist and farmer	Ethiopian Orthodox	Married	01 *kebele*	14-15 / 02/ 2016	Prominent herbalist
Mrs. Almaz (KIH-2)	52	F	Can read and write	Herbalist, farmer and trade	Ethiopian Orthodox	Married	Amarana Bodo	16-17 /02 / 2016	Prominent herbalist
Mr. Akalu (KIH-3)	55	M	Grade 4	Herbalist, weaver and farmer	Ethiopian Orthodox	Married	Metsona Gara Dita	19-20 / 02 / 2016	Prominent herbalist
Mr. Kebede (KIH-4)	60	M	Can read and write	Herbalist and weaver	Ethiopian Orthodox	Married	Hollo'o-Laka	21-22/ 02/ 2016	Prominent herbalist
Mrs. Beyenech (KIH-5)	61	F	Can not read and write	Herbalist and farmer	Ethiopian Orthodox	Married	Hollo'o-Laka	24-25/ 02 / 2016	Prominent herbalist
Mrs. Marta (KIH-6)	70	F	Can not read and write	Herbalist and farmer	Ethiopian Orthodox	Married	Amarana Bodo	26-27 / 02/ 2016	Prominent herbalist
Mr. Mangasha (KIH-7)	85	M	Can not read and write	Herbalist and farmer	Ethiopian Orthodox	Married	Amarana Bodo	29-30 / 02/ 2016	Prominent herbalist

2.2. Profile of other Key Informants

Name of other KI	Age	Sex	Level of education	Occupation	Religion	Marital status	Place of interview	Date of interview	Remark
Mrs. Berhane (KICTW)	31	F	Frist Degree	Culture officer	Ethiopian Orthodox	Married	Chencha	11 / 02/ 2016	
Mr. Gashaye (KIBW)	32	M	10+3	Health officer	Protestant	Single	Dorze	18 /02 / 2016	
Mr. Gelaye (KIC-1)	40	M	10+3	*Kebele* leader	Ethiopian Orthodox	Married	Dorze	23 / 02 / 2016	
Mr. Zenebe (KIC-2)	47	M	Frist Degree	Teacher	Ethiopian Orthodox	Married	Dorze	28 / 02/ 2016	

Annex III: Socio-demographic Profile of Focus Group Discussants

Code	Age	Sex	Level of education	Occupation	Religion	Marital status	Remark
FGD-1 (At Chencha Culture and Tourism Office on March 02, 2016)							
FGD-1.1	31	F	Frist Degree	Officer	Ethiopian Orthodox	Married	
FGD-1.2	48	M	10+3	Officer	Ethiopian Orthodox	Married	
FGD-1.3	35	M	Frist Degree	Officer	Ethiopian Orthodox	Married	
FGD-1.4	28	M	Frist Degree	Officer	Ethiopian Orthodox	Single	
FGD-2 (At Dorze Health Center on March 04, 2016)							
FGD-2.1	29	M	10+4	Health worker	Ethiopian Orthodox	Single	
FGD-2.2	30	F	10+4	Health worker	Protestant	Single	
FGD-2.3	34	F	10+3	Health worker	Ethiopian Orthodox	Married	
FGD-2.4	39	M	10+3	Health worker	Ethiopian Orthodox	Single	
FGD-2.5	32	M	10+4	Health worker	Ethiopian Orthodox	Married	
FGD-2.6	33	M	10+3	Health worker	Ethiopian Orthodox	Single	
FGD-2.7	28	F	First Degree	Health Officer	Protestant	Single	
FGD-3 (community elders) (At Dorze Amarana Bodo *kebele* on March 06, 2016)							
FGD-3.1	86	M	Grade 3	Farmer and weaver	Ethiopian Orthodox	Married	
FGD-3.2	55	F	Can not read and write	Farmer and petty trader	Ethiopian Orthodox	Married	
FGD-3.3	56	F	Can not read and write	Farmer	Ethiopian Orthodox	Married	
FGD-3.4	65	M	Grade 4	Farmer and weaver	Ethiopian Orthodox	Married	

FGD-3.5	67	M	Grade 5	Tailer	Ethiopian Orthodox	Married	
FGD-4 (community youngsters) (**At Dorze Hollo'o-Laka *kebele* on March 08, 2016**)							
FGD-4.1	22	F	Grade 8	Student	Ethiopian Orthodox	Single	
FGD-4.2	34	M	Grade 10	Farmer	Ethiopian Orthodox	Married	
FGD-4.3	18	M	Grade 9	Student	Ethiopian Orthodox	Single	
FGD-4.4	38	M	Grade 11	Private worker	Ethiopian Orthodox	Married	
FGD-5 (KIHs) (At Dorze Amarana Bodo *kebele* on March 10, 2016)							
FGD-4.1	85	M	Can not read and write	Herbalist and farmer	Ethiopian Orthodox	Married	Prominent trained herbalist
FGD-4.2	70	F	Can not read and write	Herbalist and farmer	Ethiopian Orthodox	Married	Prominent herbalist
FGD-4.3	60	M	Can read and write	Herbalist and weaver	Ethiopian Orthodox	Married	Prominent herbalist

Declaration

I declare that this thesis is my original work. It has not been presented for a degree in any university and that all sources of material used for the thesis have been credited and acknowledged.

Name: **Wagaye Wade Malo** Signature: ___________________________

Date of Submission: __________________

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