

**ADDIS ABABA UNIVERSITY**  
**SCHOOL OF GRADUATE STUDIES**  
**DEPARTMENT OF SOCIOLOGY**

**MODERN HEALTH CARE SYSTEM AND SOCIO-CULTURAL  
SETTINGS OF THE SOMALI PASTORAL AND AGRO-PASTORAL  
COMMUNITY IN JIJIGA ZONE**

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**Addis Ababa**

**May,2011**

**MODERN HEALTH CARE SYSTEM AND SOCIO-CULTURAL  
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**A THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES OF  
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## Glossary of Local Terms

Dacaar: plant leaf used as a source of home remedy to cure allergic

Du'co: a ritual activity conducted to cure a disease

Ebbe: socially and culturally ousted behavior

Ga'al: a person without a religion

Haabashi: all other ethnic groups outside the Somali community

Haabar: super natural forces (like evil spirit) that causes an illness

Hilheed: plant leaf used as one source of home remedy to cure amoeba

Jini: an evil spirit causing a sickness upon someone else.

Kumaayo/Wal Koraad: an evil eye causing sickness upon someone especially on children

Ma'alini: a religious teacher who can cure diseases caused by super natural forces

Melaah Gaacho: a place where hunger is common which is located in Kebribeyah Woreda

Urawaaweyn: plant seed used as one source of home remedy to cure constipation

Xabaasuud: black seed used as one source of home remedy to cure headache

## Acronyms

**AIDS**-Acquired Immune Deficiency Syndrome

**CSA**- Central Statistical Agency

**DHS**- Demographic Health Survey

**EFY**- Ethiopian Physical Year

**ESPS**- Ethiopian Society of Population Studies

**FSAU**- Food Security Analysis Unit

**GWHB**- Gursum Woreda Health Bureau

**HIV**- Human Immunodeficiency Virus

**KWHB**-Kebribeyah Woreda Health Bureau

**MOH**-Ministry of Health

**NGOs**-Non-Governmental Organizations

**SNNPR**- Southern Nations and Nationalities Peoples Region

**TB**-Tuberculosis

**UK**-United Kingdom

**UNCT**-United Nation Country Team

*WB*-World Bank

**WHO**- World Health Organization

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## ABSTRACT

The twenty century has witnessed the integration of the socio-cultural settings of the society in to the modern health care system implemented both in the developed and developing countries of the world. In developing countries in general and in Ethiopia in particular, the situation in health care has become so complex that medical or biological terms alone cannot effectively assess it. When health care providers ignore the psychological and socio-cultural factors, the care of patients is limited; because biology represents only part of the consequences of a malady. Hence, inquiry in to the socio-cultural settings of a society is vital for understanding the various features of the community such as, their views of health, disease, illness, and sickness and the indigenous medical beliefs and practices of the community that, they employ to prevent and treat health related problems. Similarly, such an investigation would also help to recognize the socio-cultural aspects that are challenges in the provision of services as well as aspects that need to be taken in to account in the provision of services. Therefore, this thesis primarily emphasizes on the socio-cultural settings of the Somali pastoral and agro-pastoral community in Jijiga zone, that need to be considered in the provision of modern health care services.

Both qualitative and quantitative research methods were employed for the collection of the data. In-depth interviews, focus group discussion and observations were the qualitative research methods that were used in the study. Where as survey was the quantitative research method employed to support the data collected through qualitative research methods in this study.

The findings of the study revealed that, the socio-cultural aspects of the community in the study area are challenging the provision of modern health care services and impacting the health seeking behavior of the community. The community's social and cultural aspects at the same time are linked to the most common diseases in the area. People of the area associate the causation of diseases both to the personalistic and natural factors; but the majority of diseases are believed to be caused by the personalistic (supernatural forces). Hence, for the treatments of many diseases home remedy and traditional medicines (use of ma'alín) are preferred than modern medicine. Mostly, when such treatment options failed to cure the disease, the cause is associated with the blood and a laboratory test is demanded from the modern health care institutions.

Generally, the study portrayed that, the urban, curative oriented health care program implemented in the study area has exacerbated the ill-health status of the community; because the focus is on curing while the causes of many diseases are related with the social and cultural aspects that are possible to be prevented through health education taking their cultural settings in to account. In addition, the study revealed that, the large number of male physicians who are unfamiliar to the community's culture and Somali women health extension workers who are afraid of men member of the community, and the failure of the modern health centers to incorporate traditional birth attendants who are providing safe deliveries to the majority of mothers in the study area are some of the serious challenges hindering the provision of modern health care services in the area.

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# CHAPTER- ONE

## 1. INTRODUCTION

### 1.1 Background of the Study

An increased understanding of the socio-cultural environment of the society has played an important role in the designing and development of an appropriate health care policies and programs. The critical role social and cultural factors play in determining or influencing the health of individuals, groups, and the larger society has made medical sociology important. (Cockerham, 2007).

According to Winkelman (2009:37), culture is a principal determinant of health conditions particularly in exposing or protecting society from diseases through structuring its interaction with the physical and social environment. Similarly, one cannot really understand how people react to their illnesses, sickness, death or other misfortunes with out an understanding of the types of culture they have grownup in or acquired (Helman, 2007:7). Hence, this could indicate that, humans first and fore most tend to respond to their health problems in a manner consistent with their cultural norms and values.

As far as the beliefs, attitudes, opinion and behavior of any society are the product of its culture, an attempt to design and develop and initiate public health programs requires knowledge of the culture. Further more, any initiatives hoping to have a chance of successes must immediately engage the traditional mechanisms of healing and community leaders- failure to do so can doom the program.

Over all, every society has its own ethno-medicine, that part of its cultural system that deals specifically with sickness and healing. In many parts of the world where modern health care facilities are not readily available or affordable, the wider public has continued to rely on its traditional and cultural medicine which are based on locally available natural resources and cultural knowledge, which is true of the communities in the study area.

Similarly, the cultural knowledge of medication and its ways of treatment by itself have evolved with in the socio-cultural and historical context of the society, and its epistemic frame work, principles, concepts and practices are quite different from the modern science (WHO, 2002:7).

Since, the western type of health care institutions are out of reach of most developing countries people in terms of distance and costs, especially at the village settings, the dependency of the local community in the existing cultural medication is unquestionable. A large body of evidence confirms that many people in the developing world go without health care from which they could benefit greatly, and thus they depend and choose traditional cultural healers for treatment. They prefer them not only because doctors are not accessible to them but also they believe in the usefulness and power of traditional medicine (Elujoba et.al, 2005).

In support of the above point, Elujoba et.al (2005:47) noted that an effective health agenda for the African continent can never be achieved by modern medicine alone unless it is complimented by traditional medicine practice.

Having taken in to account, the view that any model of health care system based on a single system of medicine will find it difficult to cope with the health care demands of the society in the near future, the world health organization has encouraged member countries to incorporate their indigenous traditional and cultural knowledge of medication in to the modern medicine and address their peoples health care needs (WHO, 2002). Hence, this could indicate the relevance of the indigenous knowledge of medication in the health and health related aspects of society.

Pastoralists have an indigenous knowledge that has sustained both their lives and their animals' life through out history. Indigenous medicine is an important component of indigenous knowledge system. Since, their way of life is highly interwoven with their livestock; there is always a link between access to milk and human health as perceived by pastoralists themselves (Gerald and Dorothy, 2010:16).

Ethiopian pastoralist and agro-pastoralist communities inhabit 625,000 square kilometers of the country's peripheral land mass which covers 61-65% of the total size of the country. Pastoralists comprise 11% of the nation's total population. Despite the visible and significant role pastoralists play both in the national and regional economy in Ethiopia, the sector was among the most marginalized in terms of having access to health and educational services and development opportunities. Moreover, besides contributing the lion share of the national domestic product of the country, the health care needs of the pastoral and agro-pastoral communities is less documented in Ethiopia as compared to agrarian and settled communities. Consequently the health sector has received least attention in government development programs (Getachew et al 2003).

Though, the national government of Ethiopia fully blames the mobile nature of the community as a major barrier on accessing health services, pastoral and agro-pastoral communities do have an immense of socio-cultural traditions that they are relying so as to identify illnesses, sicknesses, managing illnesses, health seeking behaviors, decision making on choosing options to seek help when they got threat to their health and many more alternative ways of healing.

Therefore, the researcher would attempt to shed light on the socio-cultural settings and the alternative traditions that need to be integrated in to the modern health care system implemented by the national as well regional state governors in Somali national regional state, Jijiga zone, Ethiopia.

## **1.2 Statement of the Problem**

Currently, many developing countries are giving special attention to the pastoral and agro-pastoral community's health and educational needs. Similarly, in recent years the government of Ethiopia has invested heavily in improving public services in Somali region especially in health care and educational facilities (Devereux, 2006). Before the period that Somali region introduces the mobile health and nutritional approach in 2004 it was the urban oriented, curative health care program being implemented in the region.

However, due to the limited involvement of the local pastoral and agro-pastoral Somali community leaders/elders and the failure of the national government to take in to account and integrate the socio-cultural and economic features of the community, the urban based curative services, rather than, the preventive primary health care services, has failed to achieve the intended policy goal of the nation.

Any initiative hoping to have a chance of successes must immediately integrate the traditional indigenous mechanisms and community leaders- failure to do so can doom the program before it truly begins (CHF International, 2006:31).

Accordingly, due to the urban based, one-size-fit all program failure to address the health needs of the community, the Somali national regional state was forced to remain being the least developed and underserved region in terms of health services and development infrastructures in the country. Along with the failure of the program, the occurrence of natural disasters, poor access to adequate health service delivery and fundamentally the mobile nature of the community has necessitated and forced the region to introduce the mobile health and nutrition approaches in the region in 2004 (Muhuyadin, 2009:4, Dabar, 2008).

However, despite the immense contribution mobile teams can do to alleviate the health problems and address the communities basic health needs in times of crisis and emergencies, still the socio-cultural aspects of the community that play an important role in the service delivery of the teams were not properly addressed and it needs a further scientific investigation.

Although various studies have been conducted both by government and non-government institutes and research centers on the mode of delivering health care services and improving the health status of the pastoral and agro-pastoral communities in general, there are no studies, so far conducted among Somali pastoral and agro-pastoral community in relation to assessing the contribution of their social and cultural aspects integration with that of modern health care delivery system.

For instance, a study carried out by Muhuyadin (2009) in the area stressed on child feeding practices, diversity of diet and the intended outcome of the mobile health and nutritional team program on children weight gain. However, even if, the study has shown the nutritional status of the region using a western culture bound way of defining health, it lacks systematic approach to study the nutritional status and other health related aspects of the region using the height and weight of children and did not clearly communicate the over all socio-cultural and economic aspects of the community. Against the modern culture bound definition of health, Helman (2007) stated that the numerical definition (weight and height) used to define normality may not much indigenous beliefs about whether a child is healthy or not. This is because, parents may see a child as healthy if he/she can smile, play, talk, respond affectionately or perform certain domestic or ritual tasks irrespective of their height and weight.

Moreover, the pastoral communities in general are viewed as mobile and living in arid and semi-arid parts of the country and mostly dependent on their animals milk and meat for their consumption which in turn leads them to malnutrition. Yet, Save the children UK (2008:83) report has indicated that pastoral community are more market oriented than farmers for their food needs so they tend to purchase a wider range of local and imported food items than do farmers, who are more dependent on their own food production. Like wise, supporting the above point, Devereux (2006) noted that, contradicting the image of pastoralists as surviving mainly on meat, milk and blood, the analysis of food consumption in Somali region reveals a great deal of dietary diversity across districts and livelihood groups and a high dependence on cereals as well as an animal products. Thus, the above given points would let for further investigation to be undertaken in the way of life of the community and their cultural feeding practices.

In addition to the above studies in the area, for instance, the United Nations country team in Ethiopia (2009:11) reported that women's access to health care services in Somali region is limited due to poor literacy levels and their limited freedom to seek services and control over resources and their body. Even if, the report has indicated some of the challenges that the mobile teams have faced in their attempt to address the health care

needs of children and women in the region, the report completely lacks an understanding of the socio-cultural settings of the community. According to Winkelman (2009:52) and Helman (2007) any society's health care system cannot be studied in isolation from any other aspects of that society, especially its social, cultural, religious, political and economic aspect.

The contribution of the socio-cultural aspects of the Somali Pastoral and Agro-pastoral community was not investigated and integrated into the delivery of modern health care system. It was overlooked and undermined by the modern health care system planners and professionals working in the area. Thus, the only viable option to address the health needs of the community is to investigate and take into consideration the socio-cultural foundation of the community which is essential for addressing public health mandates to assess community's health needs and develop appropriate health policy and programs and ensure adequately and culturally competent services.

### **1.3 Objectives of the Study**

The Study has the following general and specific objectives.

#### **1.3.1 General objective**

To assess the possibilities of contradiction in between the Somali pastoral and agro-pastoral community socio-cultural settings and the modern health care system and its service delivery.

#### **1.3.2. Specific objectives** of the study are

1. To explore the social and cultural practices and activities that promotes healthy life styles/ ill health.
2. To explore the indigenous knowledge of the pastoral and agro- pastoral community in identifying, diagnosing and treatments of illnesses.
3. To find out the role of traditional healers and birth attendants as well as the methods they employ in maintaining the health of the community where modern health facilities are present.
4. To investigate the effectiveness of the modes of modern health care service delivery systems operated in the region/ zone.

5. To identify the major barriers that exists in the diagnosis and treatments of diseases/illnesses in the clinical setting.

## **1.4 Research Method**

### **1.4.1 Study Design**

Taking in to account the nature of the subjects under study, the researcher has used a cross-sectional study design. In this type of study design, data was collected at one point in time from sample selected to describe some large population at that time.

### **1.4.2 Methods of Data Collection**

Both qualitative and quantitative data collection methods were used by the researcher. The strengths of qualitative methods are that enabled to generate detail and in depth information from the emic (insiders) perspective. Quantitative methods, strengths are that they produce factual and reliable data that could be generalizable to some larger population.

Since, the majority of the communities living in the region/ zone are pastoral and agro-pastoral people, finding an already framed list of the house holds in the zone/Woreda was impossible and this created a problem to the researcher not to use the quantitative research methods (survey). This method is exclusively used to interview health care professionals in the Woredas because they can be found at their office very easily. Where as, clients/patients and other community members were interviewed using qualitative methods because the people are inaccessible for survey due to their way of life. The combination of the two methods is complimentary and also could fill the gap of each other. Thus, the methods of data collection that were used for this study are forwarded as follows.

### **Survey**

Survey is one of the most widely used primary data gathering instrument which was used in order to gather the required information from the research subjects. Hence, in order to compliment the information gathered through qualitative research methods from the

community, key informants and traditional birth attendants the researcher has used survey questionnaire administered exclusively to the health care professionals. The respondents were interviewed using both close and open ended structured and unstructured questionnaires to be administered both by the interviewer and that of the respondents themselves. The total number of health professionals in the two Woredas was 199, out of which the researcher selected 110 sample respondents using purposive sampling techniques with their accessibility and visibility and administered survey questionnaire to them (50 out of 80 respondents in Gursum and 60 out of 119 respondents in Kebribeyah woreda). All the questionnaires were properly filled in and returned to the investigator. The researcher has selected only 110 respondents due to the mobile way of life of the community whom they serve that leads the health professionals not to be available in the time the study was undertaken.

### **Focus Group Discussion**

A total of eight focus group discussions from the two Woredas were conducted with participants mixed from the community (male/female clients), traditional birth attendants, traditional healers; officials from the zone/Woredas, Community elders and clan/sub-clan leaders . Each focus group had seven to ten participants. During the discussion the researcher had a guide to direct the discussion among the group in order to find out their genuine experience, perception, opinion and views on the topic under study.

### **In-depth Interview /Un-Structured Interview**

The use of this type of interview enables the researcher to have holistic detail information on the subject under study. To achieve these through purposive and snow ball sampling techniques 100 informants from different categories were interviewed. These are clients (both male and female) seeking help from health centers (40), clan/sub clan leaders (5), officials from the regional /zone /Woredas health bureau (15), community elders(15) and traditional healers(10) and traditional birth attendants(15) were intensively interviewed.

## **Direct Observation**

Direct observation involves observation of research subjects in a certain situation and under their own natural settings. The relationships and activities of traditional healers and their clients/patients and that of the modern health care providers and their clients were observed in their natural settings. This type of observation helps the researcher to capture the tangible events and processes in the study area. For instance in his study of culture and health, Winkelman (2009) states the importance of observation by saying that, participant observation involves a direct engagement with people's ethno medical systems, providing information about cultural illness beliefs and behaviors that affect care through patients' conceptualization of and responses to health problems.

### **1.4.3 Types and Sources of Data**

Both primary and secondary data types collected from various sources were used for the study. The primary data and secondary data types could be used to obtain first and second hand information respectively.

The sources of secondary data are published and unpublished documents, project reports, annual reports, journals, articles and books related to the topic under study. The primary data sources are generated from the research subjects.

### **1.4.4 Methods of Data Analysis**

The study has employed a combination of both qualitative and quantitative methods for the analysis and interpretation of the information gathered through the use of the above research methods.

In the first place, the qualitative data generated through the above methods is organized, transcribed, classified and ranked from primary sources and analyzed thematically through comparison. Secondly, in the analysis of quantitative data obtained from health care professionals using survey questionnaire, numbers are the principal components of analysis to make meaning full patterns of relationships among the data acquired for the

study. Descriptive statistics were employed to compare and analyze the quantitative data. Frequencies and Tables were used in describing and explaining the results of the study.

### **1.4.5 Sampling Procedure and Site Selection**

Jijiga zone is one of the nine zones that make up the Somali national regional state. The zone is perhaps the largest zone and the most heavily settled of the Somali region, nine zones, with largest a quarter of the region's populations which 80% of whom is rural (Devereux, 2006:41).

The zone is located in the north east of the Somali region comprising six Woredas namely; Gursum, Awbare, Kebribeyah, Babile, and Harshin. The zone was selected because it has both settled as well as mobile pastoralists reflecting the diverse geographical and socio-cultural settings of the area.

Regarding sampling, for this study non-probability sampling technique was used to select key informants, local/clan/sub-clan leaders, traditional birth attendants and healer, for this judgmental/purposive and snowball sampling were used.

Since the study area comprises both pastoral and agro-pastoral community, using purposive sampling one agro-pastoral and one pastoral Woredas namely Gursum and Kebribeyah Woredas were selected as research sites to the study.

### **1.5 Significance of the Study**

As it was shown from the beginning in the introductory section of this study, this study primarily focuses on investigating the association of socio-cultural settings in the delivery of modern health care services inline with that of the Somali pastoral and agro-pastoral community. Due to an increased understanding of the impacts of social and cultural aspects in the health of any society, the world health organization has included the social, cultural and psychological aspects of human beings in its definition of health.

However, still because of their mobile nature of life and that of lesser involvement in the nations politics, some groups of people such as pastoralists and agro-pastoralists

communities are being marginalized and remained under serviced from accessing health care services in a manner that is consistent with their social and cultural foundation. Hence, the out comes of this study would enable as a source of literature for the currently growing field of medical sociology in Ethiopia.

The results of the study can also provide a staging ground for the newly interested social scientists and other researchers in the area. It will also remind policy makers and concerned bodies to give attention to the socio-cultural aspects in the designing and development of pastoral and agro-pastoral community development issues in general and that of their health care aspects in particular.

Moreover, the findings of this study would reveal the importance of social and cultural settings of society in the development of attitudes, perceptions, and beliefs of health, disease and illness causation and that of the formations of behavior.

Still this research will help health care professionals, NGOs and other concerned bodies to consider the way of life of the community in the provisions of services. In general, this task is the one which has shown the need to integrate the indigenous medical knowledge of the community in the provision of allopathic medicine both in the developed and developing countries of the world.

## **1.6 Scope and Limitation of the Study**

This study is conducted in Jijiga zone, Somali region with the intent of analyzing the association of the modern health care system and that of the socio-cultural settings of the Somali pastoral and agro-pastoral community.

The focus of this study is to explore the socio-cultural settings which were significant and relevant in the delivery of the modern health care services.

More over, the study includes the challenges and barriers that need to be addressed in the diagnosis and treatments of illnesses in the clinical settings.

The role played by traditional medicine and its healers in the presence of modern health care system could still be dealt with.

The study is also not without limitations. First and foremost, the way of life of the community under study is a big challenge for accessing the required informants. Along with their ways of life still the security problem in the area has restricted the movement of the researcher. Secondly, the shortage of time and the lack of sufficient funds hindered not to include large sample size that could nearly represent the total population of the zone.

Finally, the poor educational status of the region in general and the study area in particular has forced the researcher to rely more on qualitative methods of research.

## **1.7 Organization of the Study**

This thesis is organized into five parts. The first chapter includes the introduction, statement of the problem, objectives of the study, research methodology, and significance of the study, scope and limitation and organization of the study.

The second chapter deals with the review of the related literature that has pertinent relation to the study.

Chapter three is the description of the study area including the demographic, socio-economic activities and the social organizations and social services and educational profiles of the study area.

The fourth chapter is the presentation of the data and analysis of the findings by analyzing the primary data gathered through both qualitative and quantitative research methods in support of secondary materials. The last chapter presents conclusion and recommendations forwarded by the researcher

## **CHAPTER-TWO**

### **2. Review of the Literature**

A review of the relevant sociological and Anthropological theoretical literature on the importance of understanding the integration of socio-cultural foundation of the society into the modern health care system could be the concern of this section. The role of culture and social settings in illness causation, health-seeking behavior, decision making in choosing health care resources and managing illnesses could also be dealt under this section. The section also reviews the available literatures that show the role of traditional health care system and its practitioners in the alleviation and prevention of chronic diseases where modern health care system is present.

#### **2.1 Socio-cultural Setting and Health Care**

In developing countries the situation in health care has become so complex that medical or biological terms alone cannot effectively assess it. When health care providers ignore the psychological and socio-cultural factors, the care of patients is limited because biology represents only part of the consequences of a malady (Winkelman, 2009:39). After the Second World War particularly concomitant with the development of international public health programs, the need to get information on the socio-cultural factors that affect health paved a way for the contribution of Anthropologists. This increased acceptance of the socio-cultural influences on health has led to the frequent use and elaboration of terms like illness, sickness and disease (Teshome, 2004:4).

Moreover, noting the link between the social conditions, life styles, and health situations of the society, even some nineteenth-century European physicians have argued that an improved medical care was to go hand-in-hand with the changed social conditions leading to a better life (Cockerham, 2007). Both Sociologists and Anthropologists have noted that social and cultural aspects of society are relevant in the study of health and illnesses.

The shared and learned values, beliefs, norms and ways of life of a particular group of society are believed to guide their health and illness behaviors and how care is provided (Helman, 2007).

Besides the importance of socio-cultural settings on the interaction between patients and providers and perceptions of health conditions and appropriate treatments, the existing socio-cultural settings impact on health care, would also extends to the extent of planning and implementation of health care delivery system. For instance, Cockerham (2007:121) pointed out that for those individuals and groups concerned with planning, organization and implementation of health care delivery systems, identification of the social and cultural factors that encourage or discourage a person from seeking medical treatment is of great significance.

Moreover, Sylvia and Ali (2009:18) note that the impact of culture has attracted more and more attention in cross and trans-cultural health care as it has become evident that both the health care providers and patients perception of illness and health care practices are influenced by their cultural heritage.

According to Winkelman (2009:36) patients and providers of health care need knowledge of the relationships of culture and health because; culture is the foundation of every one's health concerns and practices. Winkelman also added that, understanding how culture affects health enhances health care providers understanding of health problems and the needed care. The ability to avoid and resist diseases derives from effects of many cultural beliefs and practices on health behaviors and physiological responses.

Like wise, Helman (2007:3) noted that cultural background has an important influences on many aspects of people's lives including their beliefs, behavior, perception, emotions and attitudes to illness, pain and other misfortunes-all of which have implication for health and health care. Hence, any attempt to improve health care delivery system requires an attention to the prevailing socio-cultural settings, beliefs and practices.

Thus, due to the key role that culture plays in assessing communities health needs and developing appropriate health policies and programs, health care professionals need to have knowledge of culture and cross-cultural relationship skill because, services are more effective when responding to cultural needs (Winkelman,2009:35).

Cross-cultural skills are also important in relationships among providers of different cultures. He also stated that, improving health care requires attention to cultural influences on health concerns, conditions, beliefs and practices.

It is apparent that, due to the different way of life, different people could follow the degree of their health and health related needs could vary widely. Moreover, due to the different culture different people could belong to their understandings, attitudes, beliefs and perceptions of health and ill-health could also vary significantly. Hence, the designing and development of appropriate health care services requires a better understanding of each community's perception of health and illnesses (Ibid, 2009:37). Furthermore; effective health care system requires an understanding of the patient and their family views on the origin, significance and implication of the condition for their life.

People have natural rights to expect health care services which correspond to their own socio-cultural foundation. Although the pastoral and agro-pastoral community in Ethiopia constitutes 11% of the nation's population they are among the most marginalized in terms of having access to health and educational services and developmental infrastructures. Even where the services are available, providers do not take into consideration the socio-cultural settings of the community.

Hence, in order to address the pastoral and agro-pastoral community's health and educational needs, the government of Ethiopia has preferred and designed to reside the community in one place; because it is easier and cost effective to provide health, educational and other public services to settled community.

However, Save the Children UK (2008:84) report indicated that some agro-pastoralists in Somali region who have settled for decades see little evidence of schools and clinics in their village. Where the health facilities are present in urban areas, the social and cultural foundation of the community were not taken into account.

Thus, from this point the researcher has deduced that, the only feasible option to address the needs of the pastoral and agro-pastoral community in general and the Somali community in particular is not to make them stay rather, is to take in to consideration their socio-cultural settings in the designing, planning and implementation of health, educational and other public service programs. For instance, besides its more limitation mobile health care and nutrition teams are used to provide primary health care services to population in unstable and emergency situations (Muhuyadin, 2009 and UNCT, 2009:11).

Socio-culturally congruent care is very important and its importance cannot be over-emphasized. There fore, it is not good enough to argue that pastoral and agro-pastoral community cannot be reached with public services (health and education), because they are often on the move.

## **2.2 Cultural Barriers in Doctor-Patient Interaction**

The doctor-patient relationship is the primary foundation of all modern health care system. For patients' with a different cultural perspective, interaction with doctors can be difficult and subject to misunderstandings on both sides (Cockerham, 2007:224).

The interaction that is developed in between the patient and that of the providers is an out comes of their socio-cultural background. This is because, culture can be seen as an inherited lens through which the individual perceives and understands the world that he/she inhabits and learns how to live with in it (Helman, 2007:2). More over, Lee (2003:11) and Cockerham (2007:212) have stated that cultural distance between physicians and patients could reduce the trust and empathy, compromising the quality of care provided.

Cultural diversity and language has a major impact on how the health care services could be delivered, because communication is an essential element of the health care encounter. Misunderstandings are more frequent in communications in health care settings especially when all cultures have their own beliefs of health and sickness.

For instance Lee (2003) stated that communication barriers related to cultural and linguistic diversity are increasingly recognized as contributors to health disparities between patient groups. Lee also further stated that, the effects of cultural differences on health care use are similar to that of language; cultural differences often translate in to cultural barriers that lower access to health care.

Moreover, Sylvia and Ali (2009:6) noted that, health care providers need to have good knowledge about culture (habit, religion and so on) especially beliefs of health and sickness in patients culture. They further added that, the health care provider's attitude towards the client has a lot of impact to the care. The more the provider shows tolerance, respect and understanding to the cultural differences, the more the client develops openness and trust towards health care providers. Thus, one can understand from the above points that doctors/physicians failure to pay attention to the cultural differences during clinical encounter can leads to misdiagnosis, lack of cooperation, poor use of health services and patient alienation and mistrust.

According to Winkelman (2009) social and cultural factors are relevant to all aspects of clinical relations, not only just to communication alone. Hence, health care providers need a heightened awareness of how their culturally and professionally based relational patterns could affects patient's perceptions and consequently health care.

It is possible to say that, the impacts of socio-cultural settings of a given community are not only limited to the designing, development and delivery of health care services but also ranges to the extent of affecting the interaction of patients' with that of doctors/physicians in the clinical encounter. The interpersonal or communication skill that the physician could possess can positively develop a trust in between him/her and his/her client. In some cases health care seeker may think that he/she is not listened to or lack of attention. A service received at the first time has a lot of impact to the patient's trust.

For instance, Sylvia and Ali (2009:48) notes that when the clients can not communicate in their mother language, clients look up to health care providers as being superior and therefore not value their own ability to make decisions around their care expecting the doctor to take on the role. In turn, health care providers cannot assess whether their delivery of health care services is indeed respecting their clients' cultural values and still important symptoms of life threatening conditions could be missed.

As far as, medical treatment usually begins with a dialogue, the effectiveness of doctor-patient interaction could depend upon the ability of the participants to understand each other. For instance, Cockerham (2007) states that a failure to explain a patient's condition to the patient in terms easily understood is a serious problem in medical encounters. Further more Helman (2007) notes that in order for medical treatment to be acceptable to patients, it must make sense in terms of their explanatory models. Helman also added that, the clinician should acquire knowledge of the specific language of distress used by the patient, especially the presentation of culturally specific folk illnesses. Thus, one can understand from this point that, when clients' first experience becomes bad or not as such significant in improving their well being, their health seeking behavior for the later time could either be delayed or prolonged which is true of the community in the study area.

It is apparent that, reports from various studies indicated that, patients are presenting their illnesses to physicians in a manner consistent with their socio-cultural orientation of beliefs and perceptions about health and sickness. Similarly, people in both the developed and developing parts of the world tend to present their illness behavior using an organ of the body that has both symbolic and metaphorical significance to their culture.

Ethiopia is a country of multi-ethnic groups where around 80 formal languages could be spoken. Though, there are no so far conducted studies in the country focusing on the interaction between patients and their physicians, some indirect studies have shown that Ethiopians tend to present their illness behavior during clinical consultation using an organ of the body such as heart, lung and that of head. For instance, Teshome (2004:29) notes that in Addis Ababa the most common organ that people use for the aforesaid

purpose is a heart. He further states that, the following expressions could be cited as examples: “libe tekatele” (lit. “my heart is burnt”); “libe kelete” (lit. “my heart melted”) “liben selebegn”(lit. “my heart is emasculated”); “liben gotetegn” (lit.” my heart is pulled down”).

Hence, one can understand from the above example that patients’ expressions of illness in clinical consultation are highly interwoven with their socio-cultural views of the world. This is why Helman (2007) forwarded that in order to improve the patient-doctor relationship, the clinician’s diagnosis and treatment must make sense to the patients, in terms of their lay view of ill health, and should acknowledge and respect the patients’ experience and interpretation of their own condition.

Like most people in Ethiopia, Somalis’ especially married women tend to bring her husband along with her in a clinical consultation to narrate her illness when confronted with a male doctor. To this point, Helman (2007) and Kleinman (1980:24) have stressed that the clinician should try to discover how patients and those around them view the origin, significance and prognosis of the condition, and also how it affects other aspects of their lives- such as their income or social relationships. Yet, the failure of doctors/physicians to let the patients family or relatives appear in the clinical consultation might negatively interfere as a barrier to the both parties interaction.

In general, along with the interaction, the sense of trust that both parties could form are another important area that need to be dealt with. The ability of patients to trust their health care providers is one of the most important aspects of health care delivery. Understanding factors that influence how patients develop trust in their health care providers and being able to measure patient-provider trust in a simple, consistent way are important first steps in improving health care delivery now and in the future.

### **2.3 Perception about Disease Causation and its Treatment**

Traditional Medicine and Modern medicine maintain two parallel views regarding the causation of disease. In the modern medical system disease could be caused when a normal tissue is attacked by a pathological organism, and hence organ or organs are not

functioning or/and when there is psychological disturbances. Similarly, when ever there is a disease whose cause is unknown, it is referred to scientific investigation. Where as, in traditional medicine, however, when ever there is a health problem where its causes are unknown supernatural forces would be attributed as causes (Teshome, 2004:4). Irrespective of the perception of disease causation and its treatment held by both medical systems, patients' understanding of disease causation, symptoms, and its treatments are an outcome of the socio-cultural views of the world.

From the social constructivist point of view it is argued that, people in different society held a variety of cultural values that produce cross-cultural variation in the recognition of diseases, the significance of symptoms, their treatments and consequences (Winkelman, 2009:55). Hence, it is possible to say that the perception about disease causation and its treatment could vary from one culture to the other which in turn directly affects the mode of health care delivery system of the society.

Moreover, the influence of cultural values and social processes are central, even in the formulation of biomedical diagnosis and the conceptualization of conditions that need to be treated (Ibid, 2009).

Like wise, Lee (2003:3) stated that, the cultural belief systems of a society such as disease etiology and beliefs about major life events such as birth and deaths influence decisions about seeking health care services. Lee also added that, cultural preferences and values could also affects health behavior such as the use of preventive health care, health related lifestyle, and sources of health related knowledge.

Furthermore, Nunes (2007:15) found that cultural beliefs and customs still had a strong influence on the assistance people sought for the health and /or health related problems. For instance Kleinman et al. (1978) states that cultural preferences given for traditional treatments can be associated with reduced use of health care (Cited in lee, 2003:10).

People's socio-cultural environment could influence their views of the world and their behavior as well. An increased understanding of cultural values, beliefs, practices would play an important role in the provision of health care services in consistent with the specific culture. For instance, El-Safty (2001:3) expressed that the strong inter relationship between culture on the one hand and the health status of the population on the other hand would creates an inseparable bond that is tightly inter wined and overlapping in such a way makes it impossible to understand one with out understanding the other.

Like the people in most developing countries of the world, the majority of people in Africa tend to associate disease causation either or both to the natural and supernatural beings. In spite of, the spread of formal health care systems in different countries, Africans bypass for the traditional health care providers fro treatments of their health and health related problems. Having understood the crucial role that the deep rooted socio-cultural foundations play in Africa, El-Safty stated that an attempt at improving the health conditions of African societies has, therefore, to take in to consideration all the elements of the respective cultures, in order to help bring about successful results (Ibid, 2001:13). She further remarks that, one good formula that can help ensure the acceptability of the modern health care system is to make constructive use of the elements of the indigenous health care system by incorporating in the former.

There fore, understanding the deep rooted socio-cultural settings of the society could dictates how perceptions of disease causation and its treatment would be developed. Hence, those individuals, groups or organizations involved in developing health and health related delivery programs are required to take in account local perceptions of disease causation and the choice of health care resources for treatment.

## **2.4 Theories of Illness Causation**

Miss understandings in between providers of health care and patients are in inevitable when health care providers ignore the psychological and socio-cultural settings of their patients. Similarly, when health care providers failed to take in to account the illness narration (etiologies, symptoms, signs and causes of illness) provided by their patients,

the care they offer could be limited (Winkelman, 2009). Thus, making an enquiry in to the explanation of illness causation could serve as a stepping stone for health care professionals to take in to consideration the socio-cultural setting before they begin their operation.

Although, various studies have been conducted to address the subject of illness causation and its etiologies especially in non-western societies, under this section it is only two of the most widely and fundamentally studied theories of illness causation are briefly dealt with. These are the personalistic and natural theories of illness causation.

According to Foster and Anderson, personalistic etiologies of illnesses are believed to be caused by the purposeful, active intervention of an agent such as super natural beings (a god) anon human being (ghost, ancestral sprit or capricious sprit) human being such as witch or sorcery (Cited in Helman, 2007).

Foster and Anderson's second classification comprise naturalistic etiologies; in this category illness is explained in impersonal systematic terms. It can be caused by natural forces or conditions such as cold, wind or damp or the social environment (Ibid, 2007).

In line with the above point, Young has classified the etiologies of ill health as either externalizing or internalizing. Externalizing causation concentrate mainly on the etiologies which are believed to arise out side the sick persons body especially in the social world. In internalizing causation, it focuses more on events that occur and arise in side the individual's body (Cited in Helman, 2007).

In Africa the description and explanation of illness is often phrased in terms of social interaction in particular between members of one kinship group. The origin of illness, its treatment and prevention is linked to the quality of human relationship. Ancestors and witches are believed to play a crucial role in bringing illness and other misfortunes.

Disorder in the community is seen as leading to disorder in the health condition of its members. There fore, an illness of one family member is seen as an illness of the entire family (Van Geest, 1997).

In light of the above point, as reviewed in Tababer (2006) Young (1970:6) has asserted that Ethiopians attribute causes of health problems to either personality or natural agents and treatment is therefore, believed to be the reflection of these causes (Cited in Tebaber,2006:25).

Similarly, though there are no studies so far conducted among Somali pastoral and agro-pastoral community in relation to their beliefs about illness causation, like the majority of Ethiopians', Somali pastoral and agro-pastoral community lean to attribute the causes of ill heath to either personalistic or natural factors and the treatment may ranges from the use of home remedies, self-medication, traditional healing, religious healing to the extent of modern medicine bought from the nearby ordinary drug shops. For instance, according to FSAU (2007:30) study all types of illnesses which are not well understood including strong malaria are believed to be caused by the evil eye (wal koraad).

Furthermore, Sylvia and Ali (2009:34) noted that, Somali patient with mental heath problems believes as other Muslims that, the cause might be psychiatry or evil (Jini) cause. They further added that, since the cause of mental heath problem is the (Jini) evil, Somali coming to the psychiatry ward read to the patient some verses of Quran. The use of these is a remainder to Muslim Clients of the nearness of God and there by serve to reduce anxiety and provides senses of peace and wellbeing.

In addition to the above personalistic causes of ill-health, the Somali pastoral and agro-pastoral community could also associate illness causation to the natural conditions and the social environment. For in stance, the FSAU (2007:31) study reported that poor sanitation, water contamination and rain waters that form a pool for mosquito breeding during rainy season are believed to cause diarrhea and malaria respectively.

Conflict among house hold members and in between clans /sub-clans is also believed in causing health problems.

Generally, theories of illness causation have been dealt widely both by medical sociology and medical anthropology. If one knows as to what causes an illness one can also know how to manage and prevent it.

## **2.5 Health Seeking Behavior and Its Explanatory Models**

Treatment and health seeking behaviors of people could depend on the culturally oriented perceived causes of illnesses. As reviewed in Ameyu (2008:19), Helman (1990) notes that peoples' desire to seek for medical help depends on the etiology of the conditions whether it is believed to originate in the individual or in the natural or super natural worlds.

More over, the severity of the illness, quality of access and cost of the treatment options may determine the need for health seeking behavior (Cockerham, 2007:121). Similarly, Cockerham has further stated that, an understanding of help seeking- process in medicine can have a tremendous impact for the structuring of health care services for people living in a community both in terms of providing better medical care and making that care more accessible to the people who need it.

In light of this, an attempt will be made to discuss some of the explanatory models from the point of view of social psychology and that of medical sociology approach.

### **2.5.1 Health Belief Model**

One of the most influential social- psychological approaches designed to account for the ways in which healthy people seek to avoid illness is the health belief model of Irwin Rosen stock (1966) and his colleagues (M, Becker, 1974).The model is deduced to a great extent from the theories of psychologist Kurt Lewin (Cited in Cockerham, 2007).

According to the model preventative action taken by an individual to avoid the disease is due to that particular individual's perception that he or she is personally susceptible and that the occurrence of the disease would have at least some severe personal implications.

More over, help seeking behavior was observed to be based upon the value of the perceived outcome (avoidance of personal vulnerability) and the expectation that preventive action would result in that outcome (Ibid, 2007). Thus, the individual's subjective assessment of health situation becomes the critical variable in the utilization of health services.

Besides its effective use successfully in several studies of preventive health behavior such as dietary compliance and ethnic differences in managing hypertension, the usefulness of the health belief model is limited in that it has been applied mostly to preventive situations in which the behavior studied is voluntary.

### **2.5.2 Theory of Health Life Styles**

By drawing up on the theoretical perspectives of Weber and Bourdieu, Cockerham has formulated an initial theory of health life styles.

The theory is grounded on the belief that it is not in fact an individual's behavior but life conditions (chances) that determine the health situation of a person (Cockerham, 2007).

Depending on the works of Weber and Bourdieu, Cockerham has forwarded four major categories of social variables that have the potential to shape health life styles namely, class circumstances, age, gender, and race/ethnicity, collectivities and living conditions. It shows how particular structural variables influence health life style choices with class circumstances influences depicted as an especially strong variable.

In general, life style choices compounded by social structure in forces the person to make action to continue activities that would bring about health life style.

## 2.6 Indigenous Health care and Medical Beliefs.

It is recognized that indigenous medicine as part of a society's medical norm is an ancient and culture born strategy. Its historical origin can be traced back to the ancient Egyptian and Babylonian period where vegetables or animals were invariably used in combination with some forms of rituals to expel some forms of harmful spirits from the disease body.

Today, many of the greatest threats to an individual's health and well beings are largely stemming from unhealthy life styles and high risk behaviors. Hence, the planning of modern health care programs and the delivery of modern health care services in the contemporary world is required to incorporate the existing indigenous medical beliefs and practices of the community.

Once the world health organization has encouraged the cooperation and integration of traditional medicine with that of biomedicine in its motto health for all in 2000 , their has been a growing interest in traditional/complimentary and alternative medicine and their relevance to public health both in the developed and developing countries of the world (WHO, 2002).

According to WHO (2002:17) traditional medicine is defined as follow:

*“Traditional medicine refers to health practices, approaches, knowledge and beliefs incorporating Plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being.”*

Traditional/indigenous medicine comprises therapeutic practices that have been in existence often for hundreds of years before the developments of modern scientific medicine and are still in use today with out any documented evidence of adverse effects. It is still widely accepted and used in the prevention and treatment of physical and mental disorders as well as social imbalances. Due to its intrinsic qualities, unique and holistic approaches as well as its acceptability and affordability, it continues to be the best alternative care available for the majority of the global population, particularly for those in the rural areas of developing countries.

For instance, Peter Mwaura (2008:89) remarks that, the importance of traditional medicine for humans as well as animals in Africa both now and in the past is enormous. He further added that, for much of African communities, it is the only affordable, accessible, and socially acceptable health care.

Similarly, WHO noted that, due to lack of adequate and essential health care services in many developing countries, the contribution of traditional medicine has got enormous to these countries health care needs. Having taken in to account and recognized the role of traditional medicine around 80 % of African countries are currently using traditional medicine to help meet the health care needs of their society (WHO, 2002:19).

Traditional medicine is often embedded in the wider belief systems and continues to be an integral and important part of many people's lives. It has maintained its popularity in all regions of the developing world and its use is spreading rapidly in industrialized countries. However, despite its existence and continued use over many countries and its popularity and extensive use during the last decade, traditional medicine has not been officially recognized in most countries (Kebede et.al, 2006:127).

Ethiopia has a long history of traditional medicine through which it has developed ways of combating disease through it. The country's traditional medical system is characterized by variation and is shaped by the ecological diversities of the country, socio-cultural background of different ethnic groups as well as historical developments which are related to migration, introduction of foreign culture and religion (Getachew et.al, 2002:20).

As far as, there are different cultural groups in the nation so also there are various ways of healings options. Yet, the healing is not only concerned with curing of diseases but also the protection and promotion of human physical, spiritual, mental, material and social wellbeing of its citizens (Kebede et.al, 2006:128).

Currently, the country is focusing on primary health care at national level so as to improve the health needs of its population. In line with the country's focus, around 90 % of its primary health care is covered by traditional medicine (WHO, 2002:17).

According to the Ministry of Health (1980) long before the coming of modern medicine Ethiopia had its own methods for combating diseases, and the methods are usually known as Ethiopian traditional medicine.( Cited in Teshome, 2005). Since, the country had an in depth historical contact with the ancient Arabian states through Red Sea and Mediterranean Sea, its traditional medicine development is seen as a result of an amalgam of indigenous African medicine and exotic foreign elements.

Endashew (2007:24) also notes that, the Ethiopian traditional medical system is mainly a subcategory of the African traditional medical system with some influences from Egypt and Greece and has its own characteristic features. Hence, one can argue that Ethiopian indigenous medicine is the reflection of both African traditional elements of health care strategy and that of the Arabs. Moreover, Dawit and Ayehu (1993) noted that, the traditional medical system of Ethiopia is described as medico-religious and others as magical religions. Such description is due to, close interaction of the Christian, Islamic and indigenous religions with the traditional medical system in the country, which some times displays features related to magic, beliefs and faith in some areas ( Cited in Endashew, 2007:45).

It is widely believed in Ethiopia that, the skills of traditional medicine are given by the will of God and knowledge of indigenous medicine is orally passed from generation to generation or is acquired through spiritual procedures. Similarly, most of the illnesses and sicknesses are believed to be caused by supernatural powers. Thus, the treatment of various illnesses and sicknesses are according to the perceived causes and origins of the illness. (Kebede et.al, 2006:129).

The continued importance of traditional medicine in Ethiopia is seen by the fact that around 90% of its population is currently using traditional medicine for primary health

care at national level (WHO, 2002:17). Such a wide use of traditional medicine asserts that, the contribution of this indigenous knowledge and resource to the enhancement of health care needs of the Ethiopian population cannot be underestimated.

The Somali pastoral and agro-pastoral communities are the third largest ethnic groups in Ethiopia. Among these community studies about traditional medicine is very hard to find. However, like all other ethnic groups in Ethiopia, the Somali pastoral and agro-pastoral community could also have their own traditional forms of medicine that they use to cure and prevent diseases/illnesses when it occurs.

Like the majority of African Traditional medical beliefs, Somalis' traditionally explain behavioral problems as an expected result of spiritual causes or possession by an evil spirit. Healing for these problems is provided by religious leaders or by traditional healers. Similarly, Somali's beliefs in the causes of mental illness are predominately spiritual or metaphysical: mental illness comes from God or evil spirits (Jini); illness can also be brought on by another person or one's self through curses or bad behavior.

Since, religion is a major factor of social structure for the Somali community, visitors to the Somali client/patient at the clinical ward may read some verses of the Quran as spiritual treatment (Sylvia and Ali, 2009:34). The use of such treatment is a reminder to Muslim clients of the nearness of God.

As far as, the Somali community is pastoral and agro-pastoral by their nature, some of the sources of medicine used for treatments of diseases and illnesses are associated with the products of their livestock. For instance, it was argued that, there is a strong link between access to milk and human health as perceived by pastoralists themselves (Gerald and Dorothy, 2010:16).

Among the Somali community all forms of diseases that are not well understood including strong malaria are believed to be caused and associated with evil eye.

It is believed that, some people have evil eyes and if such people look at a child, the child suffers fits similar to epilepsy with spots on the skin (FSAU, 2007:30).

Moreover, in the absence of modern medicine facilities, the health care services provided by traditional and religious healers and that of traditional birth attendants is paramount in the Somali region. For instance, many of the child deliveries in the region are carried out by traditional birth attendants who have not received training so far.

Cognizant to the above fact, Foster and Anderson (1978:634) noted that studying and having knowledge of the indigenous health care system and medical beliefs would play paramount role in the planning of health care programs and the delivery of health care services to the concerned communities (Cited in Tebaber, 2006:32).

## **2.7 The Role of Traditional Medicine in Modern Health Care System**

The twenty century has witnessed a revolution in human health care. In the last decade, there has been a global upsurge in the use of traditional medicine and complimentary and alternative medicine in both the developed and developing countries.

Though various reasons have been forwarded for such an increase, including affordability, but also the changing needs and beliefs of its value could be taken as major reasons. For instance Hills and Finch (2006:219) states that, the increased demand for the traditional medical services in both the industrialized and non-industrialized countries is likely due to their increased formalization; improved quality and safety standards and their use as a complimentary therapy.

Likewise Teshome (2005:31) states that traditional remedies are getting closely linked to the belief systems of the people which have strong command over their behaviors and actions.

Although, traditional medicine came in to being long before the advent and spread of western medicine that originated in Europe with the advent of modern science and

technology, its use in the modern health care system is not as such significant till the twenty century. However, onwards this century traditional medicine has attracted an increasing attention with in the context of health care provision and health sector reform (WHO, 2002).

Besides the increasing cost of discovery and affordability of modern medicine in both the developed and developing parts of the world, clients' dissatisfaction could still be taken as one major reason for the radical increment of the use of traditional and complimentary and alternative medicine throughout the world. Cockerham (2010:179) for instance notes that, a widely held notion about the complimentary and alternative medicine is that its popularity is a testament to increasing dissatisfaction with modern western medicine. The majority of people in developing nations are receiving traditional health care services for their every day health care needs.

The importance of traditional medicine for human as well as animals in Africa both now and in the past is enormous. In many resource poor settings of Africa, the majority of people living with HIV/AIDS continue to depend on and choose traditional healers treatments for psychosocial counseling and health care. Today, more than 80% of the populations of Africa are using traditional medicine (Elujoba et.al, 2005:8).

The traditional/indigenous knowledge of medicine in various countries has evolved with in the socio-cultural and historical context of the society. The traditional medical system is understood to be both physically and socio-culturally acceptable and appropriate than the modern medical system for the local people. Hence, the traditional medical system has become a widely used source of health care option all over the world.

The practitioners were culturally and socially accepted by the people and were seen as ready sources of medical power (Ibid, 2005:8). Moreover, Hills and Finch (2006:221) notes that, since traditional healers in comparison to western trained doctors could share their patients cultural beliefs and values, they are widely accepted and respected in their communities and are also skilled in interpersonal relations and counseling.

Similarly, traditional health practitioners are also gate ways to community health activities, cultural specific information in sexual behavior and information channeling and specific health promotional messages to the community at large and this is not exceptional to the community of the study area.

Despite an increased use of traditional medicine in both developed and developing countries of the world to meet the health needs of their community, almost it is possible to say that the majority of WHO member states has not incorporated formally in their national health care system.

For instance, with the exception of traditional birth attendants, who have been involved in health care programs for decades throughout Ethiopia as in large parts of African continent- no other traditional practitioners' category has been officially employed with in the national health care system. Nevertheless, due to its low cost, affordability, ready availability, accessibility and perhaps low toxicity, the number of the developing and developed countries using traditional/comparative medicine has increased dramatically (Elujoba et.al, 2005:8, WHO, 2002:23).

Similarly, Teshome (2005:30) notes that, even in countries where professional medical care is highly developed; traditional healers continue to practice their real or alleged skills and attract a large number of clients who would describe themselves as well educated.

According to WHO (2002:23) over one third of the population in developing countries lacks access to essential medical services. Thus, the provision of safe and effective traditional medical therapies could become a critical tool to increase access to health care services.

It has been consistently estimated that 60 to 80% of the population of these countries are relying on traditional medicine for their basic health care needs, either on its own or in conjunctions with modern medical care.

Hence, the use of the traditional medicine in primary health care could contribute a lot in facilitating progress towards health for all in the 21<sup>st</sup> century.

In line with above point, the WHO has called for the recognition of African traditional healers to be included as part and parcel of the primary health care teams. Helman (2007:443) also notes that, traditional healers have also been promoted as an intrinsic part of primary health care. Thus, the use of traditional medicine for primary health care has increased extensively in the majority of developing countries, for example Ethiopia is using 90% of traditional medicine for primary health care (WHO, 2002:17).

Traditional birth attendants are one form of traditional medical healers being used in the majority of African countries. In fact, the recognition of the contribution that traditional birth attendants make to the primary health care has encouraged a number of African countries to initiate training program to improve their traditional birth attendant's skills and primary health care knowledge. It is estimated that around 60% of child deliveries in the world are managed by traditional birth attendants.

Besides working as traditional birth attendants, traditional healers have treated sexually transmitted diseases for generations and also they have successfully managed HIV/AIDS related problems such as chronic diarrhea, vomiting, fever, depression, oral infection and various skin conditions. Similarly, traditional healers have also played varying roles in different parts of the world to provide health care especially in directly observed therapy for tuberculosis (Hills and Finch, 2006:224). Like wise, traditional health practitioners are generally respected health care providers and opinion leaders in their communities

Hence, because of an increased role of traditional health practitioners in the diagnosis and treatments of diseases and illnesses in both western and non-western societies, Elujoba et.al (2005:47) stated that, an effective health agenda for Africa continent can never be achieved by western medicine alone, unless it is complimented by traditional medicine practices.

In support of the above point, Green points out that else where in Africa there is an urgent need for a closer collaborative relationship between traditional healers and health authorities, especially where doctors and nurses are in short supply (Cited in Helman, 2007). He further notes that, traditional healers are useful in referring sexually transmitted diseases to the health system, advocating the use of barrier methods of birth control, influencing sexual behavior and in providing counseling and emotional support to clients with HIV/AIDS and their families.

Furthermore, King (2000:9) argued that, when traditional healers engage in harmful traditional practices, there is a public health responsibility to try to change these practices which is only possible with dialogue and cooperation. Research has shown that traditional healers abstain from dangerous practices when educated about the risks. Since, in most studies Somali community are mentioned as one ethnic group practicing the worst type of female genital mutilation in Ethiopia, involving the traditional healers in the public health program could play a crucial role.

If traditional medical system is planed and developed appropriately from the national and cultural context of the concerned society, the traditional health services can be taken as an effective and cost saving means of providing socially and culturally meaningful care to the general public (Hills and Finch, 2006:227).

Generally, as shown vividly traditional medicine and its healers are playing an important role in the health care systems of both developed and developing countries of the world. Its importance is not only limited in the provision of cure to the diseases but also in the realm of prevention and promotion of healthy behaviors and healthy life styles.

## CHAPTER-THREE

### 3. Description of the Study Area

#### 3.1 Somali Region: The Place and the People

The Somali region is one of the nine regions of the federal democratic republic of Ethiopia, comprising nine administrative zones and 53 Woredas (administrative districts). The regional state is located 630 km away from Addis Ababa, in the south eastern part of Ethiopian low lands bordering Djibouti, Somalia and Kenya. It is one of the largest; perhaps the least developed and underserved region in the country; in terms of health, education and development infrastructures.

The population of the region was estimated at 4,445,219 almost 4.5 million with the majority of the people (86%) being pastoralist and agro-pastoralists. The region is overwhelmingly rural (3,822,215). With an estimated area of 279,252 square kilo meters, the region had an estimated density of 15.9 people per square kilo meter. For the entire region 665,397 house holds were counted. The average house hold size is 6.6 with a range from 6.3 in urban Jijiga to 6.7 in rural korahe zone. The largest zone of the region is Jijiga zone, with over 967,652 residents enumerated in 2007 while the smallest is fiq with 348,409 (CSA, 2010). The region is almost entirely inhabited by people of Somali ethnic groups (95.5% according to Ethiopian central statistical agency). They speak a common language, Somali and share a rich cultural heritage that spans Somalis living in Kenya, Ethiopia and Somalia. The majority of the population of the region is Muslim religion followers.

Somali region is among the worst performing regions on health and nutrition indicators for children and women in Ethiopia. It is only 21.1 percents of the children of the region are enrolled in primary schools and 9.6 percents are enrolled in secondary schools. Though the causes and types of disabilities were not mentioned, the number of disabled persons in the region were estimated to be 24,223 where 3,533 to be from urban and 20,690 from the rural population (DHS, 2006, CSA, 2010).

Currently, the region possesses six hospitals with 436 beds (4 functional and 2 unfunctional), 14 health centers with 200 beds, 93 health station, 95 health posts, around two private clinics for profit (MOH,2006). Out of the six hospitals in the region none of them are specialized hospitals rather they are district and zonal levels hospitals.

The health professionals to population ratio for the region are one physician to 1664.3 clients, and one senior nurse for 126.48 clients. The numbers of specialists in the region for instance are one internist, two surgeons, two pediatricians and one gynecologist.

The human resource distribution (health care professionals) of the region by sex is given in the following Table.

**Table1. Human Resource Distribution of Somali Region by Sex.**

Type of Profession	Total Number	Female	Male
Physicians	51	2	49
Health Officers	13	1	12
Nurses	404	103	301
Environmental Health Workers	26	4	22
Lab Tech	57	5	52
Health Assistant	108	16	92
Radiography	1	0	1
Front line Health workers	459	175	284
Pharmacists	5	0	5
Total	1124	306	818

**Source: MOH, 2006.**

Since the Somali community associates the increment of the number of children with the strength of their clan /sub-clan and that of God gifts, the use of contraceptive methods is seen as breaking Gods' rule and weakening clan's strengths (CHF International, 2006).

Thus family planning coverage of the region is the lowest of the nation which is 1.1 percent. The antenatal and post-natal coverage of the region are also very low which is 5.4% and 2.1% respectively.

According to the ministry of health (2006) although 5.4 percents of pregnant women in the region received antenatal care, it is only 2.5 percents of the mothers who has received antenatal care has delivered in the modern health care centers (MOH, 2006). Including all forms of vaccines for mothers and children, the coverage of immunization is the lowest of all regions at national level which is 2.5 percent in comparison to the southern nations and nationalities which is 84.5 percent.

## **3.2 Jijiga Zone**

### **3.2.1 Location**

Jijiga zone is one of the largest zones of the nine zones that make Somali regional state. The zone has six Woredas namely Jijiga, Awbare, Kebribeyah, Babile, Gursum, and Harshin. Geographically, Jijiga zone is located in the north east part of Somali region and bounded with oromia region, Shinile and Degehabur zone and that of Somalia.

The zone is the most heavily settled of Somali region nine zones with almost a quarter of the region's population, which 80% of them are rural (Devereux, 2006). It is a way in which a large proportion of the livestock that is traded with Somali land and the Arab world passes through its market.

### **3.2.2 Demography**

According to the 2007 population and housing census of Ethiopia the total population of Jijiga zone was estimated to be about 967,652 of these 526,398 and 441,254 were male and female respectively. Though density figures of the zone are not available, around 203,588 and 764,064 of the total zone's population were urban and rural dwellers respectively. There are 138,679 house holds in the zone and all the house holds are possible to say ruled by male (CSA,2010).

Irrespective of the causes and types of disabilities mentioned in the zone, the numbers of people who are disabled are estimated to be 5,558 to the entries zone's population where by 1,312 were from the urban and 4,246 were from the rural population of the zone. From the report both at regional and zonal level, it was the rural and urban males who mostly possessed a disability status than females (CSA, 2010).

### **3.2.3 Livelihoods and Economic Features**

The pastoralist and agro-pastoralist communities of Jijiga zone are engaged in various economic activities to earn a living. Traditional pastoralism, sedentary farming or crop production, commercial activities such as selling crops, livestock and livestock products, trade of chat and collection of bush products especially fire wood and charcoal are some of the main economic activities of the population of the study area.

According to Devereux (2006:41) over 650,000 people of the zone are agro-pastoralists. Agro-pastoralism is the dominant form of livelihood activities to earn a living in the zone as well as in the region.

As to the livelihood of the communities of the Jijiga zone, the majority of the people in the zone engage in the production of crops and rearing of livestock such as cattle, sheep and goats and camels.

In addition to these, some sections of people are generating their livelihoods from activities such as collection of fire wood and charcoal and carrying out cross border traders' commodity and daily work.

### **3.2.4 Social Organization and Social Services**

#### **Social Organization**

The basis of pastoral and agro-pastoral community social organization almost everywhere in the world is the clan, a set of patrilineally-related households traced in theory to an apical ancestor. The Somali community social structure is based on clan groups through the father's lineage.

Somalis' whether they are urban dwellers, pastoral / nomads or agricultural farmers, they are still in their hearts and minds, traditionally bounded by clan allegiance and male dominance (Abdurahman, 2005).

Like other pastoral and agro-pastoral communities in the world ,Somali community do have their own traditional social structures that tend to manage and regulate the socio-cultural and political, economical, and religious aspects of their wider community.

In the same way, besides the existence of formal political structures in the country to rule over its people, with out the involvements of traditional political structures in the formal once, it is impossible to rule over the Somali pastoral and agro-pastoral community in the region. Hence, in the majority of the Woredas of Somali region the sharing of power and authority is on the basis of clan dominancy with in that given specific Woreda.

The clans that are widely prevalent in the zone are Yabare, Bartiree, Akishoo, Gobayaa , Gari Bursuug, Abaskul Gadabursi ,Issak, and Ogaden. The distribution of the clans and that of the dominant clans that rule over each Woredas of the zone are given in the following Table.

**Table2. Clan Distribution in the Woredas of Jijiga zone**

<b>Name of Weredas</b>	<b>Clans living in the Woreda</b>	<b>Dominant clans that rule over the Woreda</b>
Gursum	Bursuug, Abaskul and Gari	Bursuug
Babile	Gari , Ogaden	Gari
Jijiga	Yabare, Bartiree, Akishoo, Gobayaa and Gari	Yabare followed by Bartiree
Awbare	Gadabursi and other minority	Gadabursi
Harshin	Issak	Issak
Kebribeyah	Abaskul, Issak, Akishoo	Abaskul

**Source: Field Survey, 2011**

The Somali community has its own unique names/titles for its traditional clan leaders. The decision made by the clan leaders are accepted by the community with out any questions. Each clan does have its own way of naming/titling to its clan leaders that could either be shared with other or not. The common names/titles of clan leaders among the Somali community are Ugaas, Sultan, and Gerad. On the basis of this general naming the names/titles of the clan leaders in Jijiga zone are given in the Table below.

**Table3. Names/Titles of Clan Leaders**

<b>Names of Clans</b>	<b>Names/Titles of Clan Leaders</b>
Ogaden	Ugaas
Isaak, Abaskul, Gadabursi, Bursug and Akishoo	Sultan
Bartiree , Yabare ,Gari and Goobaya	Gerad

**Source: Field Survey, 2011**

## **Social Services**

### **I. Educational Service.**

Educational opportunities are extremely limited in the region in general and in the zone in particular. Despite its location in to the regional capital, the people of the zone are in adequately provided with basic educational services. The literacy level of the zone is estimated to be 48.3 and 9.8 percent for urban and rural residents of the zone respectively (CSA, 2010).

Yet, in the region in general and the zone in particular, it is Islamic Quran schools which are more than secular schools performing very well by holding the majority of children before they attend in secular schools.

### **II. Human Health Service**

As shown in the second paragraph of this unit, Somali region is the least developed and underserved and worst performing region in terms of health care services and other developmental infrastructures.

Though Jijiga zone is the capital of the region and possessing large numbers of population in comparison to other zones, still the zone is not exceptional from the region as a whole, in terms of health care services and other developmental needs.

Like other zones of the region, people of Jijiga zone are also highly stricken by communicable and preventable diseases such as diarrhea, malaria, TB and sexually transmitted diseases.

The zone posse's only one zonal hospital but there is no specialized hospital. The number of human resource and health care facilities of the sampled Woredas are given in the following Tables.

**Table 4. The human resource distribution of the sampled weredas.**

Types of Workers	Gursum Woreda	Kebribeyah Woreda
All health care Workers	60	46
Health Extension Workers	21	73
Total	81	119

Source: Field Survey, 2011

**Table 5. The health care facilities of the sampled Woredas.**

Health care Centers	Gursum Woreda	Kebribeyah Woreda
Number of Health Centers	2	3
Number of Health Posts	10	33
Private Clinics for Profit	5	3
Hospital	0	0
Total	17	39

Source: Field Survey, 2011

### **3.2.5 Conflict and Its Impact on Health Situation in Jijiga Zone**

The record of conflict is as old as human history. From the daylight of human history, communities have been competing for control of resources and supremacy. The occurrence of violent conflicts had been increasingly causing social and economic damages such as human sufferings from injuries, death and displacements (Oxfam GB, 2009).

Conflict and insecurity are common in pastoralist and agro-pastoralist societies. It is seen as endemic to these societies, partly because productive resources are scarce and because, as a consequence, people move continually in search of water and grazing for their livestock (Devereux, 2006).

The Somali region in general and the Jijiga zone in particular are not exceptional to the common prevalent conflicts and insecurities in the pastoral and agro-pastoral societies of the world. Yet, this does not mean that pastoral and agro-pastoral areas in general are as violent and unstable.

Conflict and civil insecurity in Somali region take several distinct forms, including war, rebel or militia activity; inter clan resource conflicts and inter-regional disputes. The proliferation of small arms through out the region has fuelled the prevalence of civil insecurity.

Though there are no conclusive evidences that showed the incidences of illnesses and diseases caused by conflict and insecurity in general, due to the common prevalence of civil insecurity and conflict among the pastoral and agro-pastoral societies, conflict is taken as one major factor causing injuries, illnesses and even deaths in the Somali region in general and Jijiga zone in particular. For instance, according to the Kebribeyah Woreda health bureau, out of the 33333 total patients who has received treatments from the Woreda health centers in 2002 EFY around 1833 patients illnesses were caused by the violent conflicts in between or with in clans over resource competition.

The impacts of violent and latent conflicts happening in the study area are not only limited to the socio-economic damages and death and injury, but also extends to delaying access to health care services when illness has occurred. For instance, during the field work period there was conflict in between Abaskul and Bursug clans and that of Giri and Sheikash clans in Gursum Woreda over scarce resources. And this in turn was mentioned as causing delay in seeking help from the health centers.

Generally, in Jijiga zone like all other parts of the region, conflict and civil insecurities are increasingly believed as causing health problems by resulting injuries, disabilities and even deaths. Still, conflict in the zone is taken as one factor that delays health seeking behavior of the community in the study area.

### **3.3 Clan System and Gender Relations in Somali Community**

The most obvious social structure of the Somali community is the clan system through the father's lineage. This traditional structure, represent people's cultural values, its traditional history and social norms, which are so deeply engraved in the community's moral, feelings and sentiments (Abdurahman, 2005).

As always, the traditional clan leaders are useful conduit of the government policies to resolve inter-clan conflicts, security matters or as an instrument for peace-making in times of political crises between opposing political factions. In this arrangement, the leaders play a very useful and effective role on centrifugal mode. Clan leaders are well accepted by their community because they are believed as the one who perpetuate and preserve customary laws and are only custodian of inherited culture and tradition (Ibid, 2005).

The traditional social structure (clan system) of the Somali community is governed by the customary law. The customary law (*Xeer*) of the clan was the main political and legal instrument by which inter clan and intra-clan issues would be addressed, conflicts resolved and resources managed.

Pastoralist societies most often have patriarchy descent patterns and are male dominated. Men usually make the important decisions and own the animals, while women primarily care for children and perform domestic chores. Somali women throughout the Horn of Africa have a reputation for being strong-willed and influential in many arenas –they are famous for mobilizing their communities around political issues, and many women traders are wealthy and respected – yet they appear unable to break through into formal political leadership roles (Devereux, 2006).

On the time decisions are made by clan leaders over the commonly held issue of the community, some of its members such as women, social groups not belonging to the clan lineage segments and considered to be inferior or castes, and other minorities even the same clan settings would be excluded from taking part (Ahmed, 2005:10).

In the Somali society, married women traditionally have served to link the clans of their fathers and brothers, to whom they always belong, with their husbands, to whom the children always belong. Like wise, Women should not assume obligation for the clan because they move from the clan to another clan for marriage or within the clan for the same reason. Therefore, their presence is considered temporary in the clan, and as such cannot be counted on (Abdurahman, 2005).

Through exogamy marriage form women (wives) were exchanged even between clans and clan sections that were prone to fight over water and pasture. Yet, such use of women (when against their wishes) as “objects for peace-making” was one case in point of how women rights were violated (Ahmed, 2005:11).

Though women are not represented in the *Guurti* (council of elders) headed by the clan leaders of the Somali community, acts that violets the rights of women such as insult, slap by a man and rape and assaults would be seen as highly sensitive cases and the offender would be fined to pay a heavy compensation to the family of the offended. But, the compensation payment for male and female differs significantly. For instance, for the death of a man 100 camels and for the death of woman 50 camels would be paid though penalties would vary substantially (Abdurahman, 2005).

Despite living in this socio-cultural setting, currently women are having new roles in urban areas as bread winners for the family. They engage in petty, informal businesses and trade; they sit in open market selling trivial items, working as housewives, paying school and medical fees, and traveling from place to place seeking opportunity. Their role is changing fast, but still denied to access full political participation (CHF International, 2006).

### **3.4 Somali Decision Making in Seeking Health Care and Management of Illnesses**

Culture is one of the many factors influencing human behavior; it is a determinant of socially accepted behavior, value systems, beliefs and practical knowledge. Anthropologists argued that, a society's local, culturally-grounded illness theories shape its members illness behavior and treatment choices they make among traditional therapies, folk healers, and biomedical practitioners (McHugh and Vallis, 1986:173).

In light of the above point for instance, decision making on seeking health care among the pastoral and agro-pastoral Somali community is immediately made by the father. Though both parents are involved in making decisions in health seeking behavior in urban areas, mothers are the main decision makers in agro-pastoral and reverine communities (FSAU, 2007). Nevertheless, the type of illness and both the availability and accessibility of financial sources are key in the choice of the type of services that is finally used.

The management of most illnesses is based on the traditional knowledge and beliefs about the illnesses and the associated causes. Almost all forms of diseases that are not understood are associated with evil eyes (wal koraad). For example, when strong malaria is accompanied by convulsions, it is believed to be caused by evil eye where as malaria with out a convulsion is however believed to be caused by mosquito bites (Ibid, 2007).

Over all, due to lack of access to health facilities, poor quality where available, lack of money and failure to believe in modern health care services, the first line of health seeking action for most illnesses are characterized by prayers, self-medication or/and home/traditional remedies. Taking the person to modern health facilities is often considered as a last option after all other options failed to cure.

The mobile nature of their life, in adequate and in accessible health facilities, dependence on traditional cures and the time of the year as well as the amount and intensity of rain fall in the pastoral areas are also factors that interfere on the decision made to seek help from the available treatment options.

## CHAPTER-FOUR

### 4. Data Presentation and Analysis.

This chapter is specifically concerned with the presentation and analysis of the primary data gathered both through the quantitative and qualitative research methods. Using the survey questionnaire a total of 110 health care professionals were interviewed in their respective offices at the health care centers of the study area. Moreover, a total of 100 informants from different categories were interviewed and a total of eight focus group discussions were conducted using in-depth interviews and focus group discussions respectively.

The analysis deals with the information about the respondent's attitudes, opinion, beliefs and perceptions about the modern health care services. It also deals with the challenges that hindered the provision of health care services by the modern health care workers and that of the socio-cultural settings of the community which were not taken in to consideration by the health care workers in their service delivery and in turn has impacted negatively on the community's health seeking behavior.

Finally, attempts could be made to clearly communicate the indigenous knowledge of the community on identifying illnesses, disease causation, sign and symptom recognition, management of illnesses and traditional and religious ways of treating and curing diseases and controlling and prevention of illnesses and diseases.

#### 4.1 Background Characteristics of Survey Respondents

In a total of 110 health care professionals visited during the time of the study, all the intended respondents were available. Summary of the socio-economic background of the research subjects/respondents included in the survey, quantitative research is presented in Table6. Out of the total number of respondents 63.64 percent are male respondents where as, the remaining 36.36 percent are female respondents.

The ages of the respondents ranges from 20 to 60 years. The majority of the respondents are non-Somali ethnic groups whom the Somali consider as “**Haabashi**” such as 40.91% are Amhara, 34.55% are Oromo and the rest are other ethnic groups (Tigre, Gurage) and the Somali which makes 10.91 and 13.64 percent respectively. The small percentage of the Somali health care professionals in the area indicates that most of the available Somali health workers are working in the administration position at the Woredas health bureau. All the departments of the Woredas health bureau are occupied by Somali health care professionals but, the remaining other ethnic groups are supposed to work at the Woredas health centers. Yet, the high concentration of Somali health care professionals at the health bureau level has left the health centers not to offer its services in the socially and culturally appropriate manner by having the health care workers from the locality to the community.

**Table 6. Socio-Demographic Characteristics of Survey Respondents**

Variables	Frequency		Total
	Male	Female	
Sex	70 (63.64%)	40 (36.36%)	110 (100%)
<b>Educational Status</b>			
Primary Education (Certificate)	4	13	17 (15.5%)
Secondary Education (Diploma)	54	22	76 (69.1%)
Post-secondary Education (Degree)	10	2	12 (10.91%)
Others	2	3	5 (4.54%)
<b>Total</b>	<b>70</b>	<b>40</b>	<b>110 (100%)</b>
<b>Profession Status</b>			
Clinical Nurse	45	15	60 (54.54%)
Laboratory	5	3	8 (7.27%)
Health Officer	5	0	5 (4.54%)
Pharmacy	4	0	4 (3.63%)
Midwife	0	7	7 (6.4%)
Health Extension Worker	4	13	17 (15.45%)

Others	9	0	9 (8.2%)
<b>Total</b>	<b>70</b>	<b>40</b>	<b>110 (100%)</b>
<b>Service Year</b>			
1-4 Years	45	38	83 (75.5%)
5-9 Years	13	2	15 (13.63%)
10-14 Years	5	0	5 (4.54%)
15-20 Years	4	0	4 (3.63%)
21 Years and Above	3	0	3 (2.72%)
<b>Total</b>	<b>70</b>	<b>40</b>	<b>110 (100%)</b>
<b>Ethnicity</b>			
Somali	10 (9.09%)	5 (4.54%)	15 (13.64%)
Amhara	30 (27.27%)	15 (13.64%)	45 (40.91%)
Oromo	25 (22.73%)	13 (11.8%)	38 (34.55%)
Others	5 (4.54%)	7 (6.36%)	12 (10.91%)
<b>Total</b>	<b>70 (63.64%)</b>	<b>40 (36.36%)</b>	<b>110 (100%)</b>

**Source: Field Survey, 2011**

Regarding the educational status of the respondents, 15.5 percent attended primary education/certificate 69.1 percent are of secondary education/diploma, 10.91 percent are post secondary education/degree and the rest are the one who had attended other educational programs which makes 4.54 percent of the respondents. The large number of diploma holder health care professionals in the area has limited the potential of the services provided by the health centers. With these staff the health centers are only delivering minor services when complications occur clients would be referred to Jijiga, Harar and Dire Dawa.

Concerning the professional status of respondents, 54.54 percent are clinical nurses, 7.27 percent are laboratory technicians, 4.54 percent are health officers, 6.4 percent are that of mid wives, 15.45 percent are health extension workers, and the remaining are pharmacies and other related workers which makes 3.63 percent and 8.2 percent of the respondents respectively.

Though the large number of clinical nurses in the area to be supported, the large number of male clinical nurses from the given percentage is however a big challenge especially for the majority of women clients seeking help from the health centers. Since, it is a male clinical nurse who works in the diagnosis and treatments of diseases, women clients do not well come or do not fill free to have a good interaction. Like wise, the large numbers of Somali women health extension workers are not well come by the community because women are given lesser position and they do not openly educate about health issue in line with the socio-cultural practices in front of male.

Similarly, regarding the service year of respondents, 75.5 percent has served for 1-4 years, 13.63 percent served for 5-9 years, 4.54 percent for 10-14 years, but the remaining respondents had worked for 15-20 and 21 years and above which makes 3.63 percent and 2.72 percent of the respondents respectively. The majority of the health care workers in the area have served for short period and this in turn has affected their interaction with the community they serve because they are not aware of their clients' socio-cultural setting like how clients narrate illnesses (causes, sign, symptoms and etiologies of diseases/illnesses) and the treatments they seek. Similarly, the shortage of health care workers service year also affected their understanding of the behavior of the community whom they serve and in turn the services they render. On the contrary, those who have worked above five years in the area have shown that, they do not have serious problem over their work.

#### **4.2 Common Diseases in the Study Area**

In an attempt to understand the cultural views of diseases apprehended by members of the society, one has to first identify the commonly existing diseases that were diagnosed and treated by the allopathic medical healers working in that specific area.

Based on this, modern health care workers' currently working in the study area, especially those of in Kebribeyah and Gursum wereda has identified the following common diseases that fall in to the top ten diseases along with the frequency of its occurrences. The detail of the figure is given as follows.

**Table 7. Distribution of the Top-ten Common Diseases which were diagnosed in Kebribeyah and Gursum Wereda Health Centers in 2002.**

<b>Woredas</b>	<b>Name of Diseases</b>	<b>No Patients Treated</b>	<b>Percent</b>
<b>Kebribeyah Woreda</b>	Urinary tract infection	5333	16
	Maternity problems	4000	12
	Respiratory tract infection	5166	15.5
	Malaria	3167	9.5
	Diarrhea	4167	12.5
	Trauma due conflict	1833	5.5
	Peptic ulcer	3667	11
	Other infections/STDs	4500	13.5
	Other minor diseases	1500	4.5
	<b>Total</b>	<b>33333</b>	<b>100</b>
<b>Gursum Woreda</b>	Urinary tract infection	-	-
	Pneumonia	-	-
	Infection/STDs	-	-
	Malaria	-	-
	Diarrhea	-	-
	Peptic ulcer disease	-	-
	Other minor diseases	-	-
	Total	-	-

**Source: GWHB and KWHB, 2002**

According to Table7, of all the top ten common diseases that happened in the study area especially in Kebribeyah wereda, urinary tract infection (16%), sexually transmitted diseases (infection) (13.5%), and respiratory tract infection (15.5%) and diarrhea (12.5%) are the leading diseases which were identified by the health bureau of the wereda.

Maternity problems (12%), peptic ulcer (11%), malaria (9.5%), and trauma due conflict (5.5%) are also other common diseases which were happening and making merciless the life of the community. Besides these commonly mentioned diseases, other minor types of diseases such as eye and skin infection and that of tooth's problems are also common diseases that make 4.5 percent of the diseases episodes occurring in the wereda. Similarly, as Table7 shows, even if the frequency of the diseases that has occurred in Gursum wereda were not given, the nature and types of the diseases that are occurring in the wereda are more or less similar with that of the Kebribeyah wereda. The disease episodes that have occurred in Gursum wereda were urinary tract infection, sexually transmitted diseases, malaria, peptic ulcer, diarrhea and that of pneumonia.

Almost more than half of the health care workers in the formal interviews mentioned that pregnant women, children and that of elders are the vulnerable sections of the society to the above mentioned diseases. Especially, the first three of the diseases are seen as the most serious illness causing diseases that belongs to the top ten diseases recorded in the study area.

In support of the above point, evidences from the focus group discussion held among the community elders is harmonious with that of the health care workers , saying that the most prevalent diseases that are happening in the study area, are that of urinary tract infection, tuberculosis and sexually transmitted diseases.

Like wise, the information found from the in-depth interviews supported the views obtained from the focus group discussions. For instance, in a face to face interviews hold with one clinical nurse in Gursum Woreda has shown that, due to the cultural acceptance of polygamy marriage in the area men have two or more than two wives, and this is creating a serious challenges in our task of providing treatments for the sexually transmitted diseases that is happening in one of the wife, because if the case was found in one of the wife's, it is possible to suspect/assume the case on the remaining other spouses also.

She further stated that, once such a case was found on one of the male client who has come to us from a small village Borale in Gursum Woreda, and we just gave him all the needed services and finally ordered him to bring his three wives for treatment, but he failed to do so and finally we forced him through the use of Woreda administrators in order to bring his wives for the treatment. The nurse also added that the traditional harmful practices like female genital mutilation and early marriage are also complicating our service delivery by causing some forms of infections.

In line with the above points, almost all clients seeking help for their children from the health centers stated in the informal interviews saying that diarrhea, skin and eye infection are repeatedly causing illnesses on their children and youth's. From the above two supportive ideas, one can understand both from the health care workers and clients from the community's point of view that, the diseases that are commonly distressing the health of the people are diseases emerging out from the community's ways of life.

### **4.3 Barriers in the Diagnosis and Treatments of Illnesses in the Clinical Setting.**

In this section the major socio-cultural aspects as well as personal behavior of both health care workers and that of clients seeking for health care services from any modern health care system could be dealt with the resulting outputs of the interaction in the clinical setting.

The diagnosis and treatments of illnesses in the clinical setting is dependent on the first dialogue hold in between the clients seeking help and that of the providers of health care services; because the interaction that is going to be bent in between the parties is an outcome of their socio-cultural background and thus their consensus is what matters. Both parties bring ideas, thoughts, opinion and perception about the world they inhabit in general and that of health and health related problem they focus in particular from the stand point of view of their culture. Like wise, the personal behavior developed by the two parties still would play an important role either positively or negatively in the interaction formed.

Cultural diversity and language has a major impact on how the health care services could be delivered, because communication is an essential element of the health care encounter. Misunderstandings are more frequent in communications in health care settings especially when all cultures have their own beliefs of health, illness and sickness (Sylvia and Ali, 2009:6). Thus, in the study area as elsewhere, the barriers happening in the clinical settings during diagnosis and treatments of illnesses are of social, cultural and personal behavioral factors.

The details of the socio-cultural aspects and the personal behaviors causing the barriers in the diagnosis and treatments of illnesses in the clinical settings are presented in the Table 8 as follows:

**Table 8. Factors that Creates Barriers in the Clinical Setting during Diagnosis and Treatments of Illnesses**

<b>Factors</b>	<b>From whose perspective?</b>
Language	Both clients seeking help and health care workers
Religion	Health care workers alone
Sex	Both clients seeking help and health care workers
Lack of knowledge about diseases	Health care workers alone
Personal behavior	Both clients and health care workers

**Source: Field Work, 2011**

As it was mentioned earlier in Table.6, the majority of health care professionals working in the study area are Amhara and Oromo ethnic groups having cultural and religious difference with that of the research subjects. This in turn implies that, there are clear cut language differences in between clients seeking help and that of health care providers. Similarly, as of Table 6, more than half of the health care professionals in the study area are male sexes.

According to Table 8, language, sex, religion, lack of knowledge about diseases and personal behaviors were identified and mentioned as major factors that create serious

communication/interaction barriers in the diagnosis and treatments of diseases and illnesses in the clinical settings. As shown in the Table language, sex and personal behavioral factors were forwarded as major factors of barriers in the interaction both by the clients seeking help and health care professionals working in the study area. Whereas, religion and lack of knowledge about diseases and illnesses as factors of barriers in interaction were mentioned by health care professionals alone.

Like wise, the evidences found from the direct observation indicated that clients and providers of health care services do have misunderstandings, due to language over the narration of illnesses presented by the clients.

Since, most of the health care professionals working in the study area have short period of experience or service years, understanding and attempting to speak the language of their clients is impossible though not difficult. Even under some circumstances, while they are trying to identify the diseases, due to the clients inability to narrate their illnesses in short or the clients' culture of speaking longer about the symptoms and signs of the diseases may contradict or confuse the signs and symptoms with what was provided to the single specific disease. And again this in turn, influences the right diagnosis and treatments to be offered, ordered and prescribed.

For instance, in an informal interviews hold with one clinical nurse whom he told to the researcher to conceal his name, working in Bombas a small town in Gursum Woreda told to the researcher that, in case if women client happens in my office seeking help for the illness she has around her genital organ during sexual intercourse with her husband and formed infection, she is not directly going to tell the signs and symptoms of the disease rather she narrates the illness by revolving around other body parts like using the kidney, stomach and other parts. Then he continued that, this condition has confused me for the last one fresh year since I was employed and finally, I was convinced and thought by other well experienced staffs that, clients having such illnesses/cases are usually narrating their illnesses in such ways, but he replied that understanding this situation requires to be aware of the socio-cultural settings of the community.

More over, more than half of the respondents expressed that women clients seeking help from the health centers in the study area, by no means become freely open to narrate their illnesses and at the same time women clients do not well come revealing their anatomy for further diagnosis and even under circumstances there is a possibility of getting back home when the providers of services are male sex. The sex difference in between the two parties forces the male physician to give the syringe via her cloth. This is because exposing one's anatomy in front of a male who is not a husband is seen as shame or in local term as '**ebbe**'.

Further more, almost all the formal interviewees stated that, all the clients seeking for help and coming to the health centers in the study area are coming to us by having some sorts of perceptions and ideas about the causes of their diseases and that of the treatments they need. For instance, one of the common behavior clients in the study area posses is the need to have laboratory tests for their blood and urine irrespective of the diseases and this behavior is creating serious challenges in our tasks. This is because unless blood or urine test is ordered clients do not be satisfied with the given services or do not come back for check ups for the second time and even reach to the extent of creating trouble with the physician. Most respondents are saying that, this type of understandings is developed due to lack of knowledge about health and health related aspects.

Like wise, in the informal interview health care providers stated that, religion difference with their clients could interfere in the interaction and affects the outcome of their relation with their clients. For instance, one health care provider expressed the influence of religion saying that, in case if women client who is veiled in Islamic dress appears to our office what matters is not the sex difference we have but, here what is emphasized on creating the barrier in our interaction is the religion difference we have, where she may not well come to reveal her body for examination to the Christian health care provider. But he added that this may not be the case to a Muslim health care provider.

In support of the above points apprehended by health care professionals, evidences from the focus group discussions hold among the clients waiting to seek help from the health

centers of the study area has proved that, due to the language differences and the over number of male physicians except health extension workers, clients has faced barriers in interaction in the clinical settings. Similarly, the information obtained from the in-depth interviews supported the views hold by both the formal interviewees and focus group discussants.

Under some circumstances the ill experiences and limited knowledge of the majority of health care professionals working in the study area is taken as a barrier in it self by the clients who have rich experiences of going to the health centers in the study area.

For instance, in a focus group discussion hold with community/clan/ sub clan elders has shown that, most of the Somali women health extension workers and some of the clinical nurses do have ill experiences of curing and treating and lack confidences of talking and educating in front of the community where there is more number of male clients.

Though, health care professionals regard the entry of family members in to the clinical room/clinical ward as a challenge and obstacle in their service provision, clients and other community members both in and out side the health care centers do not consider as an obstacle for the providers. Yet, from this point one can understand that, physicians are examining the causes of the disease from the individual person point of views alone but, the cause might involve the family members or others and letting them to enter might help to see the illness causing factors from the multiple perspectives. In support of this point some literatures for instance Kleinman (1980) and Helman (2007) have stressed that the clinician should try to discover how patients and those around them view the origin, significance and prognosis of the condition, and also how it affects other aspects of their lives- such as their income or social relationships.

Hence, readers of this research findings are required to understand that, the socio-cultural foundations of the society such as language, knowledge of diseases and its causes and that of sex differences and personal behaviors developed starting from early to late

socialization are major factors that are creating barriers and hindrance in the diagnosis and treatments of diseases and illnesses in the clinical settings.

Similarly, the lack of knowledge about the causes, symptoms and signs of different diseases and the negligence of the community to the order and prescription given by health care professionals are still the complementary factors in the misunderstandings formed in between the two parties.

#### **4.4 Perception about Disease/Illness Causation of the Somali Community in the Study area.**

Both traditional medicine and modern medical systems does have parallel views regarding the causes of diseases or illnesses. Mostly allopathic healers tend to associate the causes of diseases/illnesses with the in ability of organ/s to function properly/normally from their point of views, where as in the case of traditional healers the major factors that causes diseases/illnesses are that of supernatural forces and that of human beings such as ghosts, evil spirits, witches and sorcery (Helman, 2007). Yet irrespective of the stands of the two forms of healings, the perception and ideas developed about disease/illness causation and hold by clients seeking help from any of the health care systems is the out comes of the socio-cultural views of their world.

Despite the position apprehended by the modern medical healers and that of the traditional medical system in regards to the subject of disease/illness causation and its etiologies, there is no uniformly agreed up on perception or idea of disease causation both in the developed and developing countries of the world, but there are two commonly argued factors whom a number of studies tend to associate the causation and these are either personality or naturalistic factors (Helman, 2007). These studies have also shown at the same time that there is variation on attributing causes from society to society.

The findings of different researchers in Ethiopia has indicated that, like other non western countries of the world, Ethiopians also tend to associate some forms of diseases/illnesses whose causes are unknown either to the supernatural forces or to that of the natural

factors. For instance Kebede et.al (2006) notes that, in Ethiopia most of the illnesses and sicknesses are believed to be caused by the supernatural powers.

Thus, like the majority of Ethiopian ethnic groups, the Somali pastoral and agro-pastoral community living in the study area has developed the perception or ideas of causing diseases/illnesses either to the natural factors or to the personalistic factors such as the evil sprit/eye, ghosts, gods, witches and sorcery.

One of the most important and interesting point found during the in depth interviews and focus group discussions hold with the clients in the health centers and that of the community leaders in the study area was that, God is the responsible body for all forms of diseases and illnesses and that of the health or well beings that is possessed by the client. This is because God is the creator and life and death giver to humans in general in the whole parts of the universe. The detail of the diseases/illnesses that were identified during the focus group discussions and the in depth interviews as either caused by the personalistic or the natural factors are presented in Table.9 as follows:

**Table 9. Diseases and their Perceived Causation**

<b>Factors</b>	<b>Diseases</b>
Personalistic	Paralyze due hypertension/ “ <i>Faalis</i> ”
	Gastric
	HIV/AIDS
	Sexually transmitted diseases
	Leprosy/ “ <i>Jusaan</i> ”
	Vitiligo/ “ <i>Baarus</i> ”
	Facial Palsy/” <i>Kumayoo</i> ”
Natural	Malaria
	Diarrhea
	Constipation/ “ <i>Calol Tagan</i> ”
	Tuberculosis/ “ <i>Qaaxo</i> ”
Personalistic and Natural	Pneumonia/ “ <i>Dhaxan</i> ”
	Malaria
	Tuberculosis/ “ <i>Qaaxo</i> ”
	Constipation/ “ <i>Calol Tagan</i> ”
	Diarrhea

**Source: Field Work, 2011**

As it was mentioned on the above paragraph, for all forms of diseases and illnesses and including health and well beings of the community is in the hands of God. This is because, God blesses those who did respect his order and curses those who failed to be abiding by his rules and regulation. Yet this does not mean that other factors are not causing diseases and illnesses up on the community.

According Table9, there are some forms of diseases that are caused both by the natural and personalistic factors and these are malaria, diarrhea, constipation (*calol tagan*), pneumonia (*dhaxan*) and tuberculosis (*qaaxo*), where as other diseases such as mental illness, paralyze due hypertension (*faalis*), HIV/AIDS, leprosy (*jusaan*), vitiligo (*baarus*),

all sexually transmitted diseases and facial palsy (*kumayoo*) are all believed to be caused exclusively by the personalistic/supernatural factors.

Evidences from the informal interviews and the focus group discussions embraced with the community and clan leaders showed that, out of the above mentioned diseases the community as a whole in the study area views HIV/AIDS, leprosy (*jusaan*), and vitiligo (*baarus*) as serious and severe diseases which were exclusively caused by God for the punishment of the patient for his/her misdeed or for the examination of the person's faith.

Hence, these diseases are viewed from the cultural point of the informants in the study area, as misfortunes both to the patient and his/her family as a whole; because they believed that the curse of God could be transferred to other generations. Since, the case of HIV/AIDS incidence in the study area in particular and the Somali region in general is very low, the pastoral and agro-pastoral community in the region as well as in the study area do not believe in the existence of the disease among their community, rather they tend to associate the disease with the non-Muslim people whom they call the *ga'al* (a man without a religion).

In line with the above point, informants from the in depth interviews alleged that mental illness and the repeated deaths of babies in one family could be viewed as an out comes of the misdeed either by the victims themselves or that of their ancestors, so that the cause for the disease and the loss of the babies during delivery is associated with the entrance of the evil spirit (*Jini*) in to the body of the patient or to his/her family. Similarly, informants also stated that children who have repeated dysentery and body weight lose are also associated with the evil eye (*Kumaayo*). Yet, the allopathic medical healers mainly relate the loss of body weight to the lack of nutrition in their consumption. Thus, the stand taken by the modern health care professionals about the loss of weight on children is not congruent with the views of the community in the study area.

In favor of the outlooks of the community towards the body loss of their children, Helman (2007) notes that the numerical definition (weight and height) used to define

normality may not much indigenous beliefs about whether a child is healthy or not; because parents may see a child as healthy if he/she can smile, play, talk, respond affectionately or perform certain domestic or ritual tasks irrespective of their height and weight.

Further more, due to the lack of rain fall and the aridity and semi aridity of the area that informants are living, there is the incidence of continues droughts and famines and this in turn, has made the respondents to view that some forms of diseases such as malaria, constipation and diarrhea are believed as caused by the supernatural forces (Haabar). This is because, during the time of drought and famine people lacks any forms of foods even including meat and milk and this can cause malaria, constipation and diarrhea. In support of this point, evidence from the informal interviews hold with the clan/community elders and that of modern health care professionals in Kebribeyah Woreda has shown that, due to the repeated occurrences of droughts and famines in the Woreda, some of its small village names were changed and replaced by the incidences it happened on them and the disease cases coming to the health center from such a small village in Kebribeyah Woreda called Melaah Gaacho (literally to mean a village of hunger) is highly interwined with the supernatural forces (Haabar). This small village is named meelah gaacho after the drought and famine has severely batter her repeatedly.

Generally, one can understand from the above findings that, like the majority of non-western countries people, the Somali pastoral and agro-pastoral community mostly tend to identify the subjects of disease causation and its etiologies to the personalistic factors such as ghosts, evil sprit, evil eye, gods, capricious sprit, witches and sorcery.

The community also associates the causes of some types of diseases to the natural forces such as warm and cold air, heavy rain fall and concentration of water in dumps and the increment of temperature from the normal degree required for the life of human beings. For instance, one informant sleeping on the stretcher and having a sputum test being suspected of tuberculosis said that the immediate factor that caused my illness is the sun which shined over my head.

Hence, this can remind us that, the perception as well as the ideas people could form about disease and illness causation is interwined with the socio-cultural views of the world in general and that of their day to day life in particular.

## **4.5 Health Seeking behavior, Treatment Options and Sources of Home Remedies**

### **4.5.1 Health Seeking Behavior of the Somali Community**

The influence of the socio-cultural settings of a society is not only limited to the delivery of modern health care services but also in the realm of the help or health seeking behavior that is developed by a given society. The treatment and health seeking behaviors of a given community is reliant on the social and cultural based perceived causes of disease or illnesses. For instance Helman (1990) notes that people seeking for medical help depends on the etiology of the conditions whether it is believed to originate in the individual or in the natural or super natural worlds (as reviewed in Ameyu, 2008:19). Like wise, Nunes (2007) found that cultural beliefs and customs still had strong influences on the assistance people sought for the health and /or health related problems.

Besides, the social and culturally perceived understanding of the help and health seeking behavior of the community, still the severity of illnesses, quality of services, cost and accessibility of treatment options in the surroundings and the knowledge of diseases/illnesses and that of information about health and health related aspects are other relevant factors in the development of help and health seeking behavior of the community concerned. Thus, under this section factors that have promoted and delayed the health seeking behavior of the Somali pastoral and agro-pastoral community in the study area are dealt with detail.

Accordingly, among the Somali pastoral and agro-pastoral community in the study area, there are widely held notion that, all types of health and health related problems are in the hands of God; because he is the creator of the universe. There fore, for all types of health related problems the responsibility is up to God.

Where as, culturally speaking the Somali community tend to associate the majority of health problems to the personalistic factors such as ghosts, gods, evil eyes/sprits, ancestral sprits, witches and sorcery.

Since, Somali community is living in the desert and semi desert parts of the country, they tend to associate other diseases with the natural factors. Thus, taking in to account these causative factors their need to seek help and have treatments could be determined.

The findings from the formal interviewees showed that, most of the time the Somali community in the study area are seeking help from the modern health care system for their children and that of women. As also directly observed in the health centers of the study area, the majority of clients waiting to seek health care services given by the centers are women and that of children. This is because, this section of the society are seen as sensitive and easily exposed to diseases and illnesses. Supporting this point for instance Cockerham (2007) noted that the age and gender status of the clients could be taken as factors in the determining of health seeking behaviors.

Similarly, the information found from the informal interviews and focus group discussions revealed that, for all types of diseases the first option of treatment is the home remedy and the traditional medicine, yet when such options failed to cure the disease there is no question that one need to seek help from the modern health care system. This is because, when the two options failed to cure, the diseased person starts to believe that his/her problem is in his/her blood and this motivates them to seek help.

Evidences from the formal interviews indicated that, more than half of the male clients coming to the health centers are seeking laboratory tests irrespective of the nature of the diseases; because they have already defined that their problem was in their blood.

Unless a blood or urine test is ordered in the examination by no means clients think that an appropriate treatment was given. Under some circumstances when the examination does not involve a laboratory tests, clients would get emotional and enforced to create

trouble with the physician and reach to the extent of defining the physician as having no knowledge of his/her fields of study.

The information found from the informal interviews and focus group discussions also indicated that clients are seeking help from the modern health care services only to have the blood or urine tests through the laboratory. Since, there are much more illegal drug shops run by the private sectors in the study area, clients who have got some forms of diseases can easily access any forms of medications with out having prescription from the concerned bodies. In support of the above point Cockerham (2007) stated that by taking in to account the existing health conditions and it's perceived out comes individuals can make decision to seek health care services from the modern health centers.

Hence, due to the availability of much more illegal drug shops in their surroundings the community's desire to seek help from the modern health care centers could be delayed; because these drug shops can provide clients what ever they seek irrespective of the diseases diagnosed and the prescription ordered to them.

As far as the Somali pastoral and agro-pastoral community is the mobile community moving from place to place in search of grass land and water bodies to their herds accessing health care services from the nearest area is difficult. Most of the time the days clients seek help from the health centers is on market days (Monday and Thursday); because on these days clients brought their livestock to the market and after they sold it they visit health centers in the study area.

For instance, one of my respondent's a clinical nurse 35, stated that except on Monday and Thursday, all the rest of the week days, the health centers working in the study area will remain being closed; because there are no clients coming to the centers for treatments. In support of this point, the evidence from the direct observation revealed that, except the above two days mentioned the health centers and its working staff's offices would remain closed.

As Cockerham (2007) stated one can understand from the above two paragraphs that, the socio-cultural environment and the living conditions lead by the community could still be taken as factors that determine health seeking behavior of the community.

On the other hand, the information obtained from the informal interviews and focus group discussions seized with the community leaders showed that, due to the prevalent conflict in between clans/sub-clans, distance to the nearest health centers and the availability of traditional healers in their surroundings, the desire and needs of the community to seek help from the modern health care centers could be delayed. For instance Kleinman et al. (1978) states that Cultural preferences given for traditional treatments can be associated with reduced use of health care (Cited in Lee, 2003:10). But from the side point of the community, the availability of illegal drug shops in each and every small villages of the zone is not taken as barriers for seeking help from the modern health centers.

Although, the information found from the formal interviewees stated that, clients are delaying help seeking behavior due to lack of knowledge about the diseases and the services provided by the health centers, the finding of the study on this section was in congruent with the idea of the health care professionals.

#### **4.5.2 Health Care Treatment Options and Their Determinant Factors**

As it was expressed on the literature and the findings of many researchers, there are three main health care treatment options for every society in the world and these are modern, traditional and home remedies. Like wise, the treatment options available in the study area are of modern, traditional and home remedies. Cognizant to this fact, the Somali pastoral and agro-pastoral community in the study area has used such healing treatment options when contracted with different diseases or illnesses.

Yet, the trends of using such treatment options are determined by several different factors such as culturally constructed views of disease/illness causation, community's views

about local healers and that of distance to the nearby health care institutions and socio-economic status of the people.

As shown in Table.9 above, it is almost possible to say that, the majority of the Somali pastoral and agro-pastoral community in the study area associates subjects of causing diseases and illnesses to the personalistic factors. In line with this point, people in the study area do also believe that some other types of diseases/illnesses are still caused by the natural factors such as worm, cold, wind and dump.

The information acquired from the informal interviews and focus group discussants revealed that, minor illnesses such as common cold, diarrhea, back pain and malaria without convulsion are treated through home remedies.

Basically the community believes that these diseases are minor and are occurring for short term duration and are easy to get rid off them by using home made remedies. Diseases such as mental illness, paralyze due hypertension, tuberculosis with serious chest pain and respiratory tract infections are believed to be caused by the super natural forces and their treatment option is the traditional medicine through the use of Islamic religious healers whom the people in the study area refer them as ma'alin (religious teachers).

For instance, one of my male informant who is 50, in Kebribeyah Woreda alleged that when an individual person is having mental illness, his/her family are first informing the case to the sheiks, because the cause is suspected as ancestral bad sprits or witches/sorcery and then the sheiks would come to the diseased home and look at the situation and prepare a certain ritual activity whom the people in the study refer to it as du'co. So as to get rid off the causative evil or ancestral spirit out of the body of the diseased, some portions of the Quran/Koran could be read by the ma'alin and a goat or sheep could be slaughtered; because the people believe that, the causative spirit likes to have the blood, so the moment the goat/sheep is slaughtered and its blood flows the agent/sprit would gets out of him/her and enter to the blood.

In holding up this point, some literatures for instance, Sylvia and Ali (2009) noted that, Somali patient with mental health problems believes as other Muslims, that the cause might be psychiatry or evil (Jini) cause. They further added that, since, the cause of mental health problem is the (Jini) evil spirit, Somali coming to the psychiatry ward read to the patient some verses of Quran/Koran. He further continued to state that, so also when a pregnant woman loss her babies in death repeatedly, the same ceremony is practiced, but so as to stop the death from occurring in that specific family, tip of the child's ear could be cut, when the blood flows out of the ear so also the causative agent/sprit would gets out and enter to the blood.

In addition to the super natural forces that are forcing the community to use the home remedies and the traditional medicine as treatment options, still in the rural areas of the zone, lack of access to the modern health care centers, the lack of money to afford for their health needs, prevalent conflicts and easy accessibility of traditional healers forces them to use traditional healings as an option. For instance in Gursum Woreda the nearest health center to the remote rural people of the Woreda to seek help is around 15-20 km and the same thing in Kebribeyah is 20-30km.

Yet, evidences from the informal interviews and focus group discussions embraced with the community leaders indicated that, basically people are using the traditional medicines due to their easy accessibility, affordable price and for the lack of believes in the modern health care services.

In spite of the traditional medicines and home remedies being used in the study area, along with its limitation still the contributions of modern health care centers in the provision of services is not to be underestimated.

As it was shown above, diseases such as urinary tract infection, sexually transmitted diseases and tuberculosis are mentioned as common diseases that were treated by the health centers in the study area.

However, evidences from the formal interviews seized with the health care professionals in the study area revealed that, due to lack of health education given to the community extensively, the people especially those of rural do not have the knowledge/information about the availability of modern health care services in their surroundings which is 15-20 km away from them and this in turn by itself could be taken as one factor that forces the people to rely on home remedies and traditional healings alone. The Gursum wereda health center could be taken as best example for this point, as it has started its function recently only three months before the study.

Overall, from the above points of views and from that of my personal observations, rural people in the study area first and for most employs home treatment options to the diseases whom they call minor, but when the home remedies fail to cure immediately they would begin to use the traditional healings which is provided by their sheiks/ma'alin (religious teachers) and then resort to modern medicine when the disease or illnesses got severe.

In line with this point, one interesting point that was found from the informal interviews and focus group discussants was that people in the study area are going to the modern health care centers to get cure of their diseases or illnesses but when getting back home they are drinking at least two to three liters of camel milk per day to rehabilitate/rebuild their body and at the same time to get rid off the causes that has brought the diseases/illnesses. Therefore, this could indicate that camel milk is drunk not only for the sake of consumption but also for getting rid off the agents that caused diseases/illnesses.

### **4.5.3 Sources of Home Remedies**

Home remedies is the most popular and yet overlooked sector of health care in many society. It is the lay, non-professional, non-specialist domain of society, where ill health is first recognized and defined and health care activities are initiated (Helman, 2007).It includes all the therapeutic options that people use, without any payment and with out consulting either folk healers or medical practitioners.

Since, the majority of the world population lacks regular access to affordable essential drugs, modern medicine is not likely to be seen as realistic treatment option. Rather it has been estimated that about 70-90 per cent of health care services takes place within the home remedy sector, in both the developed and developing societies of the world.

The medicines employed in home remedy are prepared from plants, minerals and animals and their products that are often easily accessible and available to the community with normal cost or even free of charge which is unthinkable in the modern health care sector. Like wise among the Somali pastoral and agro-pastoral community home remedies are seen as the first treatment option to be used by the wider community.

The sources of medicines employed in home remedies are plant leaves, roots and minerals and animals and their products (milk and meat). At the same time fire is also used as one source of home remedy. In support of the role of fire, the community does have one saying “Daab iyo hanuun manolaan keero” literally to mean that fire and disease no longer live together. Still the community in the study area uses modern medicines as other sources of home remedies without being ordered through prescription by the concerned bodies.

The evidence acquired from the informal interviews noticed that, almost all the community in the study area has so far used Amoxicillin (Awqumbule), Ampicillin (Qoor madoobe), Tetracycline (Qoor Caase) and Paracetamol as major sources of home remedies both for their illnesses and that of their animals diseases. Similarly, the information obtained from the formal interviews supported that, clients are coming to the health centers to seek help after they have used the above mentioned Tablets in their home.

As it was found both from the in depth interviews and focus group discussions embraced with the community leaders and clients waiting to seek help from the health centers, the major sources of home remedies are garlic, black seed (xabaasuud), milk, meat, tobacco (buuri), horn (geestoobin), hildid (plant leaf) and urawaaweyn (plant seed).

Due to the intimate association Somali have with camel, its milk is seen as one important source of home remedy. For instance, Citrin (2004) notes that drinking camel's milk is believed to be beneficial to someone who is sick, as it induces urination and bowel movements, which clear out the stomach of maladies.

The majority of the plant leaves and root medicines are used to treat diseases and illnesses that were caused both by the super natural forces (ghosts, evil eyes, evil spirits and ancestral spirits) human beings (witches and sorcery) and that of the natural factors such as worm, cold, wind, dump and the social environment.

The following Table would further exemplify the plant or animal products and the specific diseases which were treated either using plant or animal products in the home of the community.

**Table10. Plant and Animal Products Used as Medicines and the Diseases it Cures in the Home Remedy Sector**

<b>Plant Leafs or Roots</b>	<b>Diseases treated</b>
Black seed/Xabaasuud	Amoeba, headache, pneumonia, Tract infection, Back pain, TB
Urawaaweyn/plant seed	Constipation, Cough
Garlic/Toon	Cough, cold
Dacaar/ plant leaf	Sneezing problem, allergic,
Heldid/plant leaf	headache, Cough, Amoeba
Tobacco/Buuri	Snake bite
<b>Animal Products</b>	<b>Diseases treated</b>
Milk/Caano	Constipation, Malaria, pneumonia, TB
Meat/Heliib/soup/merak	Pneumonia, TB, Malaria
Horn/Geestoobin	Back pain

**Source: Field Work, 2011**

The plant leaves and roots are used as sources of home remedies by being added in to foods and tea and given to the patient.

Still plant leaves could be burnt and its smoke would be inhaled. Like wise, under circumstances plant roots could be crushed and its liquid would be prepared for drink. The root also used in a form of teeth brush for some tooth problems. The animal products such as milk and meat are used in a form of food so that it builds the patients body and rid off the causes of the disease/illness. When the community in the study area faces back pain, through the use of tool made from a horn they would provide the cure.

#### **4.6 Decision Making over treatment choice and Managements of Illnesses.**

The decision making over the choice of treatment options in any society is dependent on the culturally perceived causes of diseases or illnesses and its treatments. Similarly, depending on the gender role played in a society, the person who is going to engage in the managements of illnesses/diseases could also vary from culture to culture, but naturally speaking women are gifted in treating and managing of illnesses by preparing home remedies ranging from drugs to the required food items to the diseased. Hence, in this section the persons who are responsible in making decision over the choice of treatment options and managements of illnesses could be dealt.

In many pastoral and agro-pastoral communities, the roles of women are limited to the caring of children, cooking of food and take caring of small animals in their fields, where as men in a pastoral and agro-pastoral community are seen as the bread winners for the family by engaging in the rearing of animals, working on the farms and moving from place to place in search of grass lands and water for their animals. Still men of the pastoral and agro-pastoral community are power holders in the socio-cultural, economical and political affairs of the community. For instance Blench (2001) notes that, in most pastoral societies gender roles are strongly marked, and indeed patterns seem extremely similar across the world. Women are typically responsible for milking and dairy processing; they may or may not sell the milk, but they usually have control over the proceeds to feed the family.

Men are responsible for herding, and selling meat animals and in systems when a herd is split, women usually stay in a fixed homestead while men go away with the animals. Thus, as elsewhere in the world, Somali pastoral and agro-pastoral communities do have their own gender roles associated to its members. Like other pastoral and agro-pastoral communities women in the world, Somali women do not have power over resources such as over land, livestock and other reserved capitals.

But now a days, due to the impacts of drought and famine strikes in the study area in particular and that of the region in general, there are shifts of roles where women are engaging to the economic sector as main income generators for the family (Devereux, 2006).

Despite limited power in the political and socio-cultural aspects of the community, Somali women in the study area are playing an important role in the other aspects of the community such as in managing illnesses, making decision over choice of treatment options and recognizing of diseases and illnesses.

The information obtained both from the informal interviews and focus group discussions hold with the community elders and clients waiting to seek help from the health centers in the study area revealed that, women are the decision makers over the choice of treatment options for children, because mother's in pastoral and agro-pastoral community spent all their time with caring for their children and this could gave them the chance to know their children's real situations.

Since, the source of economy (livestock) is in the hands of the father, his last order could be waited but nothing could be changed by him except to give the needed money required for the treatment.

The role of the mother is not only limited to decision making but also, in the managements of illnesses by preparing home remedies in the forms of drugs and needed food items and sharing of life time experiences to newly married and pregnant women.

When the illnesses or diseases happened on youth and elderly members of the community the role of decision making and recognition of illnesses and diseases is the responsibility of the father. Evidences from my observations in the health centers of the study area showed that young and elderly diseased persons were brought for treatment through the aid of their fathers’.

Fathers could still play an important role in arranging ritual activities by calling sheiks to make du’co to the diseased as well as to the good of the family. Along with the fathers still mothers with her young daughters could involve in the managements of illnesses.

Generally, one can understand from the above facts that, both fathers and mothers could involve in decision making, managements and recognition of illnesses, but the power extent of mothers in decision making and illness recognition of the elders and younger children is limited.

Mother’s are the main decision makers and the one who actively engage in managements of illnesses in the agro-pastoral community of the study area but in the case of pure pastoralists their power is still limited.

#### **4.7 The Role of Traditional Birth Attendants in the Modern Health Care Centers.**

It is obvious that, traditional medicine and its healers come in to existence before the advent and spread of modern medicine in the developed countries of the world. Yet, the use of traditional medicine in the modern health care system is not as such significant until the twenty century. The situation on wards this century has witnessed a revolution in the human health care.

Although, there are no clear cut evidences as to why twenty century has witnessed a radical shift of the people from the modern health care to that of traditional medicine, the increasing cost of discovery and clients dissatisfaction could be mentioned as possible major factors.

For instance, Cockerham (2010:179) notes that, the increasing popularity of traditional and complimentary medicine in the world is a clear testament to the increasing dissatisfaction of the people with the modern western medicine.

Traditional medicine and its healers are playing significant roles in the developing countries of the world both for the health of human beings and that of their animals now and in the past. Due to their nearness and skills in interpersonal relations and counseling, traditional healers are socially and culturally accepted and respected by their community. Like wise, the traditional medicine and its healers among the Somali pastoral and agro-pastoral community in the study area are widely accepted and respected for the services they render to the community.

Evidences from the informal interviews embraced with the community leaders clearly indicated that, people of the study area are excessively using the traditional medical system for their health and that of their animals. The most common traditional medicine and healers that are used by the community in the study area are traditional birth attendants and Islamic religious teachers whom the community calls ma'alin for curing mental illnesses and some times setting broken bones due to injury during conflict or car accidents.

In holding up the above point, evidences from the formal interviews hold with the modern health care professionals revealed that, more than half of the deliveries in the study area were conducted by the traditional birth attendants.

While the health centers in the study area are ready to provide and manage the delivery services with the qualified midwives, pregnant women in the study area are going to the traditional birth attendants to deliver their baby. This idea is further exemplified by the information provided by one of the midwife who is 30 working in Kebribeyah Woreda health center, that she has noticed the pregnant women in the Woreda come to the health center either from the urban or rural area for ante-natal care and other check ups, but when the delivery reaches, it is possible to say that none of them are coming to us for

delivery and post natal care, rather they are going to the traditional birth attendants for the delivery as well as other required services. The point given in this paragraph agrees with the real situation at national level in that, in Ethiopia where the largest proportions of birth takes place at home, postnatal care provided by health care professionals is extremely low and uncommon ( ESPS, 2008). Yet, the point stated in the same token saying that, low awareness of the community about the benefits of modern health care services and low house hold decision making autonomy of women in Somali region were taken as factors for low utilization of ante-natal care services, contradicts with the findings of this study.

Similarly, the information gained from the informal interviews hold with the traditional birth attendants in the study area is harmonious with that of the health care professionals. One of my informants who is 50 working as traditional birth attendant in Gursum Woreda told to the researcher that, she would provide and manage delivery services at least to four to five pregnant mothers from the urban and rural area per day, yet some times at other day there may be no one to seek delivery. She further continued to state that, basically clients are coming to me because of my nearness to them and the safe delivery that I can provide, having taken in to account the consequences of the genital mutilation. But she did not passed with out mentioning the serious challenges she has faced during delivery as a result of the female genital mutilation.

The role of traditional birth attendants is not only limited to the provision and managements of delivery to pregnant mothers, but also they are playing key roles in the provision of health education to the community. They are seen as gate ways to community health activities, cultural specific information in sexual behavior and information and channeling specific health promotional messages to the community at large (Hills and Finch, 2006:221). The evidence acquired from the traditional birth attendants during the informal interviews revealed that, understanding the relevance of the traditional healers some non governmental organizations has provided training to the traditional medical healers about health aspect in general and other harmful traditional practices like female genital mutilation.

Holding up the above point, one of the traditional birth attendants in the study area stated that, taking in to consideration the difficulties I faced during delivery service provision and that of the trainings I have received, I am always advising and educating pregnant mothers coming to me and to that of my friends in my village.

Along with the traditional birth attendants, the other potential sources of traditional medicine and its healers are the services provided by the religious healers, whom the community calls as ma'alín (religious teachers). The religious teachers in the study area are called for any types of illnesses which were failed to be cured by home remedy. In support of this point for instance (Citrin, 2006) notes that ma'alín is a special elder who is believed to know which trees, roots and herbs from the forest can be used to treat an illness or disease.

Since, the whole community in the study area believes that God is responsible for all kinds of deeds including health and health related problems, their first option to rely on when home remedies failed is the religious healings provided through the ma'alín.

As it was noticed by Sylvia and Ali (2009:34) Islam is a very important part of the identity of Somali people and gives purpose to their life. Islam is visibly present in the daily lives and gives guidance on how to live a very fulfilling and morally good life. Even evidences gained from the informal interviews seized with traditional bone setters in the study area indicated that, traditional bone setters them selves do have religious background. Thus, having some forms of ritual activities (**du'co**) and reading some sections of the Quran/Koran, **ma'alín'** can provide cure to the diseased and his/her families.

From my observation and that of the evidences gathered from the informal interviews and focus group discussions embraced with the traditional healers and that of health care professionals working in the study area, it is possible to say that, the majority of pregnant mothers are delivering their babies through the aid of traditional birth attendants. Hence, taking in to account the major services provided by the traditional birth attendants and the

needs and attitudes of the general community towards these traditional medical healers would enable the regional as well as the zonal level modern health care planners and programmers to design and develop an appropriate health care services which is preferred by the wider community.

More over, still the role of the traditional medical healers in the provision of health education is not to be under estimated. Having seen and taken in to consideration the needs and preferences of the wider community, the Gursum Woreda health bureau has called one of the well known traditional birth attendant working in the study area to work with the health center. Based on the calling, she has been currently collaborating with the midwife of the health center.

Yet, an in depth interviews hold with her revealed that, even since she has come to this health center, there are some sorts of behavioral changes from the sides of the community and she is bringing pregnant mothers coming to her home to the health center when the delivery reaches.

Though, the beginnings of integration is to be supported and promoted in other Woredas of the zone as well as to the region, the lack of basic resources that is needed for delivery, the lack of cooperation from the side of modern health care professionals and absence of incentives offered to the traditional birth attendants are becoming challenges to the newly set up integration of traditional medical healers.

Even though, the modern health care workers in the study area know the acceptance and respect given to the traditional medical healers in the zone, it is possible to say that none of the types of traditional healers were called to collaborate with them in the service provision except the one in the Gursum Woreda. Thus, the suggestion that was given by the world health organization to incorporate traditional medical care and its healers in the expansion of primary health care services was not implemented at all.

#### **4.8 Socio-cultural Aspects and Delivery of Modern Health Care Services**

The social and cultural foundations of a given society are its basic guide lines to be followed by its community, because the views hold by the community about the world including health and health related problems are its outcomes.

The shared and learned values, beliefs, norms and ways of life of a particular group are believed to guide our health and illness behaviors and how care is provided (Helman, 2007).

Thus, the believe that culture is the foundation of every one's health concerns and practices has promoted the need to take in to account the socio-cultural settings of patients in the delivery of services by the modern health care system. Here, the importance of socio-cultural settings of clients is not only limited to the interaction formed in between health care workers and that of patients, but also ranges to the extent of planning and designing health care policies. For instance, Cockerham (2007:121) pointed out that, for those individuals and groups concerned with planning, organization and implementation of health care delivery systems, identification of the social and cultural factors that encourage or discourage a person from seeking medical treatment is of great significance.

Since, the biological or medical terms alone cannot assess the health and health related situations of the community, many countries in the developing world are getting complexes in their health care systems. Similarly, due to the strongly interwined life of the community with their social and cultural settings, their views of disease, its causes, signs, symptoms and its treatments are all dependent on their deep rooted culture.

Hence, under circumstances when modern health care system planners and designers failed to take in to account the prevailing socio-cultural settings, believes and practices of the community, the need and desire of the community to use the available services that has not considered all these things is reduced, or they do not seek help at all from this sectors, when disease/illnesses has occurred in their surroundings.

In many developing countries, where health care resources are available, due to the failure to consider the community's social and cultural settings in the public health programs many of their populations are still suffering from preventable and communicable diseases and illnesses. Holding up this point, Devereux (2006) stated that failures of the public health services are responsible for thousands of premature deaths every year especially for people living in rural Somali region of Ethiopia.

Akin to the above point, the pastoral and agro-pastoral communities in Jijiga zone are the one who are suffering from the common leading diseases that were mentioned in Table.7 which are possible to be prevented through public health programs or treated if it occurs through the collaboration of the community in a way that considers their social and cultural settings.

As it was mentioned on the background characteristic section of respondents, the majority of health care professionals' especially those of clinical nurses working in the health centers are male sex groups and this large numbers of male clinical nurses in the centers has created serious challenges for female clients coming to seek help from the health centers. This is because, according to the widely held cultural notion of the people in the study area, women do not become free to speak confidentially every thing in front of male and they are expected to cover their whole body through veil.

Hence, coming to the health centers in the study area for help results in misunderstandings in between the male clinical nurse and that of women clients; because women do not well come male professionals for treatment and even under some circumstances if they come across male health care workers they do not narrate their illness very well and by no means cooperate with the physician by revealing their body for physical examinations.

The evidence obtained from the formal interviews seized with the health care professionals indicated that, most of the time it is women clients coming to our health centers to seek help than male clients, however, due to the large number of male

professionals in the health centers, it is possible to say that, more than half of women clients are getting back home with out having the treatments when they found a male health care worker.

Like wise, the information gathered through the informal interviews and focus group discussions hold with the clients revealed that, due to the less number of women health care professionals' especially clinical nurses in the health centers of the study area, the desire of women sections of the community to seek help and assistance was delayed or reduced. At the same time, women informants in the study area complained that though we are the one who are exposed to different diseases in the area, the available health care services are not designed and developed for us by taking our culture in to account.

Here, the researcher has understood from the points raised and what was observed during the study that, the large numbers of male clinical nurses in the health centers are challenges for women clients seeking help and even, I have seen women clients getting back home with out receiving the treatments. Thus, at least having fair number of professionals especially those who works in the diagnosis of diseases in the health centers of the study area minimizes the problems of women in the study area in particular and the region in general.

Moreover, still it is the socio-cultural settings which were not taken in to consideration by the modern health care professionals in the study area that are causing the most severe but preventable diseases such as, urinary tract infection, sexually transmitted diseases and that of tuberculosis. It is obvious that one's society socio-cultural settings can either promotes or prevents the occurrences of some types of diseases or illnesses.

Like many other groups of society, the Somali pastoral and agro-pastoral community practices some forms of harmful traditional practices which endangers the health and health related aspects of women and children.

As it was indicated on the formal interviews hold with the health care professionals, many of the infectious diseases affecting the health of women in the study area are related with the female genital mutilation practices.

Evidences from the formal interviews showed that, the majority of infectious diseases such as, urinary infection and sexually transmitted diseases are mainly associated with genital mutilation. Similarly, the evidence from the in depth interviews and focuses group discussions hold with traditional birth attendants and that of clients from the community revealed that, the complications emerging during delivery and menstrual discharge are due to the genital mutilation practiced on female sections of the society. But the evidence from the formal interviews showed that knowing the cause of the most common diseases in the study area, still modern health care professionals are giving attention to the curing of the diseases rather than preventing and eradicating the factors that are causing the diseases.

Here, the researcher has understood from this point that, the health care policy and program being implemented in the area is more of curative, urban oriented and one size-fit-all program. Rather giving emphasis to health education so as to eradicate or reduce the incidences resulting from the harmful social or cultural practices which are being practiced by the community can play an important role in the reductions of the prevalent health problems.

The other major socio-cultural aspect of the community in the study area which was not taken in to account by the modern health care professionals in the treatment and cure of tuberculosis is the, close and intimate interaction family member have with the TB patients, due to lack of knowledge about the disease. Among the Somali pastoral and agro-pastoral community stigmatization and discrimination of patients is uncommon except to those who have HIV/AIDS.

Almost all informants from the in depth interviews and focus group discussions in the study area indicated that, due to the lack of health education provided to the community

on the most common diseases such as TB and sexually transmitted diseases, they were affected by these diseases seriously. Informants also said that, if we know that such diseases are communicable and fast to be transmitted, at least we can save our selves by having preventive mechanisms that do not stigmatize and discriminate the diseased.

The Somali pastoral and agro-pastoral community is a clan oriented community and the increment of the number of children with in a family is seen as the potential sources of clan strengths. Similarly, large number of children with in a family is considered as potential assets for the family and at the same time children are believed as God gifts. Thus, under this socio-cultural environment it seems impossible to implement the family planning program, but if the religious, community and clan leaders are consulted for their comment and suggestion on how to realize and implement the program, it is possible to improve the health of mothers and children and that of the house hold economy.

Since, the Somali community is clan based and have special respect for their clan leaders and religious and community elders, taking account of these agents in the implementation of any health care programs in general and family planning program in particular in the study area is unquestionable, however, failure to consider them can endanger the whole program. Supporting this statement for example CHF International (2006:31) notes that any initiative hoping to have a chance of successes must immediately integrate the traditional indigenous mechanisms and leaders- failure to do so can doom the program before it truly begins.

For instance, one of my health care informant who is 45, currently working in Gursum Woreda state that, once a vaccination for tetanus was being given at national level for women whose age was in between 15-45 and at that time, we were giving the vaccines to women starting from Thursday for three consecutive days, yet having given the vaccines peacefully on Thursday, unfortunately all the expected women has become absent on wards the first day and when we ask the reasons for absenteeism we were told that, the vaccines being given was wrongly interpreted as if it causes infertility on women and this rumor has begun to be heard on Friday after the people has got back home from

mosques. He continued saying that, by the time we did not consult any of the community / religious/ leaders/elders as well as clan leaders and this has made the vaccines program to be left with out being given to the people of the Woreda.

Evidences from the informal interviews seized with the clients waiting to seek help from the health centers in the study area indicated that, almost more than half of them knows the consequences of repeated births on their health and at the same time they also believe that having more number of children is an asset and potential sources for the clan's strengths, but due to its negative impacts both on their health and their house hold economy now a days, women have developed behavioral changes on using contraceptive methods. Informants also said that, even if we want to use contraceptive methods, our husbands do not let us to use, because they are saying that children are God gifts and no need to break God rules.

Similarly, the evidence from the formal interviews showed that, women in the study area can understand the problem, but the fear that their husbands' will marry anther wife if they uses contraceptive method would forces them to avoid its use. Where as, the points forwarded by women clients in the health centers is contrasting with that of the point apprehended by health care professionals, in that women clients said that, if health care professionals convinced our husbands by stating the impacts of large family size on the health of mothers and children and the wider community using health education things could be improved.

The information obtained from one of my women informal interviewees exemplified the above statement that, when we loss any hopes that convinces our husbands, we were forced to adopt our own mechanism and that is to use a type of contraceptive method which is not easy to be seen and observed by our husbands and that is depo-provera; this is because if I am going to use pills for example, my husband is going observe it and clash with me. So I have adopted my own coping tactic of using the contraceptive method which could be given in a form of syringe for three months and that is depo-provera.

The information gained from the formal interviews has supported the above point saying that, out of the small number of women using contraceptive methods with or without consensus with their husbands in the study area are mostly using the depo-provera contraceptive method.

Further more, supporting the above point for instance, the reality at the Somali regional level, indicated that, the percentage of depo-provera usage has increased dramatically from 22% (1996) to 29.5% (1997) and 43.6% (1998), where as, the percentage of pills usage at the same period has declined from 45.2% (1996) to 40.4% (1997) and to 37.6% (1998) in the region (MOH, 2006).

But the health care professionals were not aware of the reasons as to why the number of depo-provera users has increased and pills users has dramatically declined. Hence, one can understand from the above evidences that, the failures of modern health care professionals to consider the social as well as the cultural settings of the community concerned in its service delivery, can negatively affects the needs and desires of the community. While, for some of the health and health related challenges, male members of the community are to be blamed and educated through health education, due to the failures of the modern health care planners and policy makers to address the issue, the wider community was forced to remain underserved.

Generally, having seen the association in between the socio-cultural settings of the society and the health status of African population for example El-Safty (2001:13) notes that an attempt at improving the health conditions of African societies has to take in to consideration all the elements of the respective cultures, in order to help bring about successful results. El-Safty also further notices that, one good formula that can help ensure the acceptability of the modern health care system is to make constructive use of the elements of the indigenous health care system by incorporating them in to the modern health care system.

## **4.9 Modes of Health Care Service Delivery followed by the Health Centers**

It has been argued that, the mobile nature of the pastoral and agro-pastoral communities living in the country has made impossible the provision of public services such as health and education. Though, the current government is attempting to address the health needs of the pastoral and agro-pastoral community in general and Somali pastoral and agro-pastoral community in particular, the area still remained being marginalized and under serviced in basic health care and educational services and other developmental infrastructures.

The two common modes of providing modern health care services followed by the health care institutions are in-reach and out-reach programs. In the case of in-reach program, health care services are provided at the health care institutions where as, in the case of out-reach programs; services are given out side the health care institutions.

The out-reach, health care service provision program, mainly emphasizes on health education, childhood immunization, screening for some diseases and nutrition counseling; it there fore covers many aspects of preventive medicine and health promotion. In-reach health care service provision mode primarily focuses on investigating, diagnosis, treatment and curing of illnesses or diseases that has occurred in the clinical setting.

Although, these two health care service provision modes were implemented through out the country, due to their urban oriented nature, their effectiveness on the pastoral and agro-pastoral area of the nation in general and in Somali region in particular, is to be questioned. Having taken in to consideration the shortcomings of the two modes of service delivery, the Somali region health bureau in collaboration with non governmental organizations has implemented a new modes and that is a mobile health team approach; but still this newly implemented approach is not with out a problem; because the socio-cultural settings of the concerned community were not taken in to account (that is clan as well as community leaders do not have a place on the teams).

Evidences from the formal interviews indicated that, the most common modes of health care service delivery system followed by the health centers in the study area are in-reach programs, where clients seeking help from the centers would appear in the health centers. The observation during the field work also supported this point that, the majority of clients were receiving help from the health centers and at the same time clients are also given general education about health problem by the health care workers of the health centers. The health centers in the study area are providing services for minor illnesses and diseases, but when severe cases happen to the centers, clients could be referred either to Jijiga, Harar or Dire Dawa. During the field work in the study area, due to delivery complex, I have seen a pregnant woman who was referred to Jijiga Karamara hospital for further treatments.

Along with the in-reach program, health care professionals working in the health centers have mentioned that, though not as such significant we are also using the out-reach program in our service delivery. Here, more than half of the respondents have failed to mention at least some of the social and cultural aspects which were taken in to account in the out-reach program.

The information obtained from the in depth interviews and focus group discussions embraced with the clients waiting for services at the health centers and the community and religious leaders revealed that, the services which they have received so far is only from the health centers nothing else from others. The informants further stated that, due to the lack of awareness and lack of knowledge about some types of diseases, its cause, signs and symptoms such as tuberculosis and even lack of knowledge about the services which are provided by the health centers we were suffered a lot.

Although, there are a number of health extension workers in the region as well as in the zones, who are working at grass root level, still due to the influence of widely hold cultural notion that, women are less heard and given less attention for what they are suggesting, the achievement of the intended goal was not as such significant.

Accordingly Devereux (2006) notes that Somali society is highly patriarchal and females in any patriarchal society face gender-specific risks and vulnerabilities, or experience the effects of generic risks, and vulnerabilities more acutely than do males.

For instance, one of my informants from Kebribeyah Woreda stated that, women health extension workers in our Woreda by them selves first and for most need to be educated about their widely hold social and cultural settings; he said because when they educate for instance, about female genital mutilation, if they were asked from the male section of the community they did not answer fully; because they bashful speaking in front of men. Thus, he said that, up on the recruitment program of health extension workers, male sections of the society could be better if recruited than women; because they are respected and given attention for what they speak.

In support of what was suggested in the above paragraph for example El-Safty (2001:13) stated that, one recommended approach that can help in raising the health status of African population is targeting men to increase the use of health services; because in a male- dominated society, men have the upper hand. They control household resources; they are the major decision makers in all family matters, health included. Reaching them with the proper information about health concerns, the use of health services, and negative consequences/ complications of health problems are a positive step in seeking health care for family members, not excluding women.

From the field experiences, due to the special respect that, the community in the study area, has to the health care professionals and even to students of health fields excluding women, they call them saying doctor by giving a status of doctor irrespective of what their field is or what they are studying and learning.

Moreover, the evidence found from the informal interviewees showed that, none of their leaders as well as representatives' was consulted for any of health care service delivery programs being implemented in the study area. As a result some of the health care programs being implemented were remained fruitless.

In support of this point, the information found from the formal interviews indicated that the different types of vaccines coverage for the zone are very low.

Here, one can understand from the above point that, in several literatures it was argued that the Somali pastoral and agro-pastoral community do not want to take some forms of vaccines; because they suspect that some vaccines can result in infertility or can produce further illnesses up on their children.

But here, the researcher argues that, if religious and community/clan leaders were invited and consulted over the issues, things could be made easy; because what clan or religious leaders are saying is highly respected and accepted with out question. According to Abdurrahman (2005) clan and sub-clan leaders/elders among the Somali pastoral and agro-pastoral community is not to be underestimated; because clan leaders are well accepted by their community and are also believed as the one who perpetuate and preserve customary laws and are the only custodian of inherited culture and tradition.

Still, the evidence found from the formal interviews showed that, due to the lesser coverage of immunizations and vaccinations in the study area, their out-reach program is mainly focusing on this issues. Yet, as it was mentioned above in Table7 the most prevalent and common diseases in the study area are urinary tract infection, sexually transmitted diseases and tuberculosis, which are threatening the health and well-being of the community.

Overall, one can understand from the modes of health care service delivery system being implemented in the study area that, still the modes are not free from limitations. The in-reach program which was used by the health centers for example is influenced by the language barriers in between the client and that of providers of the services. Cultural diversity and language has a major impact on how the health care services could be delivered, because communication is an essential element of the health care encounter.

For instance Lee (2003) states that communication barriers related to cultural and linguistic diversity are increasingly recognized as contributors to health disparities between patient groups.

Similarly, giving attention to the most prevalent common diseases which are possible to be eradicated through health education by consulting the religious and community or clan leaders can achieve the intended goal of the region as well as the zone under study. Devereux (2006) has noted that, the failure of public health service are responsible for thousands of premature deaths every year along with the limited accessibility and poor quality of health services in the rural areas of Somali region.

## CHAPTER-FIVE

### 5. Conclusion and Recommendations.

#### 5.1 Conclusion of the Study

The findings of this research paper has revealed that, the socio-cultural settings of the society such as, how the community perceives the modern health care services being provided, views of diseases or illness causation, health seeking behavior of the community and decision making over the choice of treatment options and that of managements of illnesses are essential aspects that need to be taken in to account in the designing and development of modern health care services. Understanding and having the knowledge of the social and cultural settings of the society is helpful for the delivery of any types of health or health related services. This is because, any society's health care system cannot be studied in isolation from any other aspects of that society, especially its social, cultural, religious, political and economic aspects.

In many parts of both the developed and developing countries of the world, due to the incongruence between the modern health care system and the prevalent social and cultural foundations of the society and that of the views hold that, any model of health care system based on a single system of medicine will find it difficult to cope with the health care demands of the society in the near future, the world health organization has encouraged member countries to make use of their indigenous traditional and cultural knowledge of medication along with the modern medicine and address their peoples health care needs. Hence, this in turn has forced the world society to rely on the traditional or complimentary/alternative medicines for their health and well being. There fore, under this concluding and recommending chapter, the researcher would likes to deal specifically with the socio-cultural settings of the Somali pastoral and agro-pastoral community that need to be taken in to consideration by the planners of modern health care system.

The increased understanding of the Social and cultural environment of the society has played an important role in the designing and development of appropriate health care

policies and programs. In developing countries the situation in health care has become so complex that medical or biological terms alone cannot effectively assess it.

When health care providers ignore the psychological and socio-cultural setting of the society, the care of patients is limited because biology represents only part of the consequences of a malady (Winkelman, 2009:39). Thus, by understanding the association in between the social conditions, life styles, and health situations of the society, even some nineteenth-century European Physicians have argued that an improved medical care was to go hand-in-hand with the changed social conditions leading to a better life (Cockerham, 2007). Like wise, Helman (2007) notes that, the shared and learned values, beliefs, norms and ways of life of a particular society are believed to guide their health and illness behaviors and how care is provided.

It is apparent that, the influence of social and cultural settings of the society is not only limited to the forms of interactions that could be developed in the clinical setting, but also extends to the planning, designing and implementation of health care programs. For instance, Cockerham (2007:121) notes that, for those individuals and groups concerned with planning, organization and implementation of health care delivery systems, identification of the social and cultural factors that encourage or discourage a person from seeking medical treatment is of great significance. In this regard, the findings of this study partly supported the argument given in this paragraph in such a way that, due to the failure of the planners to take in to consideration the social and cultural foundations of the society in the study area, women clients seeking help from the health centers are getting back home with out having the treatment and being discouraged by the more number of male clinical nurses working in the health centers.

Similarly, in support of the above statements, the results of the study indicated that, the large number of women health extension workers in the study area has brought serious complains from the community leaders; because among the Somali pastoral and agro-pastoral community women are given less attention and were not accepted by their community when they thought about health and health related topics.

At the same time, women health extension workers themselves do not effectively engage on their task of educating the community due to the fear of men sections of the society. Thus, due to the key role that social and cultural aspects play in assessing communities health needs and developing appropriate health policies and programs, health care professionals need to have knowledge of culture and cross-cultural relationship skill; because services are more effective when responding to cultural needs (Winkelman,2009:37).

On the other hand, cultural diversity and language has a major impact on how the health care services could be delivered, because communication is an essential element of the health care encounter. According to Lee (2003) for instance, communication barriers related to cultural and linguistic diversity are increasingly recognized as contributors to health disparities between patient groups. The more the provider shows tolerance and understanding to the cultural differences, the more the client develops openness and trust towards health care providers.

Yet, still misunderstandings are more frequent in communications in health care settings especially when all cultures have their own beliefs of health, illness and sickness. Here, in this study, as it was mentioned on the background characteristics of the health care professionals working in the study area, more than half of the workers in the health centers do have some sorts of cultural differences with the wider community in the area and this in turn, has resulted in misunderstandings in between the clients seeking help from the centers and that of health care workers of the health centers in the study area. For instance, clients happening in the health centers would states their illnesses by speaking longer and some times this may not be tolerated by the physicians, because clients may confuse and mismatch the symptoms of diseases and this in turn finally lead clients to be less concerned about the treatment.

Though, some literatures states that, when the clients can not communicate in their mother language, clients look up to health care providers as being superior and therefore not value their own ability to make decisions around their care expecting the doctor to

take on the role (Sylvia and Ali, 2009), yet the result of this study, in this regard completely contradicts with this point in such a way that, when physicians failed to understand the clients health problem or both parties failed to understand each other clients could generally consider the physician as having no skill and knowledge to treat and cure their illnesses and they mostly do not prefer to seek help again from this same physician. Besides, the language barriers that could happen in the clinical settings, in between the client and health care workers in the health centers, understanding the causes of illnesses narrated by the clients is another factor that influences the provision of services.

Like the majority of other ethnic groups of Ethiopia, the Somali pastoral and agro-pastoral community attributes the causes of illnesses and diseases both to the personalistic and natural factors. For instance diseases such as: mental illness, paralyze due hypertension, leprosy, tuberculosis, HIV/AIDS and other severe skin diseases are associated with the super natural forces and human factors. Where as malaria, tuberculosis, diarrhea and constipation are believed as caused by the natural factors. Thus, the finding of this study is harmonious with the given theories of illness causations on the literature section of the study.

Although, several studies and reports stated that, the involvements of Somali women is limited in the socio-economic and political affairs of their community, currently due to the radical shifts being made in the overall life of the Somali pastoral and agro-pastoral community, the involvement of women is increasingly improved especially in the economic and health sectors of the community. Due to the strong affiliation mothers have with their children, they are decision makers over the choice of treatments options for their children. Mothers are also responsible for the management of illnesses and diseases, by arranging home remedies and preparation of food.

The Somali community is Islamic religious followers. The community associate any forms of health related problems to the curse of God for the misdeed or the test of faith. At the same time, most of the disease causative factors are related with the supernatural

and human factors such as ghosts, gods, evil spirits, evil eyes and witches and sorcery. Thus, due to such a strong hold believe that, most diseases are caused by supernatural factors, the community in the study area do not prefer to seek help from the modern health care system, because they believe that such diseases can not be cured by allopathic medicine, rather they prefers traditional medical healers. Children are the most common clients seeking help from the modern health care centers in the study area.

Though, there are some forms of modern health care institutions operating in the study area conflict, distance and lack of money at hand till assets are sold, are some of the factors hindering the community from seeking help from such modern health care centers.

As it was expressed in different studies, there are three main health care treatment options for every society in both the developing and developed parts of the world. These are modern, traditional and home remedy (Helman, 2007).

On the basis of the existing believe and perception, many diseases are caused by supernatural forces; the community in the study area is using home remedy and traditional medicine as potential options of healing than allopathic medicine. Out of the traditional healers most common in the study area, traditional birth attendants and religious healers (ma'alin) are the most widely used ones. Here, it is not only due to their closeness and nearness to the community that has made them to be used excessively, but also the belief on them is still another factor. Though, there are trained and qualified midwives in the health centers of the zone, almost all of the mothers who have given delivery have gone to the traditional birth attendants.

Since, the community in the study area is pastoral and agro-pastoral community; their ways of life is highly inter woven with their livestock. Similarly, their health and health related issue is also associated with their animals.

Hence, their animals especially that of camel would take the first potential source of home remedy. Modern medicines such as tetracycline, amoxicillin, ampicillin and paracetamol are also used extensively as other main sources of home remedies. The leaf and roots of plant such as hellebore (plant leaf), black seed, white onion, tobacco, and datura (Plant leaf) are other sources of home remedies used for curing different diseases.

This study has also identified the common diseases which are highly associated with the way of life of the community. These are urinary tract infection, sexually transmitted diseases and tuberculosis. The causes of these diseases are highly inter-woven with the socio-cultural practices of female genital mutilation and the polygamy marriage.

Even if, these diseases are easy to be eradicated or prevented through public health program and health education, due to the failure of the modern health care planners to address the social and cultural practices that are causing illnesses and diseases in the study area, these diseases are still distressing the health of the community under study. Accordingly, it was argued that, the failure of public health programs are the major factors for the majority of premature deaths in the Somali region, and the reality in Jijiga zone is not exceptional to this phenomenon.

## **5.2 Recommendations of the Study**

From the foregoing data presentation and analysis, it would be understood that, because of the failure of the allopathic medical planners to take in to consideration the socio-cultural settings of the community under study, diseases and illnesses which are easy to be eradicated and prevented through public health programs and health educations are battering the health and well being of the society and expected to remain so. Therefore, the following recommendations are geared to support and strengthen the efforts towards improving the delivery of health care services and the health status of the community.

1. Participating the local community, clan/sub-clan leaders and religious healers/ma'alin in to the development and designing of modern health care services should be promoted; because among the Somali community clan or

community leaders and that of religious healers are considered as the one who perpetuate and preserve customary laws and are the only custodian of inherited culture and tradition. At the same time they are seen as, prime force for stability and potential partners in developmental issues including health care activities.

2. Widespread intervention in the area of health education and promotion should be implemented in the study area in order to raise the awareness of the community about modern health care services provided by the centers and to sensitize the community about the health problems resulting from their socio-cultural practices.
3. The use of male health extension workers must be promoted so as to educate the community and address the primary health care issue; because among the community in the study area men are more accepted and respected than women in the social, cultural and religious aspects. In a male-dominated society, men have the upper hand.
4. The modern health care system currently being implemented in the study area need to consider the social and cultural settings of the society. Here, it is to mean that rather than blaming their way of life as a challenge to the provision of out-reach services, it is better to adjust this type of program at market places; because mostly as the evidence shows the communities are coming to seek helps from the centers during market days when they come to sale their animals. Thus on market day's people could be found collectively.
5. The beginnings of integrating the traditional birth attendants in to the modern health care system in the Gursum Woreda should be replicated to other Woredas, zones and to the region in general. This is because, it is possible to say that the majority of mothers in the study area have gone to traditional birth attendants having taken all the services given for anti-natal care from the health centers in the study area.
6. Since, the majority of the community is accessing medicines in formally from drug shops and ordinary shops, efforts must be made to educate, train and legalize the owners of these informal drug shops. This is because, at least these agents can share the information about health and health related problems and serve as one potential means's of addressing preventive and primary health care services.

7. As far as, the most prevalent common diseases affecting the health of the community are emanating from the community's socio-cultural practices in its good face, efforts must be exerted from the side of the modern health care system to emphasize on the public health program through the involvement of the concerned members of the community under study.
8. Since communication problem due to language is one major factor creating challenges in the delivery of health care service in the area, short term trainings on the local language must be given to the modern health care professionals so that it improves their interaction with the clients seeking help.
9. The small number of women health care professionals in the area is still another area of challenge for women section of the society seeking help from the centers. Therefore, women health care professionals from the community must be trained and promoted in the area.
10. Finally, due to the mobile way of life of the community creating an effort to collaborate health extension workers with agricultural extension workers or veterinary health workers will help on addressing primary health care services.

## References

- A.A.Elujoba, M.Odeleye and M.Ogunyemi (2005). African Journal of Traditional and Complimentary and Alternative Medicine: Traditional Medicine Development for Medical and Dental PHC Delivery System in Africa, Vol.2, No.1, Nigeria.
- Ahmed Mohamed (2005). A Study Report for the Traditional Structures and Local Governance: Project of the Community Empowerment and Social Inclusion Program of the World Bank Institute, Somali Land.
- Abdurahman A.Usman (2005). A case study on the traditional multi-stakeholder dialogue structures in local governance for local development. PDRC.
- Ameyu Godesso (2008). Community's Perception of Malaria and the Understanding Interventions for Its Management and Control in Jimma Town, Oromiya National Regional State, Ethiopia. Unpublished MA Thesis in Sociology, School of Graduate Studies, Addis Ababa University. Addis Ababa, Ethiopia.
- Blench, Roger (2001). You cannot get home again: Pastoralism in the new millennium. London, UK, Oversea development Institute.
- CHF, International (2006). Grass Root Conflict Assessment of the Somali Region, Ethiopia.
- Citrin, David (2006). Somali, Tuberculosis Cultural Profile. University of Washington, USA.
- Cockerham, C. William (2007). Medical Sociology, (Tenth edition) New Jersey, Pearson Prentice Hall.
- Cockerham, C. William (Ed.) (2010).The New Blackwell Companion to Medical Sociology. USA, Blackwell Publishing.

CSA (Central Statistics Agency). The 2007 Population and Housing Census of Ethiopia, Result for Somali Region, Vol.1.Statistical Report.

Devereux, Stephen (2006). Livelihoods in Somali Region, Ethiopia. UK, IDS, Brighton.

Debar Abdi M. (2008). Field report of the emergency mobile health teams in Somali region, Ethiopia. Unpublished Field Report Submitted to UNICEF, Ethiopia.

DHS (2006). Ethiopia: Demographic Health Survey 2005. Central Statistical Agency, Addis Ababa, Ethiopia.

El-Safty, M. (2001). Culture, Public Health and Community Development, Health and Enviromental Education Association of Egypt.

Endashew Bekele (2007). Study on Actual Situation of Medicinal Plants in Ethiopia, Prepared for JAICAF.

ESPS (2008). Maternal Health Care Seeking Behavior in Ethiopia: In-depth analysis of the Ethiopian demographic and health survey of 2005. Addis Ababa, Ethiopia.

FSAU (2007). Somali Knowledge, Attitude and Practices Study. Nairobi, Kenya.

Gabe,J., Mike, B., and Mary, A. E. (2004). Key Concepts in Medical Sociology. London, UK, SAGE Publication.

Gerald, J. and Dorothy, R. (2010). Annual Report: July 2009 to June 2010. Friedman School of Nutritional Science and Policy.

Getachew Addis, Dawit Abebe, Timotewos Genebo and Kelbessa Urga (2002).  
Ethiopian Journal of Health Development: Perceptions and Practices of Modern  
and Traditional Health Practitioners about Traditional Medicine in Shirka District,  
Arsi Zone, Ethiopia, Vol.16, No.1.

Getachew Gebru (2003). Pastoralism in Ethiopia and Policy Environment: Linking  
Research, Development Actors and Decision Makers. Addis Ababa. Unpublished  
document.

Gundel, Joakim (2006). The Predicament of the Oday : The role of traditional Structures  
in Security, Rights, Law and Development in Somalia. A Final Report to Danish  
Refugee Council.

Helman, G. Cecil (2007). Culture, Health and Illness, Fifth edition. London, UK, Hodder  
Arnold.

Hills, Y.S. and Finch, L. (2006). A Clinical Guide to Supportive and Palliative Care for  
HIV/AIDS; Traditional Medicine.

Kebede Derbe, Alemayehu Amberbir, Biniyam Getachew, and Yunis Mussema (2006).  
Ethiopian Journal of Health Development: A Historical overview of traditional  
Medicine Practices and Policy in Ethiopia, Jimma University Faculty of public  
Health. Jimma, Ethiopia, Vol. 20, No. 2.

King, Maurice (1966). Medical Care in Developing Countries: A Primer on the Medicine  
of Poverty and A Symposium from Mekerere, Nairobi, Kenya, Oxford University  
Press.

King, Rachel (2000). Collaboration with Traditional Healers in HIV/AIDS Prevention  
and Care in Sub-Saharan Africa: A Literature Review. UNAIDS.

Kleinman, A. (1980). *Patients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine and Psychiatry*, Los Angeles, University of California Press.

Lee, Sharon.M. (2003). *A Review of Language and Other Communication Barriers in Health Care*. Portland, Cosmos Corporation.

Mchugh,S. and Vallis,M.T. (1986). *Illness Behavior : A Multidisciplinary Model*. New York and London, Plenum Press.

MOH (2006). *Health and Health Related Indicators. Planning and Programming Department, Federal Ministry of Health, Addis Ababa, Ethiopia.*

Muhuyadin M. (2009). *Children's weight Gain in out-Patient Therapeutic Program in Three Districts of Korahe Zone. Unpublished MSC Thesis, London, UK, School of Nutrition.*

Mwaura, Peter (2008). *Indigenous Knowledge in Disaster management in Africa, Niarobi. Kenya.*

Nunes, Licas.M. (2007). *Cultural Influences on Seeking Health Care in Angola. Unpublished MA Thesis in Health Sciences, Republic of South Africa, University of South Africa.*

OXFAM GB (----). *The Building Blocks of Pastoral Felt Needs. Addis Ababa, Ethiopia.*

Save the children UK (2008). *Understanding of Livelihoods in Somali Regional State, Ethiopia, Addis Ababa, Ethiopia.*

Save the children UK (---). *Health Care for All the Challenges in Ethiopia.*

- Sylvia, A. and Ali Mohamed (2009). Somali Immigrants Need and Expectation Towards Health care in Helsinki, Metropolitan.
- Tebaber Chanie (2005). A Socio-Cultural Study of the Cause, Transmission, Prevention and Treatment of Malaria: The case of Debre Ellias Woreda, East Gojjam Zone Amhara Regional State. Unpublished MA Thesis in Social Anthropology, School of Graduate Studies, Addis Ababa University. Addis Ababa, Ethiopia.
- Teshome Bahru (2004). Annuals of African Medicine: Concepts of Health, Disease, Illness and Therapy among the People of Addis Ababa, Vol.3, No.1. Institute for Anthropology, University of Vienna, Austria.
- Teshome Dura (2005). Comparative Study of Traditional and modern Medical Practices among Woliso Oromo of Eastern Mecha. Unpublished MA Thesis in Social Anthropology, School of Graduate Studies, Addis Ababa University. Addis Ababa, Ethiopia.
- Winkelman, Micheal (2009). Culture and Health: Applying Medical Anthropology. San Francisco, Jossey-Base.
- UNCT (2009). Unite Nations Country Team Report in Ethiopia.
- Vander, Geest (1997). Tropical Medicine and International Health: Is there a role for traditional medicine in basic health services in Africa? A plea for a Community perspective, Vol.2, No.9, Amsterdam, Netherland.
- WHO (2002). WHO Traditional Medicine Strategy 2002—2005, Geneva. Switzerland
- World Bank (2009). Ethiopia : Improving Health Systems

**ADDIS ABABA UNIVERSITY**  
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**DEPARTMENT OF SOCIOLOGY**

**APPENDIX I: QUESTIONNAIRES FOR HEALTH CARE PROFESSIONALS,  
OFFICIALS AND COMMUNITY WORKERS.**

**Introduction**

This questionnaire is designed to collect information and to write MA thesis on the integration of modern health care and Socio-cultural setting in Somali region of Ethiopia: The case of Jijiga Zone. It is part of the requirement for the fulfillment of the degree of masters in sociology at Addis Ababa University. The main objective of the study is to assess the integration of the modern health care system and the socio-cultural setting of the Somali national regional state of Ethiopia, the case of Jijiga zone. To this effect your participation in the study could play an important role to the out come of the research. Hence, any of the information you gave to the researcher could be kept confidentially secret.

**General Instruction**

- ▶ In questions which do not have an alternative answers, please indicate your answer by writing in the space provided.
- ▶ In questions with an alternative answers, please choose one and indicate your choice by putting " X" in the space provided.
- ▶ When you are asked to rank alternatives, please you are kindly requested to indicate their rank by writing the number on the space provided.

**I. Data on the setting and time of the Interview**

Date of Interview-----

Interviewer's name-----

Time of Interview Conducted: Started at----- Ended at-----

Code Number-----

## II. Data on Personal Background

1. Sex: Male----- Female-----

2. Age-----

3. Educational level: Primary Education/Certificate-----  
Secondary Education/Diploma-----  
Post Secondary Education/Degree-----  
Other, Specify-----

4. Ethnic Group-----

5. Position-----

6. Profession-----

7. Service Year-----

## III General Questions on the health and health related situations of the zone/Woreda.

8. What are the most common diseases in the zone/Woreda?-----  
-----  
-----

9. Who are the most vulnerable sections of the Woreda to the above mentioned diseases?  
Children----- Youth----- Pregnant Women----- Elders-----  
Other, Specify-----

10. How does the community responds to your comments, suggestions and prescriptions?-----  
-----  
-----

11. What are the challenges you faced in your service provision in the zone/Woredas?-----  
-----

12. Have your office so far given health education on the most prevalent health problems in the zone/Woreda? Yes----- No-----

13. If your answer to Q.No.12 is Yes, How it has been given?-----

14. Does your office take in to consideration the way of life of the community in your service delivery? Yes----- No-----

15. If your answer to Q.No.14 is Yes, what are the things you have so far taken in to account?-----

16. Would you mention some of the positive practices that promote health seeking behavior in the zone/Woreda?-----

17. What about the negative activities and practices that hindered the seeking of health care services in the zone/Woreda?

18. Do the people of the zone/Woreda come early to your office for the treatment of their health problem? Yes-----No-----

19. If your answer for Q. No.18 is No, Why do you think is the reason?-----

20. What are the modes your office could follows during service delivery in the zone/Woreda?-----

.....  
.....  
.....

21. Are there relationships in between the socio-cultural setting of the zone/Woreda and that of the most prevalent health problems? Yes----- No-----

22. If your answer for Q. No. 21 is yes, please specify them.

.....  
.....  
.....

**Thank You in advance for Your Cooperation!!**

## Declaration

I, the undersigned person, assert that this thesis is my original work and has not been presented for a degree in any other university, and all the sources of materials used for the study have been fully acknowledged.

Name: Biniyam Bogale

Signature: \_\_\_\_\_

Place and date of submission: AAU, May 2011

This thesis has been submitted for examination as approved by the assigned University Advisor.

Name. \_\_\_\_\_

Signature \_\_\_\_\_

Date of approval \_\_\_\_\_

**Thank You!!**