Addis Ababa University

School of Graduate Studies

Beliefs and Practices of Traditional Medicine among Women in Reproductive Health Care: A study in Damot Woyde Woreda, Wolaytta Zone

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Acronyms

CSA: Central Statistical Agency

FDRE: Federal Democratic Republic of Ethiopia

FGD: Focus Group Discussion

ICPD: International Conference on Population Development

MOH: Ministry of Health

NGOs: Non-Governmental Organizations

STDs: Sexually Transmitted Diseases

WHO: World Health Organization

Local terms

Abasha asaa[1] - *traditional medicine practitioners*

Abasha asay – *the traditional medicine practitioners*

Abasha xaliya – *herbal medicine*

Bakkar - *the first-ever pregnant/ a woman who delivers for the first time*

B*irtaatiyaa marppiyaa* - *an injection that helps to be doing well after treatment*

B*itaaminiyaa* – *a pill containing vitamin*

Bitaamine qumaa – *Foods rich with vitamin*

Do'aa (synonymous with *"Geedoba"*) - *placenta that comes out/ delivered after the baby*

Desha - *tilted position of a fetus*

Geedobaa- *See "Do'aa"*

Gelaa - *a problem that is thought to occur when a bone in ones side or cartilaginous bone around his/her heart moves from its normal position*

Maaretissiya asaa – *Traditional Birth Attendants (TBAs)*

Shahariyo – *a pregnant woman*

Shahariya – *the pregnant woman*

Wogeeshsha (Wogesha *in Amharic)* – traditional medicine practitioners who treat sprain, wrench, cracked/broken bone

Wogeeshshatettaa - treating those with sprain, wrench, cracked/broken bone

Xapho - *vein*

[1] The language is *Wolaytigna*

Abstract

This study has been conducted with the major aim of investigating the beliefs and practices of traditional medicine in reproductive health care by emphasizing on rural areas. The reproductive health issues covered in this study are: prenatal care, delivery care, postnatal care, birth spacing service, abortion and STDs.

In order to investigate the beliefs and practices, this study has employed a cross-sectional qualitative approach; and the data are collected by making use of in-depth interviews, FGDs and key –informant interviews. The study subjects were selected purposively with the help of health extension workers of each kebeles. Sixteen in-depth interviews with practitioners of traditional medicine; twenty-two and sixteen in-depth interviews with married and unmarried women in reproductive age, respectively; two FGDs consisting of seven participants and two consisting of six participants with married and unmarried women (two with each of them); key informant interviews with health extension workers, a midwife in Badessaa health center, two senior citizens who are knowledgeable about the practice of reproductive health in the area, have been conducted to collect the primary data.

Prenatal care, delivery care, abortion service and treatment of STDs are among the major services that the rural women get from traditional medicine practitioners in relation to reproductive health; whereas birth spacing/control and postnatal care services are among the services that are not as such significant. None of the reproductive health problems is believed to be caused by supernatural force(s). And the practice of traditional medicine is not accompanied by the belief that the issues should be addressed by the practitioners because they are caused by the forces. Besides, it is widely believed that the knowledge that the practitioners have is learned from their parents, than being given by supernatural force(s).

Practitioners known as TBA; TBA and wogesha; TBA and herbalist; TBA, herbalist and wogesha; herbalist; and herbalist and wogesha are the practitioners who are engaged in provision of the reproductive health services. Traditional medicine and its practitioners have decisive place in the provision of reproductive health services in the rural areas.

Chapter One: Introduction

1.1 Background of the Study

Traditional medicine is an extensively used health system whose importance and expenditure on it is increasing very fast in many parts of the world. Its use is widespread especially in developing countries. In Africa, for instance, about 80% of the population use some type of traditional medicine for the purpose of meeting their health care needs (WHO, 2002). In the same vein, in Ethiopia, more than 80% of the population uses traditional medicine to help meet its health care needs (Fekadu, 2007; WHO, 2001).

The number of clients of traditional medicine is increasing from time to time in Ethiopia since modern medical services cover only a small part of health care in the country. Most people, especially those in rural areas, lack access to modern health care (Assefa, 1992; Belachew, 2008; Fekadu, 2007). Traditional medicine has been practiced in Ethiopia since earlier times, although it is difficult to tell the exact time. According to WHO (2001) and Anderson (2007), in Ethiopia, the traditional medical practices are recorded in oral tradition and in early medico-religious manuscripts and traditional pharmacopoeias, which date back to the 15th century AD.

Spiritual healing, traditional midwifery, inoculation, massage, hydrotherapy and thermal water, bleeding and cupping, counter-irritation, surgery, dentistry, and bone-setting are among practices of traditional medicine in Ethiopia. And

various types of medicines from plants, animals, and mineral substances are utilized while practicing the traditional medicine in Ethiopia. The Ethiopian traditional medicine is utilized to cure many diseases (such as diabetes, asthma, kidney disease, fever, fungal infections, and mental illness) that are known in the country. For almost every disease in the country there is, at least, one traditional remedy (Alemayehu, 1984; Belachew, 2008; Pankhurst, 1965; WHO, 2001). Traditional remedy is applied for health problems of people in different ages and of both sexes.

Women, just like men, benefit from traditional remedy for different health problems. Women consult traditional medicine practitioners for different health issues. Reproductive health issues are the most important among these because, unlike other health problems, they concern almost all women in reproductive age. Delivery, prenatal and postnatal care for mothers, child care for new born babies, abortion service, family planning service, and treatment of STDs are among the services that women get from traditional medicine practitioners for reproductive health issues (Assefa, 1992; Jemal et al., 2010). It is a fact that both men and women utilize reproductive health services. But it is the women who mostly utilize the services. Besides, some of the reproductive health services (delivery care, prenatal and postnatal care, and abortion services; for instance) are exclusive to women. In view of this, the focus of this study is on women's utilization of traditional medical services for important reproductive health issues that mostly require an intervention of a practitioner,

viz. child delivery, prenatal and postnatal care, abortion, birth spacing/control and treatment of STDs.

1.2 Statement of the Problem

Human history is full of individuals who claim to have indigenous knowledge and skills of healing. And the practice of traditional medicine is common to societies ranging from earlier to contemporary, rural to urban and traditional to modern (Read, 1966). The indigenous knowledge of traditional medicine, in most societies, is localized and intrinsically attached to land, i.e., it is shaped by natural environment; language, i.e., it is expressed by language; and culture, i.e., the knowledge is culturally specific. This knowledge centers around the net of relationships between humans, animals, plants, natural forces, spirits, and land forms in particular locality (Hill, 2003: 10). Kloos and Kaba (2006: 289) affirmed this by stating that the beliefs and practices of medicine in Ethiopia "*reflect the great cultural diversity of the Ethiopian people and the distribution of endemic diseases.*"

In Ethiopia, more than eighty percent of the population depends on traditional medicine for the purpose of meeting its health care needs (Fekadu, 2007; WHO, 2001). However, the reality is that many of medical beliefs and practices in Ethiopia "*remain to be studied*" (Kloos and Kaba, 2006: 289). Among them reproductive health is an important as well as challenging one. Reproductive health is associated with the life of many people. Maternal and infant mortality, for example, are directly related to birth complications and problems before,

during or after delivery. It is the traditional birth attendants who deal with these delivery related issues in Ethiopia mostly. According to Population Institute (2009), in the year 2008, only 6% of all deliveries were attended by trained birth attendants and skilled health personnel. The remaining (94%) were attended by traditional birth attendants or relatives. Traditional birth attendants still have crucial role in providing delivery service in the country, despite the fact that there is relatively better supply of modern health care services in the country.

Abortion and treatment of STDs are also among important issues under reproductive health. Abortion, according to Assefa (1992), is mostly carried out by traditional midwives in Ethiopia. STDs are also treated by (traditional) specialists of the problems. Practicing traditional medicine for these issues, even when modern health service is available, indicates the need for deep investigation of the issue and the surrounding beliefs. This study, therefore, has closely investigated the beliefs and practices.

Pinpointing the knowledge, beliefs and practices of the traditional medicine in Ethiopia, on which the overwhelming majority of the country's population depends (but which is yet to be investigated), requires conducting studies in different parts of the country that have their own culture. And hence, the major thirst of this study is to pinpoint the beliefs, knowledge and practices of traditional medicine in Ethiopia with an accentuation to rural women and their usage of reproductive health care services. The study is conducted in rural area

because, as WHO (2001) and Fekadu (2007) depicted, those who use traditional medicine in Ethiopia encompass the greater part of rural population and those people in urban areas who have little or no access to modern health care. It is known that about eighty five percent of Ethiopians live in rural areas. And that most of those people who depend on traditional medicine live in rural areas. This study, clear of doubt, contributes to expanding our knowledge of beliefs and practices of traditional medicine in rural areas of Ethiopia.

Most of the available studies on Ethiopian traditional medicine (Alemayehu, 1984; Assefa, 1992; Fekadu, 2007; Teshome, 2005) approach the issue broadly. They try to touch on the whole types of problems treated by traditional medicine meanwhile missing insight of the issues. The topic 'traditional medicine' is extensively large and vague to be studied entirely by a single research. This study, resultantly, has focused on providing a deep insight into a specific part of traditional medicine. The main quest of this study is to deeply investigate the beliefs and practices of traditional medicine for child delivery, prenatal and postnatal care, abortion, birth spacing and treatment of STDs.

While this study generally contributes to widening the horizon of our knowledge about the beliefs and practices of traditional medicine, it specifically contributes to widening our knowledge of its beliefs and practices among

women in rural areas regarding the reproductive health care issues (delivery care, prenatal and postnatal care, abortion services, birth spacing, and STDs).

1.3 Scope of the Study

According to WHO (2001: 1-2) traditional medicine:

> "*Includes diversity of health practices, approaches, knowledge, and beliefs incorporating plant, animal, and/or mineral-based medicines; spiritual therapies; manual techniques; and exercises, applied singly or in combination to maintain well-being, as well as to treat, diagnose, or prevent illness.*"

As the definition shows, traditional medicine is a vague concept; and is practiced for variety of health problems. From this vague scope of the medicine, this study focuses on its application for reproductive health issues. Reproductive health, in turn, encompasses a variety of issues. The key issues it involves are:

- Strengthening of safe motherhood (Maternal and Child Health) and reduction of maternal mortality
- Prevention and appropriate treatment of sub-fertility and infertility
- Skilled attendance at delivery, management of abortion complications, and reduction of morbidity and death from unsafe abortion
- Antenatal, postnatal and post-abortion care
- Provision of periodic gynecological checkup and care

- Prevention and treatment of gynecological and sexually transmitted infections/diseases, including HIV/AIDS
- Adolescent reproductive health services
- Family planning (birth spacing) services
- Provision of reproductive health services for older women (post-menopause)
- Diagnosis and treatment of breast and cervical cancer
- Reproductive Health Information Education and Communication for Behavior Change

(Bogue, 2004: 150; Reerink and Campbell, 2004: 14; MOH of the FDRE family health department, 2004: 3).

Beliefs and practices of traditional medicine for prenatal care, delivery care, postnatal care, birth spacing, abortion, and treatment of STDs are within the scope of this study from the above mentioned issues that are under the territory of reproductive health.

1.4 Objectives of the Study

1.4.1 General Objective

The general objective of this study is to examine the beliefs and practices of traditional medicine among women in reproductive health care.

1.4.2 Specific Objectives

- To investigate how traditional medicine is practiced for the reproductive health related issues (*prenatal and postnatal care, abortion, child delivery, treatment of STDs, and birth spacing service*); and the role and expertise of traditional medicine practitioners in dealing with the issues.
- To identify the fields/areas of specialization of traditional medicine practitioners in relation to treating women's reproductive health related issues.
- To scrutinize the source of knowledge of the practitioners from the clients' and practitioners' points of views.
- To examine women's beliefs in practicing traditional medicine and about the practitioners who treat the reproductive health related issues.

1.5 Research Questions

This study has answered the following guiding research questions:

- What are the fields/ areas of expertise of traditional medicine practitioners who address reproductive health problems?
- What are the types of services that women in reproductive age get from traditional medicine practitioners in relation to the reproductive health issues; which of them are significant; and how do the practitioners deliver the services to their clients?

- What are the sources of indigenous knowledge of traditional medicine practitioners who treat reproductive health related problems?
- What are the beliefs that are associated with the practice of traditional medicine for reproductive health related issues and its practitioners?
- What is the place that traditional medicine and its practitioners hold in relation to the treatment of reproductive health problems?

1.6 Ethical Considerations

All of the participants of this study were informed about the purpose of the study. Informed verbal consent was obtained from all respondents before the interviews and discussions. The participants were assured that the information they give would be kept confidential. Pseudo names are used to keep the confidentiality. The participants were also assured that their participation was voluntary; and they were free to withhold their consent and quit the interview anytime. The researcher recorded all the interviews and discussions with prior consent of the respondents.

1.7 Definition of Important Concepts

- ***Home remedy*** – *includes the therapeutic options that people utilize without consulting either folk healers or medical practitioners* (Helman, 1984:43).

- ***Prenatal care*** *–a health care that pregnant women gate.*

- ***Postnatal care*** *– a health care that women gate in few months after delivery.*

Chapter Two: Literature Review

This section presents relevant literature on beliefs and practices of traditional medicine, and its place in reproductive health care. The section is divided into four sub-sections: beliefs and practices of traditional medicine in Ethiopia, traditional medicine and reproductive health care in Ethiopia, summary of the literature and theoretical framework.

2.1 Beliefs and Practices of Traditional Medicine in Ethiopia

While dealing with their health problems, people around the world depend on two types of medicines, namely traditional and modern medicines. The importance of each of these two types of medicines and the surrounding beliefs varies from country to country. As different studies and reports (Fekadu, 2007; Pankhurst, 1965; MOH of the FDRE family health department, 2004; WHO, 2001) have depicted, traditional medicine is vitally important in Ethiopia since the overwhelming majority of the population practices the medicine for prevention, diagnosis and cure of diseases.

In Ethiopia, traditional medicine remains the medicine of choice while dealing with health problems because of several factors. According to Assefa (1992) one of the factors that make most Ethiopians practice traditional medicine is the inadequacy and 'incompetence' of modern medicine. He claims that most psycho-social illnesses in Ethiopia could not be treated by the modern medicine. Some illnesses, such as mental illness, are perceived to be caused by

supernatural forces, and, as a result, it is thought they should be treated by traditional specialists of the problems. The other factors that make most Ethiopians practice traditional medicine, according to Fekadu (2007) and Kebede et al. (2006), are cultural acceptability of traditional healers and local pharmacopoeias, lack of access to modern health facilities, and the low cost of traditional medicine and services. But the last one may not be always true. Sometimes practicing traditional medicine might be much costly. For instance, clients of traditional practitioners, such as spiritual healers, might be ordered to slaughter animals in the treatment process. In such kind of cases traditional medicine incurs much cost than that of the modern one.

An understanding of the alleged or real source of knowledge of the traditional practitioners is among the important issue in the understanding of beliefs and practices of traditional medicine. According to WHO (1990) (cited in Kebede et al., 2006) in Ethiopia, it is widely believed that the knowledge and skill of the practitioners of traditional medicine is given by God. This belief could be one of the reasons for cultural acceptability of traditional practitioners in Ethiopia (which is mentioned in the above paragraph as one of the factors that make most Ethiopians practice traditional medicine). Mostly the knowledge of traditional medicines, according to WHO, is passed from generation to generation orally, usually from father to a favorite child.

Understanding of the conceptualization of health and illness is also essential in the understanding of traditional medicine in Ethiopia. According to Kloos and Kaba (2006: 290) health is conceptualized as "*a state of equilibrium among the social, spiritual, behavioral and physical forces surrounding man.*" Assefa (1992) and Kloos and Kaba (2006) depicted that the nature and psycho-social contexts of illnesses are varied in Ethiopia, like in other countries. The way people perceive these illnesses and diseases, and their causes determines the type of treatment they seek. The perception may hinder the acceptance of modern medicine, which might be thought as incompetent to treat or incompatible with traditional illnesses. Since the definition of health in Ethiopia involves peaceful relations with supernatural world as prerequisites for well-health, people tend to look for the intervention of traditional medicine practitioners, even when modern medical services are available.

Different studies (Alemayehu, 1984; Belachew, 2008; Kloos and Kaba, 2006; Pankhurst, 1965; WHO, 2001) show that there are two major types of traditional medicine practices in Ethiopia; namely secular or empirical healing and magico-religious healing practices. The two groups of practice encompass spiritual healing, traditional midwifery, inoculation, massage, hydrotherapy and thermal water, bleeding and cupping, counter-irritation, surgery, dentistry, and bone-setting. Various types of medicines from plants, animals, and mineral substances are utilized while practicing the traditional medicine in Ethiopia. The Ethiopian traditional medicine is utilized to cure many diseases

(such as diabetes, asthma, kidney disease, fever, fungal infections, and mental illness) that are known in the country. Indeed one can say that almost every disease in Ethiopia has, at least, one traditional remedy.

2.2 Traditional Medicine and Reproductive Health Care in Ethiopia

Traditional medicine practitioners are increasingly involved in providing reproductive health services (Okonofua, 2002). Women consult the practitioners of traditional medicine for different types of problems related to reproductive health. As Jemal et al. (2010) indicated, women feel free to tell all their secrets to those practitioners such as traditional midwives. The below quoted paragraph best illustrates that the women consult the traditional medicine practitioners and might get remedies even for those problems that the modern medicine failed to treat.

> *"...I was sick. I stayed in bed for about a week, but the problem got worse. I went to the médecin* [doctor] *here. The problem was with my mes régles* [my period]. *My bleeding continued for 14 days before I went to Mopti to see a gyne-cologist. I got another prescription, but it didn't help me. I was fearful about mes régles lasting so long. I told my whole family, even my fiancé. It was my family that had suggested I go to Mopti. I talked about my problem with everyone, but especially with my mother. She was worried also. Then my brother recommended that I see a guerisseuse [an indigenous healer] who lived in a village about 18 kilometers from here. ...Then she gave me some medicine that she had prepared*

from leaves and roots. I used the herbs to make a tea. I drank it and was better in three days" (Slobin, 1998: 373).

In Ethiopia, traditional medicine practitioners have significant role in the provision of reproductive health care services for women. Several studies (Assefa, 1992; Jemal et al., 2010; Kebede et al., 2006) have illustrated this. According to the studies the services that are provided by the traditional practitioners include delivery and abortion services, prenatal care for pregnant women, postnatal care for mothers after delivery, child care for new born babies, provision of birth spacing medicines, and treatment of STDs. It is said that the traditional medicine practitioners assert even to help infertile women bear children.

The prenatal services that the traditional medicine practitioners provide pregnant women with, according to the studies (mentioned in the above paragraph), include checkups and advices for women during their pregnancy. Problems during pregnancy, such as "faulty position" of the fetus are treated by the midwives. Regarding delivery care, traditional midwives are the most important service providers for the largest part of Ethiopian women. As Kebede et al. (2006: 127) affirmed, in the year 2000 only 9.45% of all deliveries in Ethiopia were attended by trained attendants and health workers. The remaining 90.55% were attended by traditional birth attendants or relatives. Population Institute (2009) stated that, in Ethiopia, the percent of deliveries attended by skilled health personnel went down to 6% in the year 2008. This

shows that the number of child delivery with the help of traditional midwives is still increasing in Ethiopia, despite the fact that there is relatively better supply of modern health care services in the country. Assefa's (1992) statement further supports this argument. According to him the delivery of a baby is "almost unthinkable" in Ethiopia without the assistance of the traditional midwives.

Abortion is among the services of the traditional medicine practitioners for women. According to Assefa (1992) abortion is mostly carried out by traditional midwives in Ethiopia. Most of the time abortion is done secretly. And most women go to traditional practitioners to get the service secretly. The traditional practitioners also treat STDs, which are mostly associated with supernatural forces. People consider the disease as punishment for their sins. Hence, they go to spiritual healers, who are thought to be mediators.

2.3 Summary of the Literature: Evaluative Remarks

Previous works on traditional medicine have attempted to disclose significant information on beliefs and practices of the medicine. To mention the most important ones:

- Assefa (1992) has studied the history and nature of traditional medicine in Wallo, Ethiopia. His study, which employed document analysis method, gives detailed information on the beliefs and practices of traditional medicine. The findings of the study show that the longstanding practices of traditional

medicine are retained in the area because of the belief that the medicines are crucial heritages for survival and adaptation of the environment. The study has revealed that psycho-social problems are diverse in their nature; and that modern medicine is inadequate and 'incompetent' to treat all the problems.

➢ A "Comparative Study of Traditional and Modern Medical Practices among Woliso Oromo of Eastern Macha" is conducted by Teshome in the year 2005. The study has touched issues such as people's beliefs about causes of diseases and illnesses, and its impact on individuals preferences of medical practices; and the place of both modern and traditional medicine in the area. The study has depicted that the studied people give both natural and supernatural explanations of the causes of disease and illnesses. And this explanation has impact on the individuals' preference of medical practices. The study has found out that both traditional and modern medicines are practiced by the people based on their knowledge and beliefs regarding each system.

➢ Anderson (2007) has conducted a study on beliefs and practices of traditional medicine in Ethiopian Orthodox religion. The study was conducted in and around Lalibela town, Ethiopia. Spiritual healing was the subject that is given special attention by the study. The study has revealed that different types of spiritual healing are practiced in Ethiopian Orthodox Church. The beliefs that support spiritual healing are based on the Bible and other religious texts of the church.

While these works are appreciable in their attempt to study the beliefs and practices of traditional medicine in Ethiopia, the first two are broader in their approach. They tried to study beliefs and practices of the whole practice of traditional medicine. As compared to the first two, the third one is specific in its approach. But none of them gave attention to reproductive health care. Hence, this study fills the gap.

2.4 Theoretical Framework

Different researchers have developed numerous theoretical frameworks or approaches to study health and illness, and medical beliefs and practices. These include critical interpretive, functional, continuum based analysis, configurationist, etc approaches. These approaches are developed around the conception of health and illness, causes of diseases, knowledge of medicine, the place of medicine in the life of a group of people, beliefs that guide the practice of the medicine, etc.

From these various approaches, this study has accentuated on Configurationist and functional approaches that are discussed here based on Teshome's (2005) work. The first approach (Configurationist approach) is developed by Ruth Benedict. The approach emphasizes that the place of medicine in the life of a given group of people/society, the way in which the medicine emerges with other cultural elements, and the spirit which guides the practice of the medicine are vital issues in the study of medicine. Different

societies give different places to medical practices. In most African societies, for example, traditional medical practice holds crucial place. In most societies of developed countries, on the other hand, the place of the medicine is not as such crucial. The Understanding of this place of medicine in a given society is one of the elements that are given importance in configurationist approach (in the study of medicine). The way in which the medicine emerges with other cultural elements and the spirit which guides the practice of the medicine are also given importance in the approach. The practice of medicine is accompanied by beliefs about the medicine; which in turn guide the practice of the medicine. These are the vital issues to which configurationist approach, which gives particular attention to the importance of a medical practice to members of a given society, gives special importance in the study of medicine.

The other approach is known as functional approach. The approach is developed by Ackerknecht. It is known that one of the major assumptions of functionalist theory is the consideration of society as a whole with interrelated parts. As such the functionalist approach to the study of medicine considers society as encompassing interrelated and interdependent parts. The approach exemplifies this interdependence by indicating the relationship between disease, its causes and the characteristics of healers. The approach emphasizes that these three aspects (disease, its cause and the characteristics of healers) are interdependent. For example, if a health problem (disease) is thought to be the result of anger of supernatural force (cause), the patient is

most likely to seek the intervention of a healer who is thought to receive the knowledge from supernatural force (characteristics of healers).

This study has employed configurationist and functional approaches with modifications. Two of the three important aspects of configurationist approach (the place of medicine in the life of a given group of people and the spirit which guides the practice of the medicine); and the functional approach's assumption of disease, its causes and the characteristics of healers as interdependent are integrated in the study. The two models are selected because of their handiness for the achievement of the objects of this study.

Chapter Three: Research Methods, Materials and Procedures

3.1 Introduction

This part includes description of the study area, study design, study subjects, method of data collection and sampling method, data collection tool and analysis plan; and the justifications for choosing them.

3.2 Study Area

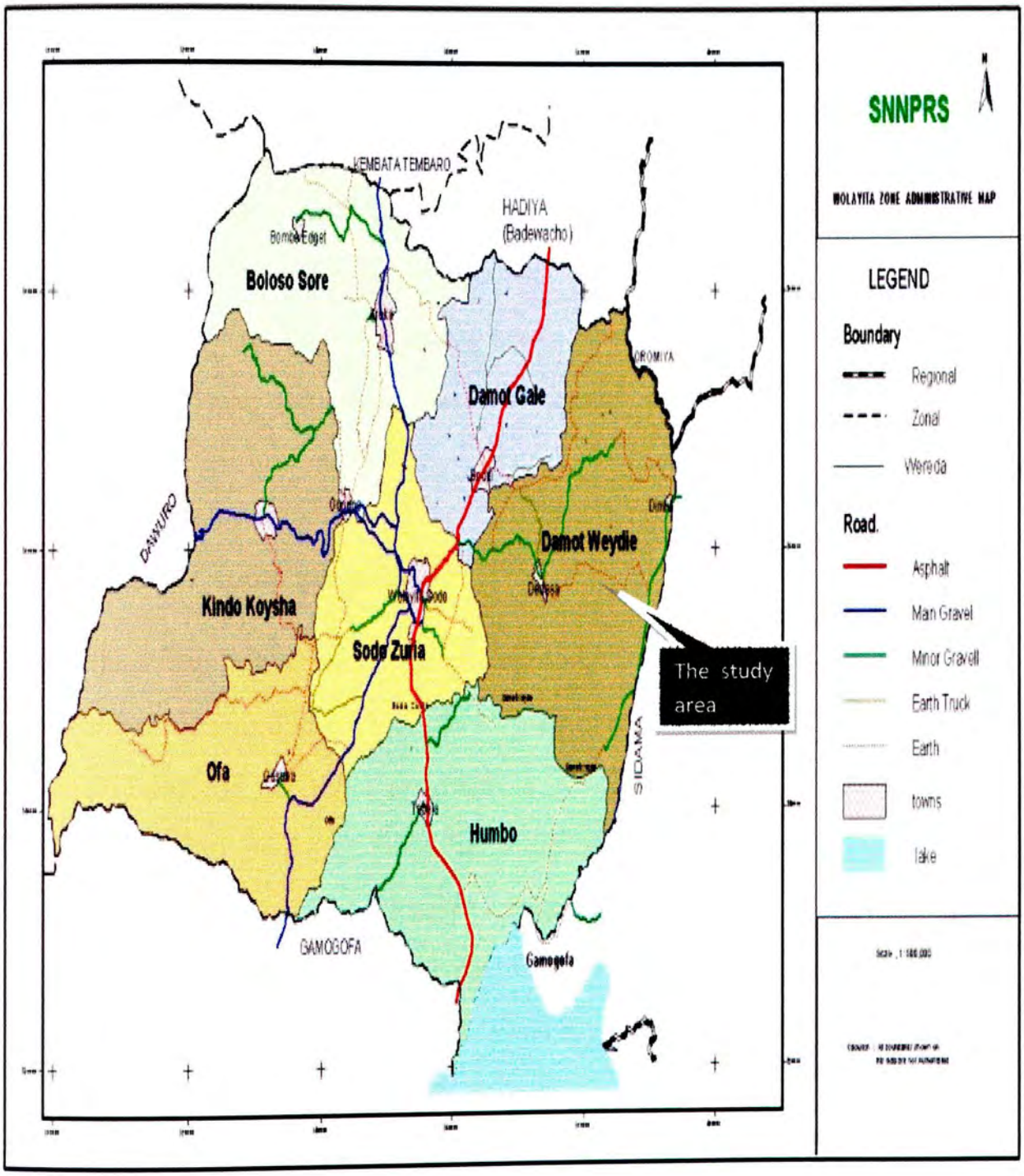
This study has been conducted in Damot Woyde *woreda*, Wolaytta, which is one of those parts of Ethiopia with their own culture. Wolaytta zone is located in Southern Nations Nationalities and Peoples Republic, Ethiopia; at 323 km distance from Addis Ababa. It is located between 6°51" and 7°35" North Longitude; and 37°46" and 38°1" East Latitude. According to the most recent (2008) census report of CSA, 1,527,908 (752,668 male and 775,240 female) population lives in Wolaytta zone. From this total number 179,047 and 1,348,861 live in urban and rural areas, respectively. The zone covers a total area of 4,471.4 km^2. The average population density of the zone is more than 385 people/square kilo meter, which makes it one of the most densely populated areas in Ethiopia. Agriculture and livestock rearing are the major economic activities in the zone. The area is rich with the practices of the traditional medicine and there are notable practitioners of traditional medicine, such as *'Yebuchamo enat,'* (who was among the famous healers in Ethiopia (Assefa, 1992: 128)) in the area. According to Wolaytta *zone* health boureau,

the total number of women who have utilized some type of reproductive health service in the *zone* is 174, 735. Although the magnitude of reproductive health problems is wide in the *zone,* its actual size is not supported by studies, according to the boureu.

Damot Woyde *woreda* is one of 13 *woredas* in Wolaytta zone. A total of 96,299 population lives in the *woreda.* Out of this total number 5,301 live in urban areas and 90,998 live in rural areas. Damot Woyde *woreda* consists of 22 *kebeles.* There are health extension offices in each *kebele.* And there are four health centers in the *woreda.* The health coverage of the woreda is one health center for 25,000 people. According to Wolaytta *zone* health boureau, the total number of women who have utilized some type of reproductive health service in the *woreda* is 43, 317[1].

[1] There could be counting duplication because of documentation problem. A woman who receives the services/different services at different times could be counted more than once.

Administrative Map of Wolaytta Zone/Study Area



3.3 Study Design

The study is a cross-sectional qualitative study which aims at describing the beliefs and practices of traditional medicine among women with an emphasis on child delivery services, prenatal and postnatal care, abortion services, birth spacing and treatment of STDs. The reason why this study is cross-sectional is that its major objective is studying the current beliefs and practices; than its change over time. The study's objectives incorporate examining the respondents' beliefs and their subjective experiences of traditional medicine. This dictates employing qualitative research method, and the study complied with it.

3.4 Selection of Study Subjects

The study has been undertaken by employing purposive sampling method. Married women in reproductive age (18-45), who have at least one child, and who have utilized the service(s) provided by the practitioners of traditional medicine for, at least, one of the following issues: prenatal care, postnatal care, abortion, child delivery, birth spacing, treatment of STDs; unmarried women in reproductive age; and the individual traditional medicine practitioners who help women with the reproductive health issues, are selected with the help of health extension workers[2] of the area.

[2] Health extension workers are those workers that are employed by the government to teach rural people about health related issues and to help them bring behavioral change. They are expected to visit each household to teach and monitor them in relation to the 16 packages. (Reproductive health package is one of the 16 packages). The

The married women are selected from six *kebeles* in Damot Woyde *woreda* (Mayo Ofore, Tora Sadebo, Tora Wolisho, Kindo Koyo, Ambe Badessa, and villages around Badessa). The researcher met the in-depth interview respondents by going into their homes with or by the help of the health extension workers. Participants of the FGDs are also selected with the help of the health extension workers. The health extension workers met the participants of FGDs in advance and made appointments with them. The researcher met the participants of the FGDs in *kebeles*. A total of thirty-four married women have participated in the study.

The unmarried women are studied because they use some of the reproductive health services (abortion and treatment of STDs, for instance) provided by traditional medicine practitioners. Besides, they could go to the practitioners in need of other reproductive health services (such as prenatal care) if they conceive before getting married or illegitimately. The unmarried women who have not utilized traditional medicine for the reproductive health are also included in the study to scrutinize their beliefs about traditional medicine with regard to reproductive health issues. The unmarried respondents are selected from those youth who came to *kebeles* to attend panel discussions and awareness creation sessions that are organized by the health extension workers of the respective *kebeles;* and from households at hand. Thirty unmarried women from the six *kebeles* are included in the study.

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health extension workers cooperate with traditional medicine practitioners for provision of child delivery and related services – if needed. There are two health extension workers in each *kebele*.

The traditional medicine practitioners who deal with the reproductive health issues are also selected with the help of health extension workers. Sixteen practitioners from the six *kebeles* are studied. All of the above respondents are selected from the six *kebeles* of Damot Woyde *woreda*. The *kebeles* are selected based on the information gained from Badessa health center that the traditional medicine practitioners of the areas are registered and could be found with the help of the health extension workers of the areas. (In most other areas the practitioners are not registered).

3.5 Methods of Data Collection

Data from both primary and secondary sources are used in this study.

3.5.1 Primary Data[3]

The primary data are generated by employing in-depth interviews, FGDs and key informant interviews.

3.5.1.1 In-depth interviews

Primary data are collected by using in-depth interviews from the practitioners of traditional medicine, from unmarried women in reproductive age (18-45), and from married women in reproductive age. The traditional medicine practitioners that are included in the interviews are those who help women during child delivery and abortion; treat them for STDs; and provide birth spacing, prenatal and postnatal care services for women in reproductive age.

[3] The primary data are collected from December 15-January 7.

This has helped to scrutinize the traditional medicine practitioners' indigenous knowledge and expertise of treating women for the reproductive health related problems and the source of their knowledge. It has also helped to investigate how the medicine is practiced for the reproductive health issues, how the services are delivered to the clients, and to explore the sources of knowledge of the practitioners from their own point of view.

In-depth interviews are also conducted with those unmarried women in reproductive age. Both those who have utilized some type of service(s) provided by the traditional medicine practitioners (for the above mentioned reproductive health issues) and those who have never utilized any of the services, are interviewed. Interviews with the former ones helped to examine their experiences of utilizing traditional medicine for the reproductive health issues, specifically those which married women do not desperately need, such as abortion; whereas interviews with both the former and the later ones helped to examine their beliefs about traditional medicine and its practitioners.

Married women in reproductive age who have at least one child are also included in the interviews. These interviews helped to examine how they practice the medicine; to scrutinize their beliefs about traditional medicine and its practitioners; and to study their experiences of utilizing traditional medicine for the reproductive health care issues, specifically for those which they experienced as pregnant women, after delivery, and during delivery - as the delivery related issues are mostly experienced by the married women and

because the issues are legitimate to the married women; and to examine the place of traditional medicine in dealing with the reproductive health issues.

Sixteen in-depth interviews with the practitioners of traditional medicine (see annex one), twenty-two and sixteen in-depth interviews with married and unmarried women in reproductive age, respectively, have been conducted. The number of interviewees is not predetermined; rather the researcher continued the interview until the collected information has reached saturation to answer the research questions. Each interview took twenty-five minutes - an hour. The interviews are conducted in the respondents' home, around their home (mostly under trees), and in *kebeles*.

3.5.1.2 Focus Group Discussions

Since FGD provides immensely rich qualitative data that is difficult to be obtained by employing other methods, this study has used the method to gain more insights about the beliefs concerning the usage of traditional medicine for the reproductive health issues by emphasizing on abortion, child delivery and STDs. The FGDs also helped to check and verify the information gained by the in-depth interviews. The participants of the FGDs are selected from both married and unmarried women in reproductive age. Four FGDs have been conducted in Ambe Badessa and Mayo Ofore *kebeles*.

Two FGDs were conducted with unmarried women in reproductive age and two with married women in reproductive age who have at least one child. Two of

the FGDs consisted of seven (unmarried) participants and two consisted of six (married) participants. The number of the FGDs, just like the in-depth interviews, is not predetermined. But the information collected from the discussions reconfirmed each other, and that of the in-depth interviews; and the discussions ended there. The health extension workers of each *kebeles* helped the researcher select and meet the FGD participants. Appointments were made with the participants of the FGDs in advance. The facilitator kept the appointment and conducted the FGDs in the *kebele* rooms. The FGDs were facilitated by the researcher. Each of the FGDs took an hour – an hour and half. During the discussions the participants were provided with soft drinks and cookies.

3.5.1.3 Key Informant Interviews

Key informant interviews have been conducted with five health extension workers (one from each studied *kebele,* except villages around Badessa), a (modern) midwife in Badessa heath center, two senior citizens who are knowledgeable about the practice of traditional medicine in the area. The interviews have provided valuable supplement to the data collected by employing the above methods.

3.5.2 Secondary Data

The secondary data have been collected from books, online and printed journals, reports of different organizations, thesis papers, and different web pages.

3.6 Data Collection Tool

Interview guide is used for the in-depth interviews and FGD guide is used for the FGDs (See appendix A). The interviews are conducted in the local language-Wolaytigna; and are tape-recorded with the interviewees consent. Field notes are also taken during the interview.

3.7 Data Analysis

The data that are collected in Wolaytigna, by using tape-recorder and field note, are translated into English; and are categorized. Then the data are analyzed by careful interpretation of meanings. And, finally, the results of the study are verified.

3.8 Field Experience

The researcher initially met Health and Health Related Service Quality Control Core Process Boureau[4] workers in Wolytta Soddo town. The workers gave the researcher important information about traditional medicine in the area and

[4] The issue of traditional medicine concerns the bureau.

helped him meet a public health officer in Badessa town (Damot Woyde *woreda*), who in turn helped the researcher contact the key informants and gave important information about the study area. The researcher went to the studied *Kebeles* by motor bike and met the health extension workers first. Then, with their help he contacted the respondents.

The researcher went to most respondents' home with health extension workers. The health extension workers helped in meeting the respondents. But they were not present during the interviews. The researcher went to some respondents' home with someone from the respondents' locality (whom the respondents know) - by meeting the individuals through the health extension workers. These individuals were made aware of the purpose of the study before meeting the respondents. They, in turn, informed the respondents why the researcher is there. Then, they are made to leave the researcher and the respondent alone. Before the interviews the researcher talked to the respondents about different issues (about the weather, environment, etc) to maintain informal relation. Besides, he made plain the purpose of the interview in the local language, i.e. Wolaytigna. (The researcher speaks the local language). The respondents are assured that all the information they give would be used only for the research purpose; and would be kept confidential. These helped the researcher earn the respondents trust.

The researcher did not face much problem with winning the respondents' trust. But there were some situations that required the researcher's patience. For

example, while the researcher went to a practitioner's home to conduct interview, the practitioner let him sit in a room and left him alone in the room. Then she returned after about fifteen minutes and asked what specific things he wants to know. After listening that she left the room again for about twenty minutes. (The researcher heard the practitioner ordering her children to wash clothes and do household chores outside the room that time). Finally she returned and asked the researcher once again what he wants to hear from her. And she gave the interview.

Chapter Four: Findings

4.1 Beliefs about Practicing Traditional Medicine and about the Practitioners Who Treat the Reproductive Health Related Issues

According to Assefa (1992) one of the factors that make most Ethiopians practice traditional medicine is the belief that modern medicine is inadequate and incompetent in dealing with most psycho-social problems. In other words, there is a belief that traditional medicine is adequate and competent in dealing with most psycho-social problems which the modern one is not. However, this study has found out that there is no such kind of belief regarding the practice of traditional medicine for reproductive health problems (except for *Wulawushshiyaa* that the modern medicine could not treat; see subsection 4.1.6.1). As Assefa (1992) stated further, some illnesses, mental illness for instance, are perceived to be caused by supernatural forces, and, as a result, it is thought they should be treated by traditional specialists of the problems. But, as far as the treatment of the reproductive health problems covered in this study is concerned, none of the reproductive health problems is associated to the belief (that the problem is caused by supernatural forces, and should be treated by traditional specialists of the problem as a result).

Fekadu (2007) and Kebede et al. (2006) have put that cultural acceptability of traditional healers and local pharmacopoeias are among the major factors that make most Ethiopians practice traditional medicine. People practice traditional medicine because it has stood the taste of time, and has "won over" the trust of

the rural people. This manifests itself by the belief people have about the practice and the practitioners of traditional medicine. The belief holds firm in the practice of traditional medicine for reproductive health issues. In other words, "Old is best!" principle works in the areas regarding the practice of traditional medicine for reproductive health problems and its practitioners as the following quote from key-informant interview [with a man of 65] clearly illustrates:

> *"Our mothers, our grandmothers, and our great grandmothers had delivered safely with the help of 'maaretissiya asaa' [TBAs]. Our wives have also delivered with their help. And our daughters have also been delivering with their help now."*

When (the in-depth interview respondent and FGD participant) women of the rural areas were asked to forward their opinion about/their view of modern medicine, none of them responded negatively; neither did the practitioners. The women take the view that modern medicine could deal successfully with various health problems, including reproductive health problems (except *wulawushshiyaa*). But, at the same time, they don't underestimate traditional medicine and its practitioners because of their firm belief in the success of the medicine and its practitioners. When the women were asked "Where should a woman immediately go when s/he faces problem(s)/issue(s) related to reproductive health?" the women indicated that, especially during labour/delivery, there is no need to go to health centers while the practitioners

who have a way with the problems are at hand. It is worth quoting here what a health extension worker (who is one of the key informants) said:

> "... *We are responsible for helping women during delivery. We are ready to go to their homes to provide delivery care whenever they call us. But the reality is that they call the TBAs; and report us after delivery. They know that we are responsible for giving delivery care for free. They, however, prefer to get the service from TBAs. ... The TBAs have reduced our work load.*"

The rural women have depicted that people come even from urban areas to get treatment/help from the practitioners. The typical situations that get mention here are *wulawushshiyaa* and a fetus that stayed in the mother's womb for long time. In view of this, they signify that traditional medicine could be a last resort for some reproductive health problems.

Women of the rural areas put that traditional medicine is so decisive in dealing with reproductive health problems. They have every trust in the expertise of the practitioners. The women are of opinion that "*the practitioners have a magic touch*," "*have 'good hands'*," and "*go out of their way to help*" them while dealing with the problems. And, as a woman spoke during an FGD "*So far, so good the practitioners of traditional medicine have succeeded in dealing with reproductive health problems and they will go far*" [A 42 year old woman, FGD participant].

4.2 The Practice of Traditional Medicine for Reproductive Health Issues

The practitioners of traditional medicine are increasingly involved in the provision of reproductive health services (Okonofua, 2002). Women consult the practitioners for different types of problems related to reproductive health. It is also mentioned that the practitioners play significant role in the provision of prenatal care, child delivery service, diagnosis and treatment of STDs, and performing abortion; and, although their roles are not much significant, are involved in postnatal care and provision of birth spacing service. The reproductive health care services that women in reproductive age receive from the traditional medicine practitioners, the ways in which they are practiced, the roles that traditional medicine practitioners play in provision of the services and their expertise on the issues are discussed in this subsection.

4.2.1 Prenatal Care

Prenatal care is one of the services traditional medicine practitioners provide women in relation to reproductive health. Previous studies on traditional medicine (Assefa, 1992; Jemal et al., 2010; Kebede et al., 2006) have stated in general terms that the prenatal care services that the traditional medicine practitioners provide pregnant women with include physical checkups and advices during their pregnancy. The studies have depicted that problems during pregnancy, such as tilted position of a fetus, are treated by traditional medicine practitioners. The present study has confirmed that these are among the prenatal care services that the traditional medicine practitioners provide.

But since the previous studies deal with the issue vaguely, this study moves on to thorough examination of the issue.

The prenatal care services that the traditional medicine practitioners provide pregnant women with could be generally classified in to three: diagnosis, treatment and advice. But, it should be made plain here that the services are not mutually exclusive.

4.2.1.1 Diagnosis

The traditional medicine practitioners, particularly Traditional Birth Attendants (TBAs) claim that, based on examination (which is made upon the clients' complaints), they could diagnose every problem during pregnancy[5] and could identify its cause/s based on the symptoms the clients tell and by palpating their body. When pregnant women come to TBAs in need of their service, the first thing the TBAs do is examination of the symptoms. They ask their clients what the symptoms are that made them need the service. And, in addition to what the clients say, the practitioners ask whether they have certain symptoms. The practitioners say that the clients seek their services for prenatal care when they experience the following symptoms (which are discussed in-detail below): when the fetus stops movement inside the mother's womb, when the mother feels tired without so much as little work, when the mother could hardly breathe, when the mother experiences apparent lack of

[5] The practitioners of traditional medicine confirm that the woman is pregnant by asking the time when her period stoped. The practitioners maintained that up to the third month of pregnancy, when the fetus mostly begins to move, pregnancy is confirmed based on what the woman says.

comfort, and when haemorrhage[6] takes place during pregnancy. (These are also the symptoms that the clients of traditional medicine practitioners pointed out as the reasons for seeking prenatal care).

After identification of the symptoms based on what the clients say and based on further questions they forward, the practitioners continue to give examination by palpating the body of the clients. The practitioners denoted that most women come to them in need of prenatal care when they experience the first three symptoms (when the fetus stops movement inside the mother's womb, when the mother feels tired without so much as little work, and when the mother could hardly breathe), which are mostly considered as the symptoms of "*desha*" (tilted position of the fetus). The practitioners depicted that women with these symptoms require further examination. So the examination continues by palpating the woman's body, especially their belly. The following quotes from in-depth interviews with the practitioners of traditional medicine depict how they conduct the examination.

Turunge Dana, a traditional medicine practitioner said:

> "*If the symptoms that "shahariya" [a pregnant woman] complains of show that the fetus has stopped its movement, I ask the woman to lie back and with these fingers* [middle and index] *I check the position of the fetus by palpating the mother's belly.*"

And another traditional medicine practitioner (Gom'ame Tura) stated:

[6] Blood that flows out of a woman's uterus

"When 'shahariya' feels tired without doing much work, when she could hardly breathe, and when she says that the fetus is not 'playing' [when it stops movement], *I let her lie on her left side....These are the symptoms of 'desha'."*

The practitioners conveyed that most of the time they diagnose "*desha*" while women complain of problems during their pregnancy. In other words, "desh*a*" is the most common problem among pregnant women who receive prenatal care service from the practitioners. The practitioners state that the pregnant mother's carelessness lies at the roof of this problem. The problem mostly comes out of the mother's carelessness in her movement and when she sleeps. The following quotes put these in the practitioners' own words.

Gom'ame Tura, a traditional medicine practitioner articulated:

"'Desha' occurs when a mother fails to be careful about her body movements. A pregnant woman is like an egg. Hence, she should be so careful about each movement she makes – especially after she completes twelve weeks [three months] of her *pregnancy. She should also be careful while sleeping. A pregnant woman should not lie on her stomach. The woman should not also have heavy workload; and should keep away from engaging in activities that require much labor."*

Tabita Adelo, a traditional medicine practitioner also stated that:

"The problem of "desha" is caused when a mother falls down, when she does not sleep in an appropriate position, or when she bends down and makes careened movements [when she lunges]."

There is another problem during pregnancy whose symptoms are similar with "*desha.*" There is no single word that expresses the problem in the local language. Rather it is expressed as "*Na'aa gedee do'aan xaaxetiyoode/ qaaphetiyoode*" [when the legs of the fetus are tied by an umbilical cord]. The problem is distinguished from "*desha*" by palpating the mother's stomach. The sources of the problem are similar with that of "*desha.*"

The other problem during pregnancy that the practitioners diagnose is tiring of a fetus. This problem has symptoms that are somewhat similar with the symptoms of "*desha*" or symptoms that are seen when the legs of a fetus are tied by an umbilical cord. Just like the above two problems, this problem is further examined by palpating the mother's stomach. It is distinguished from "*desha*" by checking the position of the fetus. The practitioners conveyed that in the case of this problem the child tires while, unlike "*desha,*" holding its normal position.

The practitioners put that some of the sources of this problem are similar with that of "*desha.*" The sources, according to the practitioners, are carrying heavy objects and engaging in those activities that require much labor. The other cause is having sex very often. As a traditional medicine practitioner [Milkite Tunta, TBA and *Wogeeshshaa*] described during an in-depth interview: "*Going to bed very often with husband during pregnancy tires a baby. It could even make a woman go into labour ahead of time.*"

"*Gelaa*" [a problem that is thought to occur when a bone in ones side or cartilaginous bone around his/her heart[7] moves from its normal position] is also among the problems during pregnancy. Actually "*gelaa*" occurs not only to pregnant women, but also to everyone. As the practitioners signified, however, pregnant women are much susceptible to the problem. The problem mostly results when the pregnant women, just like in the above cases, engage in heavy works and "unnecessary" movements. The mother could hardly breathe while she experiences "*gelaa,*" as it causes sharp pain in a place where it occurred (usually in either of her sides or around her heart).

"*Maaxaniyan metoy de'iyoo shaharasa*" [pregnant women who have problem on their womb] are among those who visit the practitioners of traditional medicine for prenatal care. This problem, according to the practitioners, manifests itself in two ways. A traditional medicine practitioner [Yambule Mamo] explains the first way that: "*Maaxanee hargido maccasaiya*" [a woman whose womb is diseased] *may utter that she is feeling pain in her "xapho"* [vein] [inside her womb]. *This shows that the woman has "hargancha suuttaa"* [diseased blood]. According to the practitioners, blood continues to flow from a woman's womb during pregnancy if she has this problem. It is said that the problem could be aggravated if the woman has sex without her will. This problem is thought to proceed from shortage of "*protiiniyaa*" [protein]. One can notice this from the solution the practitioners provide women who have the problem with.

[7] The practitioners maintained that there is cartilaginous bone around one's heart (around the lower end of sternum/breastbone).

Yambule Mamo, a traditional medicine practitioner stated the solution to the problem (and risks of the problem) as follows:

> *"If a woman eats good foods like meat, cheese, egg, and pea she could get well and deliver a healthy baby. Otherwise, the baby could be weak and sickly, and have bony legs and arms after delivery. The baby could even die after delivery."*

The second way in which the problem of womb manifests itself is incapability a woman's womb to carry a fetus. The traditional medicine practitioners call this *thinness of womb*. They depicted that a woman who has this problem may experience pains of labour or may feel as if she is having pains of labour very early (before the completion of the normal months of pregnancy). If the problem is not dealt with earlier, according to the practitioners, it could result in premature birth. Further, the practitioners maintain that *thinness of womb* could even cause death of the baby *"although science says that the problem causes nothing of the sort!"* [Dalgite Dana, a traditional medicine practitioner]. *Thinness of womb*, according to the practitioners, has a source that is similar with the source of *"xapho"* problem. This source is shortage of protein; and could be best dealt with by eating *"good foods" (like meat, cheese, egg, and pea)*. The other source of this problem that the practitioners mention is having sex during late stages of pregnancy. A traditional medicine practitioner [Ufayse Lorato] articulates that:

> *"A woman's womb stretches during pregnancy, especially during the late stages of pregnancy. If a seven or an eight months 'shahariya,'*

lives [has sex] *with her husband in this tight and stretched womb, the baby could get squashed. Living with a husband during this period is not good particularly for women who have thin/delicate womb. These women could experience premature labour or birth. Sometimes the baby may die in its mother's womb because of this problem. So, a heavily pregnant woman - particularly the one who has thin womb - should not live with her husband until delivery."*

The worst of all problems during pregnancy, as the practitioners affirmed, is when a mother loses a baby. This could occur because of different reasons (like accident, etc). As it is illustrated in the above quote, *thinness of womb* is a good example of this. The fetus could be hurt in different situations (when the mother falls down, for instance) and die. (*The way of dealing with death of a fetus is discussed below under subtopic "Abortion"*).

Sometimes, according to the practitioners of traditional medicine, pregnant women complain of some symptoms without having any of the above problems. The complaints of these women are similar with those who experience "*desha.*" After listening the complaints, the practitioners give the women physical examination. If the practitioners do not diagnose any problem, they tell the women that they "will be all right soon" and that the symptoms do not put them in danger. The practitioners affirmed that the "*bakkar*" [the first-ever pregnants] are likely to complain in such situations (without any real problem).

The above are the symptoms of problems during pregnancy, their causes and the ways in which the traditional medicine practitioners diagnose them. After

diagnosis, the practitioners treat some of the problems which are under the areas of their expertise. And, as they indicated, some of the problems require technical advice only. Discussion of the treatments that follow the diagnosis takes place in the following subsection.

4.2.1.2 Treatment

Treatment of problems during pregnancy is among the services traditional medicine practitioners deliver. As it is stated in some of the previous studies on traditional medicine (Assefa, 1992; Jemal et al., 2010; Kebede et al., 2006), the practitioners treat certain problems that pregnant women face. Correcting tilted position of a fetus is given as an example of the treatments. This study has affirmed that this is one of the problems for which the practitioners provide solutions. This study has also found out that there are other types of problems during pregnancy that the traditional medicine practitioners treat. Let us move to the discussion of the types of problems- including tilted position of a fetus-, and the ways in which they are treated.

As the previous studies touched on, the practitioners of traditional medicine correct tilted position of a fetus. The (practitioner) subjects of this study, who are engaged in correcting tilted position of a fetus, have stated that when a woman is diagnosed with the problem, they move towards treatment. The treatment is carried out by hand. The practitioners spoke of how they treat the problem and cares that should be taken during the treatment as follows.

Tabita Adelo, a traditional medicine practitioner spoke:

> *"After checking the position of the baby by my hand, I correct its position if it's not in its upright position. To correct the position I make the woman lie on this bed* [She pointed at a bed in the room, where the interview was conducted, which has a local mattress on it - called *"qancca firashiya*[8]*"*]*; then I manipulate her stomach and make the baby hold its normal position. The mother responds well to the treatment soon. Thanks to God I have never faced any problem while providing such kind of support for pregnant woman."*

In the same vein, Milkite Tunta, a traditional medicine practitioner maintained:

> *"To treat a woman experiencing "desha," I let her sleep on her back first. Then I massage her belly with butter; and gently manipulate it. This needs great care. The unskilled "abasha asay"* [traditional medicine practitioners] *could hurt both the mother and the baby while trying to give such kind of manipulation*[9]*. But, I do the manipulation with great care and correct the position of the baby. And the mother feels well soon after the manipulation. ...the butter is used to soften the woman's belly."*

While most practitioners agreed with doing the manipulation to correct tilted position of a fetus, a practitioner was opposed to doing the manipulation. She [Gom'ame Tura, a traditional medicine practitioner] emphasizes that:

[8] The mattress is made of a blade of dried grass. It is mostly used in the area because of its low cost.
[9] Pressing or moving part of a person's body for treatment by using hands.

"'Desha' could easily be corrected by letting the mother lie on her left side. I don't manipulate a woman's stomach! Manipulating a pregnant woman's stomach puts the baby and the mother in danger, see? Some 'abasha asay' do that; but that is unnecessary."

Despite the difference on the ways of treating, the practitioners are in agreement that they could deal with "*desha*" problem successfully. Few practitioners, however, make mention of some situations in which they refer the clients to (modern) health centers to get "*birtaatiyaa marppiyaa*" [an injection that helps them to be doing well after the treatment] and "*bitaaminiyaa*" [a pill containing vitamin], according to the practitioners. But a midwife in Badessa health center, who is one of the key informants of this study, depicted that no medicine of the sort is given to the women. She has put that women in such situation are given IV.

Treatment is also carried out when a fetus is tied by an umbilical cord. The same procedures - with those that are used for treating "*desha*" – are followed while dealing with this problem. As in the above case, a practitioner who opposes manipulating a pregnant woman's stomach still holds her position; whereas other practitioners maintain that the treatment takes place through manipulation.

"*Gelaa*" is treated just like other bone problems (like break or crack in bone). Bone-settling therapy is applied for bone problems, and "*gelaa*" is no exception. When problems occur on a person's bone, the traditional medicine

practitioners (particularly the "*Wogesha*" (bone-settlers)) treat it by giving them massage or by manipulation. It is common to use butter during this massage/manipulaation. "*Gelaa*" is treated in the same way with other bone problems.

Women who lose a baby are also treated by the traditional medicine practitioners. The treatment process, however, is considered as abortion. So, it will be discussed below (under subsection 4.2.4 which deals abortion).

All of the above treatments are mostly provided for women who have completed four months of pregnancy. The women visit practitioners when they experience certain symptoms, rather than for regular checkups. The clients are expected to go to the practitioners' homes to get the help of the practitioners for the problems (except for delivery, which will be discussed under subsection 4.2.2). The practitioners use a room of their home to provide the treatments. The clients pay a little money for the services (five - fifteen birr). Sometimes the services are provided without payment (in cash). Some practitioners indicated that they do not ask their neighbors to pay for the services they provide. A practitioner, for example, indicated that she doesn't ask people in her village to pay her for the services because they help her by ploughing her land and doing physical works, as she doesn't have son and her husband is sickly.

The traditional medicine practitioners do not treat all the problems during pregnancy that they have diagnosed. Some problems require advice only. What follows is a discussion of the advice.

4.2.1.3 Advice

Advice is among the services traditional medicine practitioners deliver the pregnant women for some problems. Tiring of a fetus is one of those problems for which the practitioners offer expert advice. The practitioners explain that in such condition they advice the women to take "*bitaamine qumaa*" (which is used synonymously with "*protiiniyaa*" to refer to foods like meat, cheese, egg, and pea) and rest. As a traditional medicine practitioner [Turunge Dana] stated clearly:

> "*If the problem is found to be tiring of a fetus, I let the woman go home to take rest. And tell her to get sufficient 'bitaamine qumaa"* [foods rich with vitamin].

In addition to that they give the women a steer to abstain from "*going to bed very often;"* and keep away from carrying heavy objects and engaging in those activities that require much labor. This, according to the practitioners, helps the women avoid facing the problem again.

"*Xapho*" problem is the other problem for which the practitioners respond with advice. Since the source of the problem, according to the practitioners, is shortage of "*good foods,*" and drinks they are recommended to take them. The

ıood foods" the practitioners recommend include: egg, meat, cheese, butter, ıd pea; and drinks like milk.

he traditional medicine practitioners put that pregnant women, who have *'hin womb,*" are among those who heed their advice. They maintain that, like *xapho*" problem, there is no treatment for the problem, save heeding advice. So, they advise the women to get the "*good foods*" – as this problem is also hought to proceed from shortage of protein. They also advise them to abstain rom sex during late stages of pregnancy lest they encounter premature labour or delivey.

When pregnant women complain of some symptoms without having any real problem, the practitioners note the necessary cares that should be taken. The practitioners also indicated that it is advisable to every pregnant woman to drink herbal tea made of "*Naatiraa*" (which is known as '*Nech reyan*' or '*Natira*' in Amharic and "Artimisia vehan" in its scientific name) for about fifteen consecutive days preceding delivery. The practitioners put that this avoids the funky (unpleasant) smell of the woman's internal body, which is thought to be revealed during delivery. They maintain that the blood that flows during and after delivery and "other things that escape during delivery" would not have odor if a woman drinks "*Naatiraa*" before delivery. The women are also advised not to drink a medicine to expel tapeworm. A medicine that is locally made from "*koosuwaa ayfiyaa*" [the seeds of "Hagenia abyssinica" (scientific name); "*koso*" (Amharic name)] is commonly used to expel the worm. The practitioners

traditional medicine indicated that the medicine could terminate pregnancy t is taken by pregnant women.

2.2 Delivery Care

elivery care is the most common service traditional medicine practitioners ovide women with in relation to reproductive health. In earlier times, with ight changes now a days, almost all deliveries in rural areas (except those nat require the intervention of professionals in health centers/hospitals ecause of complications) take place at home – mostly with the help of TBAs. here is a famous saying in Wolayttigna that shows an intrinsic relationship etween delivery and TBAs – "*Yelanaara giyaa bin yelissiyaara/maaretisiyaara son attawsu*" [literally, while the one to borne goes to market, the birth attendant stays home]. [*The meaning of this saying is not what it seems and, as a result, needs much explanation. It will be discussed below under subsection 4.5*].

The practitioners of traditional medicine, their clients, and the key informants are of like mind regarding the role of the practitioners in delivery care. All of them agree that the role of TBAs is still so important in rural areas, despite the availability of health centers and health extention workers. Let us see what each of them says:

Turunge Dana, a traditional medicine practitioner has put:

"*People call me when a woman starts labour – whether it is daytime or midnight. I go to the woman's home whenever they call me; and help her in delivery and take* [help in delivery/expelling of] *the 'geedobaa'* [placenta that comes out/ delivered after the baby]. *I have attended the delivery of so many children around my locality. You see children over there? All these are born in my hands* [with my help]. ... *As far as I know, no one in our locality has gone to health center for delivey.*"

ı the same view one of the clients of the above quoted practitioner said:

"*I have delivered four children in her* [the above quoted practitioner's] *hands. All my neighbors have also delivered many children in her hands without any problem. ... No one thinks of going to health center for delivery, since she is here. God has put her here for us!*"

ʌ 65 year old key informant also stated:

"*Our mothers, our grandmothers, and our great grandmothers had delivered safely with the help of 'maaretissiya asaa' [TBAs]. Our wives have also delivered with their help. And our daughters have also been delivering with their help now....*"

n the same vein a health extension worker, who is one of the key nformants, pointed out:

"*... We are responsible for helping women during delivery. We are ready to go to their homes to provide delivery care whenever they call us. But the reality is that they call the TBAs; and report us after delivery. They know that we are responsible for giving delivery care*

for free. They, however, prefer to get the service from TBAs. ... The TBAs have reduced our work load."

ll of the above quotes clearly show how crucial the role of the traditional ıedicine practitioners is in delivery care of rural women, which mostly takes lace in the clients' home.

he practitioners provide the care when women report labour pain. :xamination goes on following the report, just like in prenatal care, by ıalpating the mother's stomach. The practitioners claim that they know vhether the baby is ready for delivery or not or, in their words, whether it is real labour" or not by palpating the mother's stomach. They say that there is ılso another sign that shows whether it is "real labour" or not. This sign, ıccording to them, happens on the mother's stomach below her navel. There happens a black vein which shows that it is the "real labour." And when this happens they become ready to "*take*" the baby. They state that the baby arrives soon after the sign. (The women are made to delivery by kneeling down because it is thought that their hip could be damaged otherwise).

When the baby arrives or "*comes to the verge,*" the practitioners "*take*" it by their hands. And they lose no time in cutting the umbilical cord after "*taking*" the baby. The practitioners signified that they cut the umbilical cord by blade. (Some practitioners noted that they sterilize the blade before cutting by heating it to a very high temperature). They use their three fingers (index, middle and ring) to measure off the point of cutting. The right point of cutting the umbilical

ɔrd, according to the practitioners, is at the three fingers-breadth from the oint where the umbilical cord is attached to the baby. Then they make a knot ɣith the piece that is left with the baby. (The practitioners get ten – twenty birr ɔayment for the service). The piece dries and falls away in the third or fourth lay. There is a custom of burying the piece in the corridor of the baby's ɔarents' home or around the pillar of the (traditional) house. It is believed that he baby would die if the piece is left or buried elsewhere.

The practitioners put that if the baby drinks "fluid" (amniotic fluid[10]) during delivery, its life is in danger. So, they take extra care to avoid that. But if the baby drinks it, they hold the baby upside down and softly hit its back so that the fluid comes out. After that the practitioners move towards taking out the "*geedobaa*" [placenta]. Sometimes it may take much time until the "*geedobaa*" comes out (See the third quotation below). The practitioners pointed out that expelling the "*geedobaa*" also demands much care. The practitioners explained this during the in-depth interview as follows.

Meseret Anjulo, a traditional medicine practitioner explained:

> "*The mother is safe if the 'geedoba' comes out swift. Otherwise, I wait until it comes out. It demands care until the 'geedoba' comes; lest it cuts inside the mother's womb out of traction and causes danger to her. The mother's stomach swells up and the quantity of blood flow increases when it cuts.*"

[10] The liquid that a baby lives in inside its mother's womb.

ı the same way the other traditional medicine practitioner [Turunge ·ana] depicted:

> *"I get the 'do'aa'* [synonymous with "geedobaa"] *by inserting my hands into the woman's womb, if it cuts inside the mother. But it is a tiresome job to get the 'do'aa' after it cuts. It is better to be careful before that happens."*

t is said that the unskilled "*maaretissiya asaa*" may cause such kind of ɔroblems during delivery. They could also put a baby in danger by pulling it luring delivery. But the skilled ones gently manipulate the woman's stomach ınd "take" the baby. One of the clients of traditional medicine practitioners ıarrates (during in-depth interview) how a TBA helped her when she had rouble just before delivery:

> *"It was during my first delivery that I had a terrible time. I suffered much when the legs of the baby got stuck in one side. That time, I could scarcely breathe. My sister, who lives with me called a practitioner* [a TBA who lives in her locality]. *Then she* [the TBA] *came and released the stuck legs; and 'my life was back!' It is quite amazing the baby arrived out of thin air after that. I also had trouble with the 'geedobaa' that time. It stayed quite a while. But she helped me be rid of it."*

As in the case of prenatal care, however, there are rare situations in which the practitioners refer their clients to health centers for delivery care instead of helping them by themselves. As few practitioners uncovered, these situations arise when the baby comes in wrong position, when the baby is hurt inside the

ıother's womb, when the mother tires or loses consciousness, or "*when the ›omb doesn't give space to take the baby*" [because of slenderness]. But they mphasize that these situations arise rarely; and the practitioners rarely refer ıeir clients to health centers as a result.

'here is also another situation which is similar with the one that arises during ırenatal care. This situation happens when the women claim that they are in labour pain" while they are actually not in it. This happens mostly for the *bakkar*," as the practitioners affirmed. The practitioners stated that the *bakkar*" may consider pains, mostly after completion of their seventh month of ›regnancy, as labour. Those who are not "*bakkar*" could also consider certain symptoms as labour during late stages of pregnancy.

There is a belief about births that take place ahead of time. It is said that babies could be born as early as seventh months of pregnancy sometimes. A common belief in the area regarding babies born ahead of time is, however, that babies that are born in the seventh month of pregnancy could grow healthily; while those that are born in the eighth month would never grow.

4.2.3 Postnatal Care

Postnatal care is not as such a recognized service among the services provided by the traditional medicine practitioners for reproductive health care. The practitioners indicated that women visit them every now and then for postnatal care, unlike for prenatal and delivery cares. The practitioners said that this is

› because women rarely face significant problem in postnatal period. There :e also practitioners, although few, who even claim that no woman ever faced problem after they helped them during delivery. Aster Mada, a traditional ıedicine practitioner is a case in point:

> *"So many women delivered babies with my help. But I don't remember any woman who came to me complaining of any problem after delivery. No woman Thank God!"*

The clients of traditional medicine practitioners confirmed this during in-depth nterviews and FGDs that it is not common to face serious problems after delivery. Sometimes minor problems might happen after delivery; the practitioners and their clients are like-minded that home remedy[11] is preferable on the case. The minor problems after delivery that could best be dealt with home remedy include: backache, pain in bruise that mostly happens after delivery on the skin between vagina and anus, and pain in breasts. Bathing with warm water is believed to reduce pain in bruise and breasts. Backache, on the other hand, gets better by massage and by eating body building foods.

In the postnatal period body building foods are recommended not only for getting well from backache, but also for the whole well-being of the mother and for living by the expectation that a woman should be fatter when she is back to her "normal" life after delivery. Wishes that people extend a woman after

[11] See subsection 1.7 for its definition

ivery (while visiting her) shows the expectation as clear as day. While leaving
: woman after the visit, it is customary in the rural areas (the study areas) to
/ goodbye (by extending good wishes) as follows: "*Penggiyaa menttada kiya!*"
terally, wishing her to be immensely fat so that she could not get out the
or unless it is widened).

ıe traditional medicine practitioners stated during the in-depth interviews
at, just after they are done with delivery of babies and the "*geedobaa,*" they
fer the women advice to take body building foods and drinks. The body
ıiding foods and drinks that are recommended for women during postnatal
:riod are: porridge made from barley flour, porridge made from "*itimaa*" [*a*
ɔwder prepared from the root of false banana* (known as "*Enset*" in Amharic)],
ɔup made from barley flour, linseed and oatmeal; and liver (of cow and sheep,
tc), which is thought to replace the blood that is gone during and after
elivery. In addition, the practitioners advise their clients to get sufficient rest
nd take care of themselves; and to be careful with their babies.

s the practitioners pointed out, the following are the cares that should be
ıken with the babies in the postnatal period: the babies' navel should not be
uttered, the babies should not be put around fire, gas should not be burned
round the babies, and the babies should not be left in other kids charge.

.2.4 Abortion

raditional medicine practitioners play vital role in rural areas as far as ɛrmination of pregnancy is concerned. Both married and unmarried women isit traditional medicine practitioners for terminating pregnancy, as the ɔllowing quote from key informant interview with a health extension worker hows:

> *"Women come here and request us to terminate pregnancy. Most of these women are married women. Mostly they tell us that they have missed period and need contraception pills to terminate the pregnancy. This time, we teach them the use of contraception pills and make them aware of the danger of terminating pregnancy. We don't do abortion. So, we advise them that they should give birth to the baby. The women, however, go to traditional medicine practitioners to undergo abortion. ... The unmarried youth do not dare to come to health centers for abortion because of fear of being labeled. They directly go to the practitioners."*

The practitioners of traditional medicine, who provide abortion service and their clients have also affirmed this. Married women need abortion service when they conceive in unplanned way. They go to either TBAs or herbalists (those who prepare traditional medicine from plants/animals) when this occurs, as they could not get the service in the local health centers. Actually only two women admitted that they had undergone abortion (with the help of TBAs). But those women who talk about other women in their family or women whom they know who had undergone abortion with the help of traditional

:dicine practitioners are not few. When the married women are asked where ey would go (either to health centers or to traditional medicine practitioners) a situation that forces them to terminate pregnancy arises, most of them dicated that they would go to traditional medicine practitioners. The others id that killing a baby is sin, and they would not go to any one of the two to irry out abortion, as a result.

ne unmarried women in reproductive age also indicated that they prefer aditional medicine practitioners to terminate pregnancy, in case it occurs. /hen the women were asked (during FGD) what they would do if they conceive efore marriage, they reflected that it is far better to terminate pregnancy than *becoming a topic of discussion in the village.*" Regarding the preferable place of arrying out abortion, the women put that no one could escape "*becoming a opic of discussion*" unless the abortion is carried out in a secure place – in the ome of the traditional medicine practitioners. The following quotes from FGD nd in-depth interview with unmarried women vividly illustrate this.

A 23 year old woman, participant of FGD of unmarried women reflected:

> "*You could go to a health center for abortion. But if someone sees you there, that's all! The news will spread to the whole village in a short while. You could, however, abort in secret in the home of 'abasha asaa'.*"

n the same vein a 25 year old unmarried woman stated during in-depth nterview that:

"There are women in our village who carry out abortion for little birr. It is safe to abort there because no one could see you there. The practitioners finish it within short time. ...Going to health centers may require much money, since a woman is expected to go to Baddesa [the capital of Damot Woyde *woreda*] *for abortion."*

The ongoing discussion shows the decisiveness of the place of traditional medicine practitioners in performing abortion. There are, however, practitioners who do not want to be called abortionist by admitting their role in it. They rather try to escape by signifying that what they know about abortion is what they heard from others. There are, for example, practitioners who refuted that they don't perform abortion while their clients (of other services) and neighbors are pretty sure that they do perform it. There are also others, who said that they don't carry out abortion because of their belief/religion. A practitioner who said "*In the name of God! I don't perform abortion; I'm believer of God!*" [Dalgite Dana, a traditional medicine practitioner] (When the researcher asked her whether she performs abortion) is a shining example.

The practitioners who admitted that they carry out abortion put that it is the unmarried youth who mostly visit them to undergo abortion. They said that most of the time women come to them for abortion after the eighth week of missed period. The time gap could extend up to the sixteenth (rarely up to twentieth) week of pregnancy. Both those who perform abortion and those who "heard from others" depicted that they know the age of the fetus by asking the mother when she saw her last period; and by noticing the movement of the

tus, which mostly begins in the fourteenth week of pregnancy. The ractitioners, further, depicted that risks increase to the mother with the ıcrease of the age of the fetus. So, according to them, the mother should come s soon as she recognizes that she has conceived.

wo ways of carrying out abortion are practiced in the rural areas by raditional medicine practitioners. The first one is cutting the body of the fetus n to pieces manually. (No anesthesia is used to reduce or avoid pain). This is lone by inserting a metal with sharp edge into the mother's womb. The pieces ıre taken out by a twisted metal. The practitioners signified that the mother ;ould bleed profusely while or after performing abortion.

The second way of performing abortion is giving the women "*abasha xaliyaa*" herbal medicine] prepared from roots, seeds and leaves. The medicine is prepared by squeezing/crushing the roots, seeds, and leaves. The practitioners disclosed that the leaves/seeds they/"others" use to prepare the medicine include: "*Ankkaa licuwaa*" [the most tip of the leaves of "Croton macrostachyus" (sc. name[12]); "*Besana*" (amh. name[13])]; "*garaa licuwaa*" [the most tip of the leaves of Bitter leaf or "Vernonia amygdalina" (sc. name); "*Grawa*" (amh. name)] or "*garaa ayfiyaa*" [the seeds of Bitter leaf]; the leaves/seeds of "*Hanqooqua*" [the seeds of "Embelia schimperi" (sc. name); "*Enkoko*" (amh. name)]; and "*koosuwaa ayfiyaa*" [the seeds of "Hagenia abyssinica" (sc. name); "*koso*" (amh. name)]. Some of the roots which are used

[2] Scientific name
[3] Amharic name

) prepare the medicine that the practitioners disclosed are: "*Wosolluwaa*" Impatiens rothii" (sc. name); "*Ensosela*" (amh. name)] and the roots of Juttaa" ["Ensete ventricosum" (sc. name); "*Enset*" (amh. name)]. (These are the erbs that are revealed by escaping the secrecy of the practitioners, while other uestions about the herbs are evaded under the pretext of conveying that "*You lon't know them! They're not found here*").

'he practitioners pointed out that the fetus might not expel soon after taking he medicine. It mostly expels after hours or sometimes after few days. The luration differs depending on the age of the fetus (this also determines the noney paid for the service, which ranges from one hundred – five hundred birr) and the amount of the medicine taken. Furthermore, the practitioners signified that the medicine could take the mother's life instead of the fetus if it is overdosed on.

As it is mentioned earlier (under subtopic "Prenatal Care"), traditional medicine practitioners expel fetus when the mother loses it, in addition to expelling by killing it. The process of expelling this fetus is similar with expelling the later one. The practitioners, however, pointed out that "*abasha xaliyaa*" is infinitely preferable to expel the dead fetus. The practitioners put that expelling a dead fetus is much difficult than terminating normal pregnancy. Some practitioners claim that traditional medicine is much effective while dealing with the situation. The following quotation from in-depth interview with a practitioner [Zazote Tunta] provides a very good illustration of this:

"Sometimes I encounter women who complain of a fetus that stayed in their 'stomach' for a year and half or more than that. Once, for example, a woman with a fetus that stayed for three years in her 'stomach' came here from a town. This sort of fetus is too risky to the mother. The mother could not conceive another baby unless it is expelled. Doctors could hardly expel this kind of fetus. It is so challenging even to the "abasha asaa." The woman [with a fetus that stayed for three years in her womb] *told me that she went to a doctor to expel the baby. But the doctor did not expel it. Finally she came to me. I gave her medicine. She drank it and the fetus came out. You know, this is the help of God more than mine."*

4.2.5 Birth Control/Spacing

The role of traditional medicine practitioners is so tiny (nearly worthless) in the provision of birth control service. The practitioners pointed out that women very rarely consult them about birth control. In addition, they indicated that the women do not see them purposely to consult them about birth control, but they do consult them about it while visiting them for other services – either during prenatal care or after delivery. The practitioners stated that the (traditional) birth control methods they know are continuous breast feeding after delivery and "day counting" (periodic abstinence from sex during women's fertile period). The practitioners signified that they know the women's fertile period by asking them the duration of their period and the gap between its cycle.

he clients of traditional medicine affirmed that the traditional medicine ractitioners do not give any birth spacing pill/medicine. Most women ndicated (both during the FGD and in-depth interviews) that if they need the ervice, they could get it for free from health extension workers of the espective *kebeles*. The health extension workers also stated that they teach he women about birth spacing services they provide, in spite of the fact that a ew women take the advantage. (Family planning is one of the sixteen packages on which the health extension workers work).

4.2.6 Sexually Transmitted Diseases (STDs)

The diagnosis and treatment of STDs is among the services that the traditional medicine practitioners provide in relation to reproductive health. The traditional medicine practitioners diagnose those STDs that are known (and exist) in the rural areas; and very few experienced practitioners treat some of the diseases. The STDs are treated only by few experienced practitioners because, as Bekelech (2007) stated, STDs are among the diseases that should be treated either by modern medicine or by "high level" traditional medicine practitioners. The STDs that the traditional medicine practitioners diagnose and treat, together with the symptoms and the treatments, are discussed as follows. (The diseases discussed here are those that are known and exist in the area now. There were diseases like "*kitigniyaa*" [syphilis, "*kitign*" in Amharic] in the area. But it is said that the diseases do not exist in the area now).

2.6.1 *Wulawushshiyaa* (Hepatitis B)

ulawushshiyaa ("*Yegubet begnet*" (amh. name)) is a STD which is treated only traditional medicine practitioners (traditional medicine). Both the actitioners and their clients are in agreement of this. Articles on STDs (Bovo, 99; The Well project (2009)) also affirm this. It is stated in the articles that ere is no treatment to the infection/disease. Traditional medicine actitioners and their clients, however, put that there is treatment to the sease; and that it is curable. (The health extension workers and others who ork in modern health centers appreciate the traditional medicine actitioners' role in treating the disease). It is widely believed in the area that ne disease is caused when a person steps on the urine of dog, when a bird alled *"Wurkawurkkuwaa"* [bat] flies straight above a person's head or when ne bird urinates on a person head, when a person urinates by facing onto ainbow, when a person stays much time in the sun. Besides, it is believed that he disease produces small eggs inside the patient's blood[14] that spread to blood in) her/his whole body.

The traditional medicine practitioners depicted that the following symptoms could be observed on a person who has the disease: urine mixed with blood; the whole skin, nails and eyes go yellowish. It is said that change in the color of the body parts is the most important sign to distinguish the disease. A person with these symptoms, as the practitioners signified, should be treated as soon

[14] Although the eggs could not be seen, it is believed that the color change of the skin of the patient indicates that the eggs are there in the person's blood (and are spreading).

possible. Otherwise, the patient could die following the spread of the eggs to e blood in) the whole body. In addition, the practitioners indicated that the ;ease "doesn't like" making [gets worsened if a person makes] much)vement or running [or runs]. If a person who has the disease makes much)vement or runs, the eggs spread swift and the person could die resultantly.

though most practitioners diagnose the disease, only two practitioners (who epare herbal medicine) affirmed that they treat the disease. According to the actitioners, the treatment is carried out in two ways. The first way of carrying it the treatment is giving the patients a herbal medicine, which is made by inding/milling a bat (the bird which is thought to cause the disease). The ledicine, as the practitioners put, takes the disease away with simultaneous iarrhea and vomiting. The other way of carrying out the treatment is giving he patients medicine by powdering it on banana and by preparing it like a igarette to be smoked by the patient. In addition to that, a local drink called *parssuwaa*" ("*tella*" in Amharic) and raw onion are advised to be taken on the ide. The practitioners, further, advise the patients to avoid taking milk and weet things.

.2.6.2 Yaataa/Cabduaa[15] (Gonorrea)

aataa ("*Cheb*t" (amh. name)) is a STD whose name seems phobic to the rural eople. Both the clients and the practitioners shared a common hatred to the

[15] Although some practitioners claim that *"Yaataa" and "Cabduaa" are two different STDs, the symptoms they oint out are somewhat similar. Other practitioners, on the other hand, state that these are just two names of a sease. Here they are considered as names of a disease because of similarity of the symptoms the former ones put fferently and because of the claim of the latter ones. Most clients know it by the name "Yaataa."*

ıease. This is manifested by the ways in which it is expressed. The awfulness the disease is expressed in phrases like "*Yaatay nagaranchaa!*" [the disease "sinful"], "*hegee bitaa!*" [it is evil], "*godi ixxoogaa*" [it is god-awful]. *Yaataa,* like *Wulawushshiyaa,* is believed to be transmitted by sexual intercourse th a person who has the disease/infection.

ıe symptoms that are observed on a woman who goes down with *Yaataa,* cording to the practitioners, include: white vaginal discharge/urine, itching ıd burning on vagina, sores on vagina, mouth goes whitish, loss of weight, ıd blood flow. While some practitioners signified that they only diagnose the sease, some others said that they provide advises to avoid worsening of the roblem. These practitioners put that the patients should not take milk, cheese nd raw meat to avoid worsening of the problem. The practitioners indicated ıat there are practitioners who provide medicine to the patients of *Yaataa,* 'hereas two herbalists affirmed that they offer the patients a drink of ıedicine.

.2.6.3 HIV/AIDS

> "*A person could not get AIDS from thin air, but from other person's blood. A person could get it if he has sex with a menstruating woman. If they are not careful and don't use things like condom, they could get it. AIDS goes to a man if a woman who has the disease has intercourse with him without condom*" [Milkite Tunta, a traditional medicine practitioner]."

ving sex with a person who has HIV/AIDS, sharing blade and blood contact
h a person who has HIV/AIDS are the causes of HIV infection that the
ctitioners pointed out. There is no traditional medicine practitioner who
ims to treat AIDS, although there are practitioners who claim to diagnose it.
e practitioners identified different (with some conflicting each other) signs as
mptoms of the infection/disease on women. According to the practitioners
e women who have the disease: have "no blood," continuous bleeding, their
ıole body goes whitish and pale, have unpleasant body smell, their arms,
gs, and the whole body goes skinny (it is difficult, according to the
actitioners, to find out the disease on fat women/men), their lips go dry, have
oblems on their lungs because it catches their lungs (this one is examined by
alpating the lung).

raditional medicine practitioners have varied views of the impact of HIV/AIDS
n conception, delivery, and on the baby. There are practitioners who say that
IV positive women could not conceive because the disease "burns" the uterus
nd because of continuous blood flow. Others say that although the mother
ould conceive, she could not deliver it. As a traditional medicine practitioner
Lo'iitee Bassaa] puts:

> *"In case a woman who has AIDS conceives, she could not deliver the baby normally because her womb is diseased just like other parts of her body, and she has a diseased fetus, as a result. The mother could go to doctors but they could not help the woman deliver a healthy baby. It could not stay in the mother's 'stomach."*

the other hand, there are practitioners who say that HIV positive women ıld conceive and deliver just like other healthy women. But the baby could : grow because, clear of doubt, he gets the disease from his mother/parents. ıce the baby is the result of his parents' blood, he could not escape the virus, :ording to the practitioners. None of the practitioners believes that a child m HIV positive mother/parents could grow.

3 Specialization /Expertise area(s) of Traditional Medicine Practitioners who Address[16] Reproductive Health Related Issues

aditional medicine practitioners, as it has been discussed so far, are engaged the provision of prenatal care, delivery care, postnatal care (although not gnificant); and in carrying out abortion and treating STDs. (As it is mentioned ›ove in subsection 4.2.5, the role of traditional medicine practitioners is most worthless regarding birth control/spacing service and is not included ere as a result). This study has found out that the expertise/specialization ea(s) of the practitioners who address reproductive health related problems e: TBAs, herbalists, TBA/*wogesha*, herbalist/*wogesha*, TBA/herbalist/ *ogesha* (See table 1 below).

[16] Diagnose/treat/offer advice for

.ble 1: Expertise/specialization area(s) of traditional medicine practitioners who .dress reproductive health problems and the reproductive health problem s/he .dresses

xpertise/specialization :ea(s)	**No. of Practitioners**	**Reproductive health problem(s) s/he addresses** [17]
BA; TBA and *wogesha;* BA and herbalist; TBA, erbalist and *wogesha*	14	➢ Prenatal care ➢ Delivery care ➢ Postnatal care (advise) ➢ Abortion ➢ Diagnosis/treatment of STDs
Herbalist; Herbalist and *vogesha*	2	➢ Abortion ➢ Diagnosis/treatment of STDs
Total no. of practitioners	16	

TBAs take lion's share in the provision of reproductive health care service in he rural areas as far as the practice of traditional medicine is concerned. As he above table shows, most of those who provide reproductive health care ervice for women in the rural areas are TBAs. While some TBAs have pecialized in delivery related services (TBA only), others have expertise in vorking as *wogesha* (who help people with wrench, sprain, and racked/broken bone) and/or herbalist (those who prepare traditional medicine rom plants/animals). It is worth mentioning, however, that both those who are

[17] Based on what the practitioners affirmed and what their clients and key informants depicted.

own as TBA only and those who work as *wogesha* and/or herbalist in dition to being TBA provide prenatal, delivery, and postnatal care; and carry t abortion and diagnose and/or treat STDs. Regarding STDs, these actitioners diagnose STDs (except HIV/AIDS. As mentioned in the subsection 2.6.3, some of the practitioners claimed to diagnose it – not all) but do not eat all of the STDs.

actitioners who specialized as herbalists and those who work as both erbalist and *wogesha* carry out abortion and diagnose and treat STDs. These actitioners could diagnose and treat the STDs that others, who don't know ow to prepare the "*abasha xaliyaa,*" could not. For instance, herbalists could eat "*Yaataa*" by giving the patients a herbal medicine, while the others offer dvice only to avoid worsening of the disease. The treatment of *Vulawushshiyaa* also requires knowledge of "*abasha xaliyaa.*" (On average, one undred sixty women visit a practitioner in a year in relation to reproductive ealth issues).

The Source of Knowledge of the Traditional Medicine Practitioners from the Practitioners' and Clients' Points of Views

4.1 The Source of Knowledge of the Traditional Medicine Practitioners from the Practitioners' Point of View

> *"My mother was a well-known 'hillanchcha.' She reaches even remote villages; and people come to her from remote villages. I didn't like her work because she was always busy with it. 'Yaatiyaaro ta na'atettan uufas' [I used to accuse her of her work when I was young]. I used to say 'Oh, here we go again. Your people are coming!' But after I got married, I went to my mother's home to deliver my first baby.* [It is customary in the area to deliver the first baby in the home of the woman's family]. *My mother helped me during delivery. After that she said 'my child, you used to underestimate my work. But I help people experiencing difficulties just like yours.' Then she said 'when I die, you could help yourself and others experiencing difficulties. Do like this during labor, cut umbilical cord like so.' I have also learnt 'wogeeshshatettaa'* [treating those with sprain, wrench, and/or cracked/broken bone] *after that."* [Milkite Tunta, a traditional medicine practitioner (TBA and *Wogeeshshaa*)].

An understanding of the alleged or real source of knowledge of the traditional medicine practitioners is among the important issue in the understanding of beliefs and practices of traditional medicine. According to WHO, (1990) (cited in Kebede et al., 2006) in Ethiopia, it is widely believed that the knowledge and skill of the practitioners of traditional medicine is given by God. This belief could be one of the reasons for cultural acceptability of the practitioners in

thiopia (which is one of the factors that make most Ethiopians practice aditional medicine). According to WHO (1990), mostly the knowledge of aditional medicines is passed from generation to generation orally, usually om father to a favorite child. This study has also found out that the nowledge is passed from generation to generation orally. As the above quote hows, parents transmit the knowledge to their children.

The parents pass their indigenous knowledge of traditional medicine to children of their sex (the same sex with them). Those practitioners known as TBAs and the majority of others, who are engaged in the provision of reproductive health care services for women, are women. Most of the women (practitioners who are respondents of this study) have signified that their mothers/grandmothers had the knowledge of traditional medicine, and that they have learned the skill from them (except a practitioner who claims that she has received it from God.) Two male (practitioner) respondents of this study, on the other hand, put that they have learned it from their fathers.

Unlike those practitioners who affirmed that they have learned from their parents, there is a traditional medicine practitioner who claims that her knowledge of traditional medicine is a result of prayer. The practitioner [Dalgite Dana] states:

> *"I had prayed to God to give me this knowledge when I was a child. Then I have received this knowledge from him. I'm believer of God* [I'm Christian]. ...*I had begun the work when I was older."*

Although only a practitioner claimed that she had received the knowledge from God, it is common to hear most practitioners associating their success with the help of God. A practitioner who said "*...This is the help of God more than mine*" [Zazote Tunta, a practitioner] while explaining how she carried off expelling a fetus that stayed for three years in its mother's stomach" is a case in point.

4.4.2 The Source of Knowledge of the Traditional Medicine Practitioners from the Clients' Point of View

> "*Where do you think they* [the practitioners] *could get the knowledge except from their families? Mostly children learn this sort of skills from their parents. They get it either from their fathers or mothers by imitating what they do.*" [A 38 year old woman, in-depth interview].

The Clients of traditional medicine practitioners have a belief, as quoted above, that the expertise that traditional medicine practitioners have (on dealing with reproductive health problems) is learned from their families/parents, than being given by God. As in the case of the traditional medicine practitioners, however, the client's of the practitioners put that God gives them a hand with success of their service/treatment. What a woman said during in-depth interview illustrates this: "*The practitioners have a way with the* [reproductive health] *problems. No one could have such a magic touch without the help of God*" [A woman in mid-30s, FGD].

There are also clients who believe that the practitioners are near at hand because of God. A woman's statement during in-depth interview clearly puts this: "*I have delivered four children in her* [a practitioner's] *hands.... No one thinks of going to health center for delivery, since she is here. God has put her here for us!*" [A client, in-depth interview]. But these might not connote a belief that the practitioners received the knowledge from God. In view of this, it is obvious conclusion that from the point of view of the clients of traditional medicine practitioners, the source of indigenous knowledge of traditional medicine practitioners (who deal with reproductive health problems) is their parents' knowledge - than the endowment of God/supernatural force(s).

As different studies (Alemayehu, 1984; Belachew, 2008; Kloos and Kaba, 2006; Pankhurst, 1965; WHO, 2001) have shown there are two major types of traditional medicine practices in Ethiopia; namely secular or empirical healing and magico-religious healing practices. The latter one involves spiritual healing. The practitioners of spiritual healing are believed to help/treat people with the knowledge/skill, which is thought to be given by supernatural force. But, as both the practitioners (except one) and their clients have affirmed, the source of knowledge of traditional medicine practitioners who address reproductive health related problems is not supernatural force. The practice of traditional medicine for reproductive health, resultantly, falls into the category of the secular/empirical one.

.5 The Place that Traditional Medicine and its Practitioners Hold in Relation to the Treatment of Reproductive Health Problems

As one could catch on to the discussion so far, traditional medicine and its practitioners hold crucial place in the rural areas as far as dealing with reproductive health issues is concerned. The data collected from all of the primary sources indicates that the practitioners (and the medicine) are so significant in the rural areas in dealing with the issues. The practitioner's role and expertise (that makes them even dare to oppose what science and doctors say as discussed under subsections 4.2.1.1 and 4.1.4) in carrying off the reproductive health problems; the types of reproductive health services the practitioners provide; the clients' view of the services; and the following famous saying best illustrate this.

- ***'Yelanaara giyaa bin yelissiyaara son attawsu giida'***

As it is touched on under subtopic 4.2.1.2, this is a famous saying in Wolayttigna. The literal meaning of this saying is that while the one to borne goes to market, the birth attendant stays home. The saying shows the intrinsic relationship between delivery and TBAs. It also indicates the place of traditional medicine and its practitioners in dealing with reproductive health problems. This saying is used to convey that a person is in an inappropriate place/ in a place where s/he is not expected to be.

is worth throwing light on the view of (modern) health workers about raditional medicine in the end. Health workers affirm that traditional medicine as crucial place in the rural areas. The health extension workers, who work in *ebele* level, have indicated that traditional medicine plays significant role in ne rural areas. Besides, they have put that the traditional medicine ractitioners' role is supplementing theirs. According to the health extension vorkers, the residents of each *kebele* are categorized into groups known as *haggaazaa*" for meeting the goals of health extension packages. Each *haggaazaa*" consists of 56 households, one "*bego meliktegna*" (volunteer: esident of the *kebele* who has taken few weeks training on first aid and on some basic supports), and traditional medicine practitioners. The health extension workers maintained that the traditional medicine practitioners play important role in the rural areas, especially in delivery care that mostly takes place in the clients' home. The health extension workers also appreciate the practitioners' role in treatment of "*Wulawushshiyaa*" (hepatitis B), which has no modern treatment. The health extension workers are of the view that traditional medicine could be utilized best by giving the practitioners training.

A midwife and some other health workers in Badessa health center also acknowledge the crucial role of the medicine in the rural areas. But the midwife has disclosed that sometimes rural women come to the health center when placenta cuts inside the mother's womb while the traditional medicine

ractitioners carry out abortion. She has also indicated that the herbal ıedicine that the practitioners give to expel the fetus sometimes takes the ıother's life. The midwife has, however, affirmed that the practitioners play mportant role in delivery care, prenatal care, and treatment of *wulawushshiyaa.*"

Wolaytta *zone* health boureau officials have stated that Health and Health Related Service Quality Control Core Process Boureau, which is under the zone ıealth boureau, controls and follows up traditional medicine (practitioners). The *zone* officials and the Health and Health Related Service Quality Control Core Process Boureau workers indicated that the practitioners are being given training and equipments in cooperation with some NGOs that work in health areas. They have stated, like the health extension workers, that traditional medicine could be utilized efficiently by giving the practitioners training and providing them equipments. Incorporation of traditional medicine into the modern one, according to them, is given attention nowadays.

hapter Five: Summary and Conclusions

his study was carried out with the major objective of examining the beliefs nd practices of traditional medicine among rural women in reproductive calth care. The types of (traditional) reproductive health services available in ıe areas to be practiced by the women; the role and expertise of traditional ıedicine practitioners in providing the services to the women; the beliefs ccompanying the practices; and the place of the medicine and its practitioners ıave been covered in this study in accordance with the objectives.

'his study has found out that prenatal care, delivery care, abortion service and reatment of STDs are among the major services that the rural women get from raditional medicine practitioners in relation to reproductive health. Although ıostnatal care is provided by the practitioners, it is not as significant as the nentioned services. Traditional medicine provides nearly worthless service in he rural areas regarding birth spacing/control.

Prenatal care is among the crucial services of traditional medicine practitioners) for women in relation to reproductive health. The prenatal care services that the traditional medicine practitioners provide pregnant women with are discussed under diagnosis, treatment and advice. "*Desha*" (tilted ıosition of a fetus); tying of legs of a fetus by an umbilical cord; tiring of a fetus; "*gelaa*" (a problem that is thought to occur when a bone in ones side or cartilaginous bone around his/her heart moves from its normal position); womb problems: "*xapho*" (vein) problem and "thinness of womb;" losing a baby

'e the problems during pregnancy that the traditional medicine practitioners agnose. From these problems those that the practitioners carry off by eatment are: "*desha,*" tying of legs of a fetus by an umbilical cord, "*gelaa,*" sing a baby. There are also problems during prenatal period for which the ractitioners heed advice. These problems encompass: tiring of a fetus, "*xapho*" roblem and "thinness of womb." Besides, the practitioners give the clients a eer about the general cares that should be taken until delivery.

elivery care is the most common service the rural women get from traditional nedicine practitioners in relation to reproductive health. The practitioners nostly go to the woman's home to offer delivery care up on request. By noticing ne signs on the woman's body they check whether it is "real labour" or not. If is "real labour," they "take" the baby, cut the umbilical cord, and take the *geedobaa.*" And give the necessary cares to the baby, if required.

Postnatal care is not as recognized as prenatal and delivery cares provided by he practitioners in the rural areas. The major reason for this, as the ractitioners and their clients put, is that women do not commonly face serious roblems after delivery. As they have affirmed, minor problems might happen fter delivery sometimes. It is said that these minor problems such as ackache, pain in bruise that mostly happens after delivery on the skin etween vagina and anus, and pain in breasts could be dealt with home emedy. Bathing with warm water is believed to reduce pain in bruise and

easts. Backache, on the other hand, gets better by massage and by eating ›dy building foods.

ıe role of traditional medicine (practitioners) is vital as far as termination of ·egnancy is concerned. Both married and unmarried women visit traditional edicine practitioners for terminating pregnancy. Unmarried women in :productive age signified that becoming pregnant before getting married ıakes a woman "*a topic of discussion in the village.*" This could be avoided, :cording to the women, only by getting rid of the fetus in a secure place – in ıe home of the traditional medicine practitioners. The married women, on the ther hand, go to traditional medicine practitioners because they could not get ıe service legally. The traditional medicine practitioners carry out abortion in wo ways: by cutting the body of the fetus in to pieces manually by inserting a ıetal with sharp edge into the mother's womb; and by giving the women a lrink of "*abasha xaliyaa*" [herbal medicine] prepared from roots, seeds and eaves. A dead fetus that stayed in a mother's "stomach" for more than a year is lso expelled in the way.

Traditional medicine provides nearly worthless service in the rural areas egarding birth spacing/control. Women so rarely visit the traditional ›ractitioners to get the service. The practitioners stated that the (traditional) ›irth control methods they know are continuous breast feeding after delivery ınd "day counting" (periodic abstinence from sex during women's fertile ›eriod). They, however, affirmed that they offer the service so rarely.

agnosis and treatment of STDs is among the services of traditional medicine actitioners. The STDs that the practitioners claimed to diagnose are *ulawushshiyaa* (Hepatitis B), *Yaataa* (Gonorrea), and HIV AIDS. Among the TDs *Wulawushshiyaa* is widely believed to be caused when a person steps on e urine of dog, when a bird called *"Wurkawurkuwaa"* flies straight above a erson's head or when the bird urinates on a person's head, when a person rinates by facing onto rainbow, and even when a person stays much time in ıe sun. Besides, it is believed that the disease produces small eggs inside the atient's blood that spread to (blood in) her/his whole body. Although modern ıedicine, according to Bovo (1999) and The Well project (2009), claims that there s no treatment to the infection/disease, this study has found out that the isease is treated by traditional medicine (practitioners). *Yaataa* is also iagnosed and treated by traditional medicine practitioners. There are ractitioners who claim to diagnose HIV/AIDS by checking the physical signs nd by palpating a patient's lung. But none of the practitioners claims to treat he disease.

The specialization/expertise area(s) of practitioners who deal with reproductive ıealth issues are: TBAs, herbalists, TBA/*wogesha*, herbalist/*wogesha*, and TBA/herbalist/*wogesha*. Those practitioners known as TBA; TBA and *wogesha;* TBA and herbalist; and TBA, herbalist and *wogesha* provide women with prenatal care, delivery care, postnatal care, abortion service, and diagnosis/treatment of STDs. Those known as Herbalist; and Herbalist and

ogesha, on the other hand provide women with abortion service and iagnosis/treatment of STDs.

lthough WHO (1990) depicted that it is widely believed in Ethiopia that the nowledge and skill of the practitioners of traditional medicine is given by God, oth the practitioners of traditional medicine (except one practitioner who laims that she took the knowledge from God) and their clients put that the ource of knowledge of the practitioners is learned from their parents. The arents pass their indigenous knowledge of traditional medicine to children of heir sex (the same sex with them). The practice of traditional medicine for eproductive health, resultantly, could be categorized under the ecular/empirical one than magico-religious one.

As Assefa (1992) indicated, a belief that traditional medicine is adequate and competent in dealing with most psycho-social problems which the modern one s not, is among those beliefs accompanying the practice of traditional medicine. This study has found out that there is no such kind of belief egarding the practice of traditional medicine for reproductive health problems except for *Wulawushshiyaa* that the modern medicine could not treat). Besides, none of the reproductive health problems covered in this study is reated by traditional specialists of the problems because of a belief that the problem is caused by supernatural force(s). The rural women do not have negative view of/opinion about modern medicine. They are of the view that modern medicine could deal successfully with various health problems,

:luding reproductive health problems (except *Wulawushshiyaa*). At the same ıe, the women have firm belief in the success of traditional medicine and its ıctitioners. The women indicated that they have every trust in the services of ıditional medicine practitioners, which stood the taste of time. This is a belief at accompanies a view that, especially during labour/delivery, there is no :ed to go to health centers while the practitioners who have a way with the oblems are at hand. The women are of the opinion that "*the practitioners ıve a magic touch*," "*have 'good hands'*," and "*go out of their way to help*" them hile dealing with the problems.

ıe types of reproductive health services the practitioners of traditional ıedicine practitioners provide; the practitioner's role and expertise in carrying ff the reproductive health problems; the clients' view of the services; a famous ıying "*Yelanaara giyaa bin yelissiyaara son* attawsu" show the decisive place ıat traditional medicine and its practitioners have in dealing with reproductive ealth problems.

ealth workers in (modern) health centers and health officials admit that raditional medicine has crucial role in the rural areas. And the role of the raditional medicine practitioners in delivery care, prenatal care, and treatment f "*wulawushshiyaa*" is acknowledged. Although some problems related to the ractice of traditional medicine are disclosed, it is said that the medicine could e utilized efficiently by giving the practitioners trainings and equipments.

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pendix A: Interview and FGD Guides

In-depth Interview Guide 1

is interview guide is prepared to collect data on the beliefs and practices of ıditional medicine for reproductive health issues - from women in ɔroductive age.

I. Socio-economic Information

1. Age
2. Sex
3. Religion
4. Educational level
5. Family size

II. Practice of Traditional Medicine

6. What are the services that traditional medicine practitioners in your area provide?
7. What are the services that traditional medicine practitioners in your area provide women in reproductive age with?
8. Have you ever received any service from any traditional medicine practitioner?
9. What are the services that you have received from traditional medicine practitioners for reproductive health issue(s)?

➢ **Prenatal Care**

10. Have you ever received prenatal care from any traditional medicine practitioner?

11. What was the problem/symptom that made you seek the service?

12. How did the practitioner help you?

13. Why did you choose the traditional practitioner for the service?

14. How much did you pay for the service?

- **Delivery Care**

15. Have you ever received support from traditional medicine practitioner during delivery?

16. Have you ever delivered a baby with the help of traditional medicine practitioner?

17. How did the practitioner help you?

18. How many children did you deliver with the help of traditional birth attendants?

19. Why did you choose the practitioner for the service?

20. How much did you pay for the service?

- **Postnatal Care**

21. Is there any service that the practitioners provide women after delivery?

22. Have you ever received any service from the practitioners after delivery?

23. How did you determine that you need the service?

24. Why did you choose the traditional practitioner for the service?

25. How was the service you have received?

➢ **Abortion**

26. Do the practitioners of traditional medicine provide any service/medicine to a woman who wants to terminate pregnancy?

27. How do you see the service traditional practitioners provide women with during abortion?

28. What do you think are the factors that make people have an abortion?

29. What would you do if you encounter a situation that forces you to terminate pregnancy arises?

30. Where would you go (either to a health center or to a traditional medicine practitioner) on the case? Why?

31. Have you ever undergone abortion with the help of traditional practitioner? Please elaborate on the situation.

32. Why did you choose the traditional practitioner for the service?

33. How much money do the practitioners ask to perform abortion?

➢ **Birth Spacing/Control**

34. Do the traditional medicine practitioners provide any birth spacing service?

35. Have you ever received any birth spacing service/pill from any traditional medicine practitioner?

36. How was its result?

37. Are the modern birth spacing services available around your village?

38. Are they accessible?

➢ **STD**

39. What are the STDs you know?
40. Which of them exist today?
41. Do the traditional medicine practitioners offer any service in relation to STD?
42. What are the services?
43. How successful are the services?
44. Have you ever undergone STD treatment by the traditional medicine practitioner?
45. What symptoms made you seek the treatment?
46. How was the result?

III. Beliefs about Traditional Medicine and its Practitioners

47. What opinion/view do you have about modern medicine?
48. What about the traditional one and its practitioners?
49. Where should a woman immediately go when she faces problem(s)/issue(s) related to reproductive health? Why?
50. Which of the available medical options (traditional and modern) do you think should people try as a last resort? Why?
51. What opinion do you have about the place of traditional medicine (and its practitioners) in the treatment of reproductive health related problems?
52. What opinion do you have about the traditional healers who treat reproductive health related problems?

53. Is there any reproductive health problem for which you think people must go to traditional medicine practitioners? Why?

54. What do you think is the source of indigenous medical knowledge of the traditional medicine practitioners?

55. Is there anything that you want to say about traditional medicine and its practitioners?

In-depth Interview Guide 2

is interview guide is prepared to collect data on the expertise, role, source of owledge, of traditional medicine practitioners in dealing with reproductive alth issues - from the practitioners.

I. General information

1. Age
2. Sex
3. Religion
4. Educational level

II. Source of Knowledge

5. At what age did you start treating people?
6. From whom did you learn this skill?
7. How did you become a known healer?
8. What is the source of your indigenous knowledge of healing?

III. Type of Treatment S/he provides

9. What are the types of services you provide?
10. What type of service do you provide for women in reproductive age (18-45)?

A. Prenatal Care

11. For which problems of women during pregnancy do you provide solutions?
12. What are the symptoms of the problems?

13. How do you diagnose the problems?

14. What are the sources of the problems?

15. What are the solutions you provide them with?

16. How much do the clients pay for the service?

B. Delivery Care

17. How do you help women during child delivery?

18. What are the cares that should be taken during delivery?

19. What is/are a problem(s) that could arise if the care is not taken?

20. Have you ever faced any problem while helping women during delivery?

C. Postnatal Care

21. For which problems of women after delivery do you provide solutions?

22. What are the symptoms of the problems?

23. What are the solutions you provide to solve the problems?

D. Abortion

24. What do you think a woman should do if she gets pregnant without her will?

25. What if a situation that forces her to terminate pregnancy arises?

26. Is there anything that people do around here to terminate pregnancy?

27. What is the role of traditional medicine practitioners on the case?

28. How is it performed?

29. Have you ever carried out abortion?

30. How do you perform it?

31. What are the criteria that women should fulfill for getting abortion service?

32. How much do the clients pay for the service?

E. Birth Spacing/Control

33. Do you provide any birth spacing service for women in reproductive age?

34. What traditional birth spacing options do you know? Which of them do you provide the women?

35. How successful, do you think, are your services for birth spacing?

36. How often do women see you to get the service?

F. Sexually Transmitted Diseases/STDs

37. What are the STDs you know?

38. Do you deal with any of them?

39. What are the services you provide those with the STD(s)?

40. How do you diagnose/treat the STDs? What are the symptoms of the problems?

41. Do you think that your services are better than those provided by the modern medicine?

42. Have you ever referred people with reproductive health related problems to modern medicine?

43. Has anyone who received modern medical treatment came to you for the treatment of reproductive health related problems?

FGD Guide

his discussion guide is prepared to collect data on the beliefs and practices of raditional medicine for reproductive health issues - from women in eproductive age.

Discussion Points:

1. Prenatal and postnatal care services
2. Support during delivery
3. Abortion
4. Birth spacing services
5. STDs
6. Reasons for practicing traditional medicine
7. The source of knowledge of the traditional practitioners

ppendix B: The Profile of Traditional Medicine Practitioners

able 2: The Profile of Traditional Medicine Practitioners

ebele	No.	Name of the Practitioner*	Sex	Age	Educational level	Area(s) of Expertise/ Specialization
Mayo Dfore	1	Tabita Adelo	F	38	Illitrare	TBA, *Wogesha***
	2	Dalgite Mada	»	Late 40s	»	TBA
	3	Meseret Anjulo	»	42	»	TBA, herbalist
Tora Sadebo	4	Zazote Tunta	»	45	»	TBA
	5	Turunge Dana	»	50	»	TBA, *Wogesha*
Tora Wolisho	6	Dawit Mandado	M	38	*Meserete timirt****	Herbalist, *Wogesha*
	7	Mirtnesh Teshome	F	45	Illitrate	TBA, herbalist, *Wogesha*

indo oyo	8	Gom'ame Tura	»	40	»	TBA
	9	Lo'iitee Bassaa	»	40	»	TBA, herbalist
	10	Ufayse Lorato	»	32	»	TBA
mbe Badessa	11	Yambule Mamo	»	45	*Meserete timirt*	TBA, *Wogesha*
	12	Milkite Tunta	»	40	Illitrate	TBA, *Wogesha*
	13	Tamirat Alemayehu	M	32	Dropped from 6th grade	Herbalist
	14	Ayalech Ayka	F	28	Illitrate	TBA
Villages around Badessa	15	Dalgite Dana	F	38	»	TBA, *Wogesha,* herbalist
	16	Aster Mada	F	50	»	TBA

Pseudo names are used by giving consideration to ethical issues

* Bone-settlers/those who treat wrench and sprain

**Literacy education

Declaration

the under signed, declared that this thesis is my original work and it as never been presented for the degree in any other university and that l sources of materials used for the thesis are duly acknowledged.

)eclared by

ame Yared Paulos

ignature

)ate 13/05/11

Confirmed by

Name P MURUGAN

Signature

Date 13.05.11