Understanding the Role of Traditional Health in Eye Health Care in Gurage Zone, Southern Ethiopia

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Table of Contents

Abstract

Traditional medicine plays an important role in the eye care delivery system in Ethiopia. The focus on traditional medicine (TM) practice allows for a much richer understanding of why certain groups within a population are more likely to suffer specific type of illnesses than others. It also helps us understand social conditions and its association with higher prevalence of health inequity among communities. These social conditions involve access people have to resources to avoid risk or ill health such as money, power, social support, social network and prestige. While many assert that some people have greater resources than others, existence of poor social conditions add for a higher inclination for the utilization of traditional medicine. In addition, although little have been acknowledged about forms of marginalization and discrimination, these can play a huge role in individual's health treatment choices. Despite the practice of traditional medicine wide-spread occurrence, understanding the role and knowledge of traditional healing practices and practitioners is limited and has frequently been overlooked.

The goal of this research paper was (1) to understand the role of traditional medicine in the eye health care; (2) to understand the level of coordination between traditional medicine practitioners and modern healthcare providers in Gurage zone, Southern Ethiopia. To complete the analysis, a three-month descriptive ethnographic study was carried out in Gurage zone in Southern Nations and Nationalities People of Ethiopia (SNNP) between December and February, 2017/18. In-depth interviews with traditional healers and modern healthcare practitioners were performed alongside lengthy observations at their practicing sites in the region. The qualitative data was analyzed using a descriptive thematic analysis.

Findings demonstrated that, the utilization of traditional eye medicine (TEM) was more frequent among traditional healers themselves, rural residents and people with little/no access to modern eye health care. The practices of traditional healers covered a wide range of illnesses including various ocular disorders mostly using herbal medicines and Holy Water. Poorer social conditions such as cost of treatment, lack of adequate health information, long distance to healthcare centers were also a factor for an increased use of TM among the Gurage community. The health administration office in Gurage zone had a very limited knowledge and interaction with traditional healers. Although traditional medicine plays a pivotal role in the eye care delivery in the region, health practitioner's perspective towards traditional healers was found to

be slightly negative. Some health practitioners discounted the need for collaboration with THs and pointed out that if they increase the reachability and accessibility of healthcare centers to rural areas of the region, it is possible to reduce the negative impacts of TM use. Traditional medicine was also found to be overlooked by researchers and political figures. It is, therefore, time that TEM be well researched and areas of potential collaboration be identified to enhance the quality and coverage of eye care in Gurage zone.

Foreword

This paper fulfills several components of my plan of study through its ability to better comprehend health inequities across marginalization and vulnerability. It is crucial to analyze the intersections between categories of identity stands in contrast to conventional practice and theory, which tends to see marginalization as mutually exclusive categories. Marginalization become a point of entry into a wider context such that correlations between health inequities and identity categories. These are suggestive of underlying political, economic, and social causes that have served to reify inequities between groups of people.

First, through the literature review, I was able to analyze the overlapping root causes of the social determinants of health, and the lack of access to adequate provision of services to an individual or groups. This furthered my understanding of health inequity and its relation to access to resources. It's important to affirm that access to healthcare, health equity and policy should address the different needs of marginalized and vulnerable groups by addressing the underlying processes that likely have an influence on health outcomes. This directly relates to the learning objective under component one and two of my plan of study.

Second, by focusing on marginalized communities such as Gurage people of Ethiopia, I was able to understand the discourses around "deserving bodies" and distribution of resources are "socially determined" thus health consequences vary. Moreover, this furthered learning objective of component three in which I was able to differentiate the role of different social institutions, particularly the state in shaping the vulnerability and precariousness of certain bodies.

Third, I was able to understand the connections between access to resources and the use of traditional health practices that shape the health of a population. This further helped me examine limitations of traditional medicinal approaches to public health outcomes and the weak enticements to work with traditional healers. Traditional medicine being the first level of contact for many Gurage people when they require medical care, introducing safe use of traditional medicine to supplement primary healthcare is crucial. This contributed to my understanding and use of traditional practitioners as a resource for disseminating health information to bridge the health gap rather than be a barrier to increased health service utilization and improved levels of health.

Furthermore, by focusing on the poor health outcomes of marginalized and vulnerable people thought out my two years of study, I have developed a deeper understanding of the underlying factors that lead to marginalization and exclusion in the first place; distinguish more about the unique circumstances and needs of marginalized and vulnerable populations. The shift needs to be made from discussing the various determinants of health to implementing change to create improved circumstances for the people that are in need of such policy changes.

Acronyms

AU- African Union

CAM- Complementary Alternative Medicine

HP-Health Practitioners

MVGs-Marginalized and Vulnerable Groups

NGO-Non-Governmental Organization

OAU-Organization for African Unity

SDOH- Social Determinants of Health

SNNP Southern Nations Nationalities and People

TECP-Traditional Eye Care Practitioners

TEM- Traditional Eye Medicine

THs- Traditional Healers

TM -Traditional Medicine

WHO- World Health Organization

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1. Introduction

Many scholars (Marmont, 2005; Evans and Stoddart, 1990; Link and Phelan, 1995; and Carastathis, 2015) write about the social determinants of health; these are the social conditions that determine health. Many of these authors talk through these ideas in the context of mortality and morbidity outcomes resulting from one's geographic environment and social location. Carathathis' (2015) gives a qualitative lived account of how social conditions result from austerity practices (figured as the state's capacity to determine 'who is disposable and who is not'). These are directly linked to the lived experiences of people in a given space, especially those deemed minority groups. Social conditions reproduce inequality through a demographic point of view across age, gender, income, and ethnicity and through a binary lens of mortality, of death and living, by perpetually pushing marginalized and vulnerable minorities outside of the sphere of belonging (Zola, 1972). Marginalized and vulnerable groups (MVGs) are both subject to, and blamed for, conditions of unemployment, poverty, and ill-health that are exacerbated by racial and gender discrimination besides social conditions (Marmont, 2005).

It is important to study health inequity from a different social point of view. It is possible to discuss the crucial role that social determinants of health (SDOH) play in the expansion of inequalities, the distribution of health resources, and the extent of access to them (Williamson et al., 2015). A social determinants of health framework may illuminate intersectionality of various factors and the distinctions among lived experiences of discrimination by multi-disadvantaged people. In this regard, Bourgois and Schonberg (2009) employ social approaches of Karl Marx, Pierre Bourdieu, and Michel Foucault to examine the subjective experiences and propose the "theory of abuse." This theory, they claim, situates the suffering experiences of socially vulnerable groups in the contexts of structural forces and embodied manifestations of distress (16). Yet the concept of "abuse" is not exclusive in their studies. It refers to the general misuse of power in social relations, moral economy of sharing, and gray zones.

The authors (Bourgois and Schonberg, 2009) elucidate not only the everyday violence and social forces, including race, gender, and class, but also the structural and symbolic violence towards minority groups. Their work can link social theories and public policy practice to

address social injustice by surfacing the hidden aspects of social problems illustrating marginalized individuals. They contend that the primary focus of policymaking should be "harm reduction," and that there are no "magic-bullet" solutions (304). They argue that socio-economic forces are the main sources of suffering in the context of MVGs, and they represent the human cost of the neoliberal model (Foucault, 1991).

I found the use of Foucault's understanding of socio-economic and political forces to be particularly interesting in the case of the Gurage region of Ethiopia. These populations have suffered poor distribution of resources, such as clean water and, hydroelectric power supply, poor infrastructure and therefore people experience unimaginable poor living conditions. They experience higher levels of health inequalities, more disease epidemics, and premature death than any other counterpart city in the country (Addis, 2002). The empirical evidence presented by Marmot (2005) also highlights how health inequity and disparity is shaped by social structures and processes, particularly the uneven distribution of wealth and other social resources. The uneven distribution of economic and social resources, in addition to other factors render certain bodies more vulnerable, precarious, and powerless, as they continue to struggle for equity and survival.

In this case of Gurage people, the Ethiopian government, has claimed and enacted multiple levels of intercessions through policy initiatives, front line medical interventions, and public health outreach. These have all been relatively ineffective in reducing health disparities. Another theme that I found important in various school of thoughts was the pervasiveness of ethnic dominance both within the country and the community (Bourgois and Schonberg, 2009). It is noteworthy that even in an absence of other forms of power, many participants in the community had their power restricted through processes of racialization and through poor socioeconomic conditions (Bannerman et al., 1993). Racial discrimination and related inequalities are also embodied and can cause intergenerational health harms.

It is also crucial to look at health equity as a social justice and economic issue (Evans and Stoddart, 1990). The impact of the lived social conditions of some minority group's impact not only morbidity, but also who is subsequently blamed for these morbid circumstances in the first place (Dhamoon and Hankivsky, 2011). Economic growth, while necessary, is not a

sufficient condition in itself for achieving equitable health. There is a growing need to develop a more complex framework that outlines the steps to be taken to create a more subtle yet complex method to reduce health disparities among populations. The development of such type of complex framework helps us understand ones health that's away from the traditional way of treating the categories of determinants of health as homogeneous variables (Carastathis, 2015). Because it accounts both material and relative poverty as important determinants of health, that each contribute independently and synergistically to health outcomes in various ways (Poland et al, 1998).

Another key point that came up by Conrad (1985) was the notion of stigmatization. This is relevant to this research, as I am looking at discrimination and marginalization among people of Gurage and how that serves as a barrier to attaining modern healthcare services. Similar to patients required to take medication in order to curb epilepsy in Conrad's piece, patients with eye problems also have to take medications and seek medical attention, especially if their condition is severe. However, most incidences show that this group of people prefer to use traditional medicinal treatments because of poor perception and acceptance of traditional medicine practice among healthcare workers and the stigma associated with it (Balcha, 2014). In other words, stigma exists when prerequisites such as status loss, separation, stereotyping, and discrimination (racism, ableism, etc.) occur simultaneously in a power situation that allows them to function (Poland et al., 1998).

Link and Phelan (1995) argue that stigma occurs in its usage -- the way it is utilized by those who are in power over those who are weak, or have less power. One of the concepts that stood out for me was the notion of 'structural discrimination', that focuses on institutional racism, which "refers to accumulated institutional practices that work to the disadvantage of racial minority groups, even in the absence of individual prejudice or discrimination" (p. 372). There is stigma around certain types of THs and traditional medicine practices in which some illnesses are given more/less importance than others, depending on who is experiencing them based on their class and status. Hence, there is a sort of uncanny structural discrimination within stigma itself (Chrisler et. al 2017).

What this means is that the reason certain traits or conditions are stigmatized is due to insufficient social conditions of interaction. In other words, stigma related to health and deviance, can be explored from the point of conflict as well as interactionist sociology. As such, stigmatisation can be connected to both exploitation and oppression. As a matter of fact, Scambler quotes Young's (1990) modes of oppression, which states that "not only exploitation but marginalisation, powerlessness, cultural imperialism and violence" impact some groups more than others (p. 453). This aims to explain why certain groups or individuals experience shame and blame in comparison to those that do not.

In the past few decades, medicine is increasingly replacing religion and law as an institution of social control. Zola (1972) argues that this has led too much of daily life being medicalized. He cites examples such as the medical profession's role in determining whether individuals on trial use "good practice" and "accepted modes of treatments". Strong (1979) argues that individuals have the choice to go to the doctor, follow prescriptions and can choose not to return to the doctor if they do not like the medical approach. However, Strong's (1979) argument willfully ignores that many individuals do not have total freedom to determine whether they want to seek treatment or be subject to treatment. Seniors with dementia, individuals suffering mental health problems, marginalized and vulnerable individuals do not have "bourgeois freedom" over their health. (Chrisler et. al 2017). It is essential to critically examine the role of medical institutions and how it exerts power to govern and discipline individuals' behaviours within a social system (Zola, 1972; Conrad, 1975). Many of these scholars have highlighted the importance of analyzing the dark and detrimental side of medicalization against culture. Furthermore, medical institutions are becoming more complex analytic to sociological concept that highlights the social construction of medical diagnosis and illness categories and how it becomes a form of social control and disciplinary regime by undermining the role of culture in one's society (Chrisler et. al 2017).

I found the debate around health inequity, marginalization, stigma and culture all relevant to this research in regards to the state's use of supporting institutions to control the population for the purpose of power and political reasons. Although the focus of this paper is not on the power of politics, I would like to mention that its use as a form of soft power by the state

to control what's right and what's wrong. Conrad's (1985) article seemed to confirm what I believed about the state's role in managing society for the purpose of its own benefit. Strong's (1979) perspective on the constraining role of capitalism has allowed me to think about politics paternalism. Strong stated that certain groups, including the poor and marginalized, would not come under the domain- the medical system because there would be no potential profit in treating them.

In general, in Ethiopia, the social determinants of health – employment, literacy, income – among other things within the Gurage people is lower in comparison to other races living outside of the region (Addis et al., 2002). Experiencing the low-end of these social determinants means embodying an increased rate of health inequities and facing significant health risks/illnesses. These provides a wider context such that correlations between health inequities and identity categories that are suggestive of underlying political, economic, and social causes that have served to reify inequities between groups of people. (Courtright, 1996). Therefore, a social determinants framework is prevalent to unpack health disparity within social relations and historical context that underlie identity construction. The social determinants of health can also be looked at to determine the primary causes of health inequalities among vulnerable populations (Xue et al., 2007). In this paper, I take up this call by studying MVGs, specifically, the Gurage people of Ethiopia.

2. Background

2.1 Traditional Medicine

In this paper, I will examine (a) the role of traditional medicine in the eye care delivery system and (b) the degree of integration between TM practitioners and modern medicine in Gurage zone. I will situate findings in relation to the social, and cultural context of health in the region. In African traditional healthcare systems, the use of plants and animal products for medicinal purposes has long been an important part of the healing tradition. This ancient therapeutic approach continues to benefit many communities, and has contributed greatly to Western medical practices (Balcha, 2014). The World Health Organization (WHO) defines traditional medicine (TM) as "health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises,

applied singularly or in combination to treat, diagnose and prevent illness and maintain well-being" (WHO, 1996, pp. 3). According to Kassaye et al., (2007), "It is likely that the profound knowledge of herbal remedies in traditional cultures, developed through trial and error over many centuries, along with the most important cures was carefully passed on verbally from one generation to another. The use of medicinal plants as a fundamental component of the African traditional healthcare system is perhaps the oldest and the most assorted of all therapeutic systems". It is well also known that many continents in addition to Africa, such as Asia and Latin America use traditional medicine to meet some of their primary health care needs.

In Africa up to 80% of the population uses TM for primary healthcare (Balcha, 2014). Over one-third of the population in developing countries lacks access to essential biomedical and pharmaceutical medicines (WHO, 2001, pp. 318-327). Using institutions involved in health promotion and education, and aspects of TM, it's possible to produce a more efficient use of domestic medical resources, and enhanced self-sufficiency in resources in poor countries such as Ethiopia. The provision of safe and effective traditional medicine and/or complimentary alternative medicine therapies (TM/CAM) could thus, become a critical tool to increase access to health care and reduce health inequalities (Bannerman et al., 1993).

African traditional healing traditions have existed for centuries. In most regions of rural Africa, the local community finds affordable healthcare through traditional healers. This is sometimes the only healthcare option available (Abdullahi, 2011). Traditional medicine practices include the practical skills and knowledges that are based on experiences and beliefs that are indigenous to various cultures. TM is believed to improve and sustain health, diagnose, or offer treatment to different types of diseases in the human body (Abdullahi, 2011). Most countries in sub-Saharan Africa have the highest ratio of traditional healers (THs) compared to the Northern parts of Africa and other regions of the world. Practitioners include a range of healers such as diviners, herbalists, and medicine men among others. It is impossible to isolate traditional African healthcare practices from religion since most of the healers are also priests, community religious leaders, and high priestess (Miselles, 1998).

The idea of culture, spirituality and religion is especially important to African wellbeing, since it incorporates different social, and historic settings of health services

(Bannerman et al., 1993). When analyzing the effect of culture, value systems, and religion on one's wellbeing, it's important to stress that these factors keeps on influencing individual patient care choices, gender roles and differences which can influence health outcomes (Kassaye et al., 2007). Similar to Ethiopia, the role of THs in many African countries such as Benin, Cameroon, Chad, Cote d'ivoire, Gabon and Mali is enormous (Addis et al., 2002). Although, the practice of TM and modern health practice coexist and continue to bring more positive outcomes, the level of understanding of health and disease among THs healers need to be gaged in order to enhance the soundness of their treatment guideline (Edwards et al., 2008). In light of the advantages of customary TM, numerous Asian, African and South American nations have permitted the advancement of a dual system of medicinal care in which people can pick whether they visit TM or Western model facilities (Lambert, 2011).

Traditional medicine (TM) has maintained its popularity in all regions of the developing world and its use is rapidly spreading in industrialized countries. In China, for example, traditional herbal preparations account for 30%- 50% of the total medicinal consumption (WHO, 2005, pp.1-12). For many developed countries, there is a phenomenon of increasing traditional /complementary alternative medicine (TM/CAM) popularity. In Australia, for instance, it has been demonstrated that about 68% population used TM/CAM at least once in 2005, relative to 52% in previous Australian studies (Xue et al., 2007). There are two additional factors that contribute to the rising TM/CAM popularity in developing countries: (1) accessibility and (2) affordability when compared to allopathic medicine. There are healers in almost every village in Africa; the estimated healer per population ratio is 1:350. On the contrary, it is estimated that in the year 2000, Africa had less than one ophthalmologist for every 500,000 people. Asia had one for every 200,000. In Tanzania, Uganda and Zambia, the ratio of TM practitioners to population is 1:200-1:400 which contrasts starkly with the availability of allopathic practitioners, where the ratio is approximately 1:20000 or less (Mhame, 2000).

Respect and strong faith is given to THs who offer health services to people in rural areas that lack modern medical services. According to Courtright (2000), traditional healers in Africa are respected by the community, partly because of their acquired knowledge, their age, their ability to provide answers and treatments that are meaningful to the community, and their

position as the moral core of the community. Their moral influence is strongest among older adults and the elderly. There are significant gender differences observed in the activities of male and female healers. While male healers treat children, women and men; female healers tend to treat primarily women and children. Some female healers also serve as traditional birth attendants (Addis et al., 2002). The cost of traditional medicine is variable, depending upon the nature of the treatment, the kind of disease being treated, and the relative wealth of the client as perceived by the healer. High cost is generally associated with measures to bring good luck or to treat infertility and sexually-transmitted diseases (Courtright et al, 2000). Diagnoses are based primarily on discussing the patient's history or through interpreting dreams, rather than on physical examination. Sorcery and witchcraft are commonly proposed etiologies (Courtright et al, 2000).

In Ethiopia, the vast majority of the population lives in rural areas where healthcare coverage is low and existing public sector resources are stretched to the limits. Hence, in Ethiopia, up to 90% of the population uses TM due to the cultural acceptability of healers and local pharmacopeias, the relatively low cost of TM and difficulties in accessing modern/Western health facilities (Lambert, 2011). Ethiopian healers are more commonly known as Traditional medical practitioners. Before the onset of Christian missionaries and Westernized medicine, TM was the only form of treatment available. Traditional healers extract healing ingredients from wild plants, animals and rare minerals. Largely because of the costs associated with modern health practice, TM continues to be the most common form of medicine practiced in the region. Many people living in rural areas are believed to be unemployed or have little/no income which makes it challenging to pay out of pocket for most Western medicinal treatments (Kloos, 1974).

As stated by Pankhurst (1996), in Ethiopian culture, there are two main theories for disease etiology. The first is attributed to God or other supernatural forces, while the other is attributed to external factors such as drinking unclean water and eating unsanitary food. Most genetic diseases or deaths are viewed as the 'will of God'. Ethiopian TM is heavily reliant on magical and supernatural beliefs that have little or no relation to the actual disease itself (Pankhurst, 1996). Many physical ailments are believed to be caused by the spiritual realm which is the reason why healers are most likely to integrate spiritual and magical healing techniques.

Traditional medicinal practice is strongly related to the rich cultural and religious beliefs of Ethiopia, which explains the emphasis of its use.

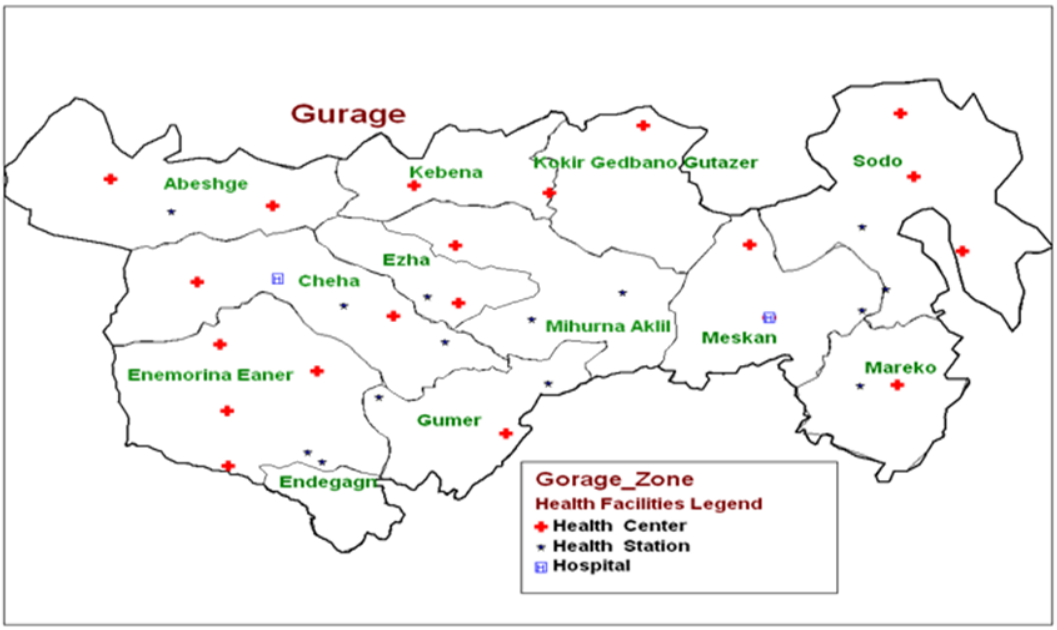
Treatment for eye diseases with THs is generally less expensive than Western medical practice. Healers use a variety of products (plant, animal, etc.) to make decoctions for face washes, "fume baths" and for direct application to the eye (Courtright et al., 2000). Scarification (tattooing) is often performed as a preventive and curative procedure. There is limited information on specific traditional eye practices and/or traditional eye medicines and almost no information exists on the traditional eye care activities of traditional eye healers. Products used to treat diseases vary from city to city and healer to healer. According to Courtright et al (2000), there is no inventory of traditional eye medicines (TEM). No investigations have been carried out to determine the most commonly used products, those that are particularly harmful and those that might have curative properties. As different parts of plants (leaves, bark, roots, etc.) and animals are being used in different ways, understanding the properties of specific traditional eye medicines will be complex. The complexity is increased because TM is dynamic, changing with the cultural, political and economic environments of the setting in which healers live (Pankhurst, 1996).

Having recognized the significance of TM more readily, greater attention has been paid by governments of many developing countries in recent years to promote the widespread application of the practice in health care. This has given a new impetus to relevant research, investment and design of programs in TM dominated areas in many countries. For instance, The Organization for African Unity (OAU) decision on the decade of TM was made in 2001. The First AU Session of the Conference of African Ministers of Health, which was held in April 2003 in Tripoli, Libya. It adopted the plan of action and implementation mechanism which was endorsed by the AU Summit Heads of State and Government in Maputo in 2003. Recognition, acceptance, development and integration of TM by all member states into the public health care system by 2010 were the main objective of the plan (WHO, 2003).

2.2 Gurage People: Ethiopia's Afro-Asiatic Society

Gurage people are Semitic-speaking, agriculturalist ethnic groups. They are considered one of the richest regions of Ethiopia because of its agricultural and natural resources.

According to Abdullahi (2011), these people are believed to be the Afro-Asiatic ethnolinguistic group inhabiting the fertile and semi-mountainous region some 153 miles South and West of Addis Ababa, Ethiopia. According to 2007 national census, Gurage people make up an estimated population of 1,867,377 (or 2.53% of the total population of Ethiopia) or 7.52% of the Southern Nations, Nationalities, and People's Region (SNNPR). Ethnically, while the Gurage people consider themselves as one homogeneous people, there are 11 dialects spoken by the people (Addis et al., 2002). Although they are divided into several sub-groups, the three main sub-groups are the Sebat-bet Gurage found in the Western part of Gurage land – the two other sub-groups being the Northern Kistane cluster and the Eastern Silte-speaking cluster. The Gurage's have their own unique culture, history, language, and civilization. These are diversified not only in their linguistics, but also in their cultures, norms, and traditions (Kassaye et al., 2007). Other regions of Ethiopia like, enjoy, and share their traditional foods and dancing. Gurage people are well-known for their hard working traditions particularly for their skilled trading within and among other regions. They are well recognized and respected as they are one of the best examples of trade success around other parts of Ethiopia.



Administrative woredas of Gurage zone along with the health facilities

A typical house in Gurage region is made of mud and with a wooden spokes which are built in a perfect circle around a central pillar. Some of them have two stories and can be quite

cavernous inside. Many people in the Gurage region are notorious for taking lots of pride in their dwellings and will paint them or landscape them with flowering plants and bushes (Mesfin et al., 2014). Locally-made pottery and animal remains such as horns hangs around the inside wall in neat rows. Often a small section on one side of the house is equipped for livestock (cows, sheep or goats, and perhaps a horse), which are kept in the house during the night. Gurage people speak Guraginya or Gurage languages which belongs to the larger Afro-Asiatic, Semitic language phylum. Guraginya is related to Geez (and subsequently Amharic and Tigrinya).

A well-maintained Gurage house

In an overt observation, Gurage people are socio-economically disadvantaged. They live a sedentary life based on agriculture, involving a complex system of crop rotation and transplanting. Ensete (also enset, ensete edulis, äsät or "false banana plant") is their main staple

crop, but other cash crops are also grown, which include coffee and chat (Abdullahi, 2011). After a minimum of seven years of cropping an ensete, Kocho, which is a common product of ensete is prepared to serve as a source of food for the family. Kocho is made by shaping the ensete paste to a thick circle and wrapping it in a thin layer of ensete leaves. Sometimes the paste is just cooked over a griddle. Kitfo-- a minced raw beef mixed with butter and spicy pepper is commonly attributed to the Gurage people. Animal husbandry is practiced, but mainly for milk supply and dung (Abdullahi, 2011).

Gurage people sharing their traditional food (Kocho, Kitfo and Yougurt)

When it comes to basic family structure, Gurage people have extended family members which are much larger than the typical Western nuclear unit. For majority of the time, men are the oldest of all family members and are considered as the head of the household. They are responsible for major decision making, providing the family with basic necessities and are in charge of all money transactions. The men spend most of their time on farming and socializing with their peer groups. Women are responsible for domestic activities such as cooking, cleaning and taking care of children. Although the father is seen as an authority figure, majority of the work other than farming lies on the shoulder of the women. At a certain age, children are required to take over their father's role in taking care of the family even if the father is still at his working age. For these reason, children often live far apart from their parents to urban living at a very young age. Not only that Urbanities children have a far more responsibility in supporting their family who live in rural regions, they are also considered less successful if they are unable to relocate their whole family to urban places.

Gurage region poorly developed roads

Although, Islam is the majority religion (60%) followed by Christianity (40%) in Gurage region, there are parts of Gurage people who do believe in Supreme Being and a Creator god called "Waq" (Sky God). According to Mesfin et al. (2014), Gurage people participate in traditional religious practices such as offerings to Waq, their supreme deity. “They hang effigies of ancestral gods in their houses to ward off evil spirit. Evil spirits are strongly feared for their possessions and causing bad health or even death to people”. A ritual illness that affects particularly men are called Awre. If this happens, breathing is often labored. Seizures and trembling overcome the patient, and in extreme cases, even partial paralysis of the extremities. If the symptoms doesn’t subside in few days, the evil spirit is given a name through a ritual called divinitation and a traditional healer will be called up on. The TH will exercise customary exorcism practices to expel the evil spirit. The process ends with the evil spirit announcing to leave that person after being satisfied with the food provided to it and being treated fairly.

The first and newly built Mosque constructed with concrete

Majority of the population live under absolute poverty with little/no sustainable income and access to resources. In spite of the Gurage region being close to the capital city, Addis Ababa, it's far more marginalized than the rest of the surrounding cities. The Ethiopian new development strategy to eradicate poverty faces even more daunting challenges in the social, economic and political sphere in this particular region (Roba et al., 2010). The government's effort in trying to solve the complicated socio-economic as well as political problems, has compounded its woes. As if the chronic social and economic problems from which the region has suffered are not enough, disease (whether it be malaria, mental illness or the new pandemic, HIV/AIDS) is ravaging the region and wiping out the most productive sectors of its population. These conditions may arise not only from scarcity of resources but weak governance of the state (Lewallen, 2001).

These poor social conditions have an association with disease because they involve access people have to resources to avoid risk or ill health including money, power, social support, social network and prestige. While many people assert that Gurage people have greater natural resources than others, they do not acknowledge that poor social and economic structures can also play a huge role in population's health. This lack of awareness may be due to the focus exclusively on disease rather than health. Furthermore, as how social conditions are conceptualized is so important to understandings of Gurage people's health. As Shim (2010) highlighted, epidemiologists understood a relationship between social and economic conditions and their strong relations to poorer health outcomes. However, many of the Gurage people perpetuated stereotypes regarding making unhealthy life choices (such as the use of TM) rather than understanding the underlying issues for their choices and poor health outcomes.

Gurage Children

3. Literature Review

In this paper, since the goal was to understand the role of TM in relation to eye health care in Ethiopia, and its increasing public health concerns, I began by searching for articles and reports listed under several scholarly websites. For the purpose of this study, journal articles and a computerized database search on psych INFO, web of science, UN Global Issues and annual reports were conducted. I used “traditional medicine”, “eye health care”, “eye care in Ethiopia”, “traditional healers” and “traditional health beliefs” as major subject headings. Like a stone

thrown into water, the impact of using herbal and scientifically unproven practices to cure various types of illnesses, has immediate and direct consequences. Progressively, the waves will be transmitted directly or indirectly to a large group of community with the vast majority of such practices making children more vulnerable (Hadi, 2017). The impact of "traditional medicine" can also be studied further for other immeasurable factors. Based on the practice of TM and the impression of using THs, I have included articles that met my criteria regardless of the year, place of publication, and the field of publication.

Developed nations have observed the rising trend in alternative medicine, especially the use of herbal medications. Examples of herbal medications consist of herbs, materials containing herbs, and products made from herbal products, which have herbs as the main ingredient (Abdullahi, 2011). Cultural and economic factors have been attributed to the wide use of traditional medication in most of the countries in Africa. Research findings from different sources show that developed countries such as Canada and Germany have about 70% of the people using traditional means of medication while Ethiopia has about 90% use of herbal medication as major health care (Addis, Abebe, Genebo, and Urga, 2002).

Below are some studies carried out in various countries describing the role of traditional healers and traditional medicine practice; rationalisation on why some communities tend to rely solely on TH practices; and if stigma plays a role in TH practice.

Balcha (2014) used both qualitative and quantitative research methods in the rural areas of the Oromo people, Ghimbi District, on the southwest of Ethiopia. The quantitative study considered 50 traditional healers. Some of them identifies as 'doctors of the eye' and offered treatment for various eye illness, as well as other complications in the body. Under the qualitative research, key informants were selected by a non-probability purposive method. Interviews were done with traditional healers on a one-on-one basis considering how diseases that affected the eye were diagnosed and treated. The results showed that, out of the 50 traditional healers that were considered in the research, 10 of them had been practitioners for over 20 years, 20 of them had been practitioners for between 15 to 20 years, and 10 were in the field for 10 years while the rest had been practitioners for less than 10 years with no formal education. Eye diseases that were treated included; cataract, trachoma, and glaucoma among

others. The researchers concluded that, as a result of poor accessibility to health services, more so in the rural parts of Ethiopia, there is a high dependence on traditional medicine for the purpose of primary health requirements. However, traditional medication has been neglected in terms of therapeutic capabilities while adverse conditions have not been fully studied scientifically.

A study was carried out on traditional eye medicine in Nigeria to assess the method of diagnosis and treatment among THs. According to the research that was conducted in Benin-City, Edo state in Nigeria by Ebeigbe, (2013), three areas were randomly selected which included; Egor, Oredo, and Ikpoba-Okha. About one hundred traditional healers were engaged to undertake the research (Ebeigbe, 2013). About seventy (70) of the total number were known to be traditional eye doctors who are responsible for treating various eye conditions including other diseases. Interviews were with each traditional healer in relation to how they conducted their diagnosis as well as how they treated people with eye diseases (Ebeigbe, 2013). The traditional healers were visited in the places where they consulted their clients and data collection included structured questioners that consisted of open ended questions as well as oral interviews. The results found out that about 46% of the traditional healers used the history of patients as an important means to diagnose patients as compared to the physical examination of the eye (Ebeigbe, 2013). On the other hand, about 50% of the participants considered both physical examination and history as important. Among them, about 30% used the inversion of the upper eyelids to conduct their physical examination. The traditional healers treated all types of redness of the eye as conjunctivitis while any alteration from this seemed complicated for most of them (Ebeigbe, 2013). Some of the traditional healers argued that they were able to treat cataracts through offering different kinds of herbal concoction till progress is achieved while others referred their patients to hospitals.

A recent study by Gupta et al. (2017) determined the type and nature of traditional eye medicine (TEM) and use and practices related to self-medication for ophthalmic diseases in a rural Indian population. The researchers employed a population-based cross-sectional method to randomly select 25 rural regions in India. The findings indicated that, of the total 2160 participants' interviewed, 396 (18.2%) reported using ophthalmic medications from THs or

relatives without consulting an ophthalmologist, mainly for symptoms like watering (37.1%), redness (27.7%), itching (19.2%) and infection (13.6%). Twenty-six percent (26%) participants were practicing self-medication with medications that are known to work or by borrowing left over medicines from nieboughers and family members. The authors concluded that the rural regions of India use of TEM was prevalent and well-recognized.

We should also emphasize the role of poverty in shaping health inequalities through a SDOH approach. There is a social gradient embedded in health. For instance, individuals located further down the social ladder tends to have lower life expectancy and are more susceptible to diseases. The health inequities are determined by uneven economic arrangements and poor social programmes. Therefore, those people who have poor living conditions experience higher levels of health inequalities, more disease, and premature death. The empirical evidence presented by Marmot (2005) highlights how health inequity and disparity are shaped by social structures and processes, particularly the uneven distribution of wealth and other social resources. On the one hand it's vital to conceptualize the social and environmental determinants of health in considerably spreading the utilization of unapproved and easily accessible traditional medicines. On the other hand, it implicitly emphasizes the potential deficiencies embedded in poverty and only come to surface by allowing poor frameworks excluding certain groups of people (THs and its users).

The link between the use of TM and lower socio-economic status (SES) was studied by Shih at al., in 2012. The study was carried among children and adolescents of Taiwan to determine the association between SES and TM use. The researchers employed a National Health Interview Survey that included 5971 children and adolescents in Taiwan. The study found out that there is a high use of TM among the participants that are under the category of lower SES curve. Although the study used a large, nationally representative survey, it has some limitations. The responses to survey questions were mainly dependant on the participants parents recall ability, willingness to report and accuracy of the information provided. Additionally, because the study was cross-sectional in nature, the authors were unable to determine for certain whether the parents of the children are the real cause of TM use in children.

A similar study was observed in Enugu State by Stella et al. in 2013. The objective of the study was to find out lower SES such as safety, reliability, effectiveness, availability, cost, and other factors influence use of TM. A cross-sectional survey using 21-item questionnaire consisting of socio-demographic and stem questions that have been standardized and validated for reliability of response was used. There was a 75% response rate among the selected participants. Twenty-six (12.7%) of the respondents had at least primary education, while 16% used traditional medicine because it is cheaper and 31.3% because it is believed to cure many diseases including mental illness. The study showed that 19.1% of the respondents were without formal education and 79.9% with at least primary level of education use TM. They also found that there was a significant relationship between TM use with age, occupation, educational level, family setting and religion. The researchers concluded that socio-economic factors such as cost, effectiveness, availability, safety of the product, educational level, income, age and sex affect the patronage and use of traditional medicine.

In most cases, traditional healers use medicinal substances which were first diluted in water before using them for the treatment of the eye. Additional herbal and non-herbal substances which caused pain and irritation were also used since these substances were perceived as a proof of potency. Some of these substances may be alkaline or acidic and caused visual burns. Attention was not made in terms of the substances dosage, action, keenness on concentration and sterility (since the substances are mixed and prepared without any concern for hygiene) (Ebeigbe, 2013). This has resulted in some patients suffering more or becoming blind in the long run. The study of Carvalho et al., carried out a study in 2009 that investigated the practices of self-medication and the use of home-made herbal products by THs for the treatment of ocular diseases. They conducted the study using a cross-sectional analytic survey of consecutive patients seen in the ophthalmology emergency room of a teaching hospital. Their sample included 561 subjects, where 40.5% reported self-medicating; 29.4% used a homemade herbal preparation and 11.1% used a manufactured product. According to the authors “the use and application of self-medication were not in any way related to the medically judged severity of the presenting condition or the pain level of the patients”.

Similar to other developing countries in Africa, Tanzania has a high demand for eye care (Maregesi, & Kauke, 2016). There is high dependency on traditional eye medicine for the treatment and care of eye diseases. This could be attributed to the presence of very few ophthalmologists, lack of money to buy required medicine as well as distant health facilities to the larger population. The biggest challenge is the use of traditional medicine and methods applied for diagnosis and treatment which may result in worse health conditions that may include blindness. In an ethno-medical study that was carried out in Kigoma district in Tanzania by Maregesi, & Kauke (2016), traditional healers as well as individuals with some knowledge in medicinal plants were interviewed. The interview was based on various eye treatments for eye diseases and was done in their homes by the use of questionnaire. The languages used were Kiswahili and vernacular for reliability in the information collection. It was found out that different plant types were used so as it was believed to offer treatment and cure for the eye. Little awareness of the health risks associated with traditional eye was discovered and little was done in terms of managing their pain and follow-up after administration of the treatment.

Another relevant study was performed in Atyak sub-county, Nebbi district-Uganda by Nyathirombo & colleagues in 2002. The researchers wanted to analyze how wide-spread the use of traditional eye health practices were among the community and what factors determine people to use them as a treatment option. Both quantitative and qualitative studies were conducted. In the quantitative study, 824 heads of households from 42 villages selected by multistage cluster sampling method were orally interviewed and their responses recorded onto pre-tested questionnaires. In the qualitative study, a non-probability purposive sampling method was used to select key informants and focus group discussions. Fourteen traditional healers and 19 other key informants were interviewed in total. Six focus group discussions were held to collect information from the community. The study revealed that about 44% of head of households in Atyak community used some form of traditional eye health practices. The reason behind the wide prevalence of using traditional eye practices were attributed to; false beliefs about causation and cure of eye diseases, their readily availability, cheapness, influence of social groups, trust and confidence in traditional healers and presumed failure of modern medicine to cure eye diseases. The researchers also found out that plant extracts were the most commonly used practices along with other forms of rituals, human saliva, breast milk, soil, steam baths, surgery

and animal products in which some extracts and practices were potentially harmful to the eye and vision.

There is also some degree of linkage between shame, stigma and exclusion (marginalization). Labelling arises in the process of stigmatization, as social facts become attributed to bodies marked as deviant (Scambler 2009). We can understand how stigma attributed to THs and the mechanism of exclusion comes to exert a form of structural violence. Not only it results in a status loss for THs as they come in contact with structural barriers that limit the practice of healing, but also encounter stereotypes that are shared in the use of modern healthcare centers during interaction. The stigmatized group then is a lived experience of the complex relation between stigma and discrimination, as they move within society. This stood out to me, because it makes me wonder if there is a possibility for medical practitioners to also become the "wise" and provide a more nurturing social context for their patient's (THs) experiencing stigma.

Kaboru et al, in 2006 conducted a cross-sectional study in two Zambian urban sites that supports the above claim. The authors explored biomedical and traditional health practitioners' experiences of and attitudes towards collaboration and to identify obstacles and potential opportunities for them to collaborate regarding care for patients. One hundred fifty two health practitioners and 144 THs were selected for the study. As a result, the study found out that there is a very low level of experience of collaboration, predominated by HPs training THs (mostly traditional birth attendants) on issues of safe delivery. However, both groups of providers overwhelmingly acknowledged the potential role of TM in reducing the spread of many diseases, lack of trust between THs and HPs was found to inhibit the collaboration. Although there is a growing indication that both parties want to collaborate and work together, the lack of a real collaborative framework integrating THs with the healthcare system was at odds with the needed comprehensive approach to disease control.

4. Statement of the Problem

Across time, space, history, culture, and personality, there is one thing we all have in common. There is one thing we all seek: health. Yet many people define health differently and many seek different paths to reach it. Some cultures have all that society covets, and still don't

experience health. While others have none of it, and yet feel deep well-being (Mesfin et al., 2014). Guided by a social justice agenda, it's important to attempt to unpack how health is constructed in order to fully understand the extent of social relations and the historical context through which an identity category comes to be. Effort should be made to understand the interconnection between systems of oppression. The identification of these factors could lead to further focus on why some of experience true health and others do not, and the provision of ways through which the health effects and implications of the factors could be mitigated for the benefit of the MVGs.

With large percentages of marginalized and vulnerable minorities across Ethiopia, it is simply not wise for the study of the practice of TM to be intentionally ignored. The Gurage population of Ethiopia is one that suffers massive degree of poverty which has one of the higher rates of morbidity and mortality rates. This is more evident in individuals located further down the social ladder that tends to have lower life expectancy and are more susceptible to diseases. These highlights the importance of social and economic determinants of health and how health inequities are determined by uneven economic arrangements and poor social programmes. Therefore, those people who have poor living conditions experience higher levels of health inequalities, more disease, and premature death. Broadly speaking, the qualitative lived account of Gurage people and how poor social conditions result from austerity practices are directly linked to the lived experiences of persons in a given space, especially those deemed minority groups. Therefore, the identification of the factors that could lead to further focus on why ill-health arises in the first place, the understanding and role of traditional medicine in the provision of ways through which the health effects and implications could be mitigated for the benefit of Gurage population is crucial. There are five key reasons (elaborated below) that this study is timely and important.

First, as traditional medicine is the first level of contact for rural people when they require medical care, it is imperative for governments to take immediate steps to introduce the use of safe traditional medicine to supplement primary healthcare. Governments should provide conducive environments and best approaches needed for the development of safe traditional medicine practices to its people (Lewallen, 2001). Second, psychological, social, cultural,

political and economic factors generally influence how people use health services; eye care services are no exception. In the last two decades, there has been a significant rise in the use of TEM worldwide, even though there is no sound scientific evidence to justify the use of TEM. According to Theorode (2008), "Approximately 80% of the population from the developing, as well as the developed countries, use traditional services for diagnosis, treatment, prevention of diseases or maintenance of good eye health". With growing numbers utilizing TM, it's important to study its contribution to one's society.

Third, use of self-administered eye drops for ophthalmic conditions is a common practice in rural populations. The use of self-administered therapy in cases of ophthalmic disease can delay institution of effective therapy and negatively impact visual outcomes. It has been reported to be "an expected outcome of a malfunctioned health care system with poor accessibility to quality eye care services" (Roba et al., 2010, p. 27). Understanding attitudes and practices related to self-treatment in relation to access to modern health centers in the Gurage population can provide insight on how to better serve these marginalized groups of people. Forth, Ethiopia records trachoma as the second leading eye disease. It is most common among young children between the ages of 1 to 9 years. At any single time, the percentage of active trichomia disease in children attains a percentage that is about 50 % of the total population affected (Roba et al., 2010). The results of various studies, women contribute the largest percentage when it comes to the total number of people affected by trachomatis trichiasis as well as consequent blindness caused by corneal scarring (Edwards et al., 2008). While the prevalence of trachoma is the same for both boys and girls, it tends to be more active in adult women as compared to adult men, most likely because of their frequent interaction with children. In some regions, the case of trachoma is holoendemic, affecting most of the children with active trachoma and so affecting adults displaying signs of conjunctival scarring (Mutombo, 2008).

Table 1. Comparison of age specific blindness (<3/60 better eye presenting) prevalence rates (per 1000 population) in Jimma and Gurage, Ethiopia

Age group	Jimma	Gurage	Excess blindness in Gurage
40–49	7.16	34.0	4.7
50–59	13.1	66.5	5.1
60–69	83.0	122.2	1.5
70+	175.2	279.2	1.6

Blindness and low vision in Jimma Zone, Ethiopia: results of a population-based survey; Zerihun, 1997

Although it is known that the main cause of trachoma infection is poor personal and environmental conditions, THs use a number of plant extracts to treat patients presenting with wide range of eye problems. A good example is taenicides (Roba, Zondervan, and Patel, 2010). Individuals who also took an overdose of the traditional medicine known as Hagenia abyssinica have repeatedly been found with problems in the central nervous system and blindness (Edwards et al., 2008). Trachoma is easily treatable with Western mode of drugs if presented at early stages. However, because of the widespread acceptance of THs, many people delay treatment and subsequently present with complications which can cost them their eye sight. Cross contamination is also another important issue that needs to be considered while delaying seeking medical attention (Theodore, 2008).

Last but not least, a number of other research findings have also shown that cataracts are the major cause of blindness in Ethiopia. Blindness that results from cataracts is mainly due to a lack of accessibility to treatment (Nwanza & Kabasele, 2001). Although a simple surgical procedure can prevent blindness from cataract, people in rural settings prefer to visit THs in the hope of getting their eye sights restored. But in most cases, what this does is create delays in seeking medical care and results in further complications. The identification of such factors could lead to further focus on why the issues arise in the first place, how to deal with the health concerns raised by such factors, and the provision of ways through which the health

effects and implications of the factors could be mitigated for the benefit of marginalized populations.

5. Research Objective

The purpose of this research paper is to examine the role of traditional eye medicine that may limit the full enjoyment of health. This study grabbed my attention in that, first, the health of communities is tied to the health of individuals. Although, TEM has been variously attributed to individuals as behavioral life style choices, factors such as (a) barriers to access to primary eye care services; (b) success of traditional treatment; (c) a desire to take control over medical treatment; (d) the communication gap between patients and Western model eye care providers; and (e) influence of culture can impact the choice of treatment modality (Scambler, 2009). Second, despite policies and programs in empowering marginalized and vulnerable minorities, significant race-based health disparities remain in many Ethiopian cities and Gurage people are no exception. Third, Gurage people experience higher levels of poverty, unemployment and economic exclusion which led to their extensive health disparity when compared to other regions of the country. Lastly, to this day, Gurage people have pervasive inability to exercise political power by influencing public discourse and policy debate that are directly linked to their health outcomes.

5.1 General Objective

- To understand and examine the role of traditional medicine in the eye care delivery system in Gurage zone

5.2 Specific Objectives

- Determine the role of traditional medicine practitioners and practices (TM) among THs in Gurage Zone.
- Determine the level of coordination between THs and modern healthcare delivery system in Gurage Zone.

6. Subjects and Methods

6.1 Study Area and Period

This study was conducted in Gurage zone, the Southern Nations, Nationalities and People (SNNP) Region of Ethiopia, located 153 kilometers away from the capital, Addis Ababa. There are 15 woredas (sub-cities) in the zone, with a total population of 1,690,745. Sixty eight percent of the total population residing in the region has limited access to health service; 33% utilize the health services available in the region. As to the health facilities in the region, there are 3 hospitals (1 belongs to a NGO), 26 health centers, 13 upgraded health centers and 327 functional health posts. ORBIS International Ethiopia (a non-governmental organization) is the major performer in eye health along zonal health institutions. There are no registered THs identified in any woreda. The study was conducted between December, 2017-February, 2018.

6.2 Study Design

A cross sectional design using qualitative data collection methods was employed to address the objective of the study.

6.3 Population

6.3.1 Target Population

- All traditional healers and trained birth attendants working in the zone
- Health practitioners and health administrators of various health organizations working in the zone

6.3.2 Study Populations

- Ten traditional healers and trained birth attendants working in the zone during the study period
- Seven health practitioners and administration (Zonal Health Offices and Head of NGOs) workers in the region.

6.4 Sample Size and Sampling Techniques

6.4.1. Sample Size Determination

I recruited THs using ‘snowballing’, in which recommendations from one group were used to locate other groups. THs in different parts of the zone were included. Additionally, health administrators working in eye health care delivery were included in the qualitative data collection. I stopped collecting further data, when saturation was reached with the interviews (no new data or themes) (approximately 10 categories).

6.5 Data Collection

I used qualitative methods of data collection. I conducted in-depth interviews with THs and health administrative workers in various organizations. I collected qualitative data using a semi-structured questionnaire. We talked about the role of THs in eye care delivery system. I audio recorded all interviews and took notes to record other verbal and non-verbal cues. A translator was working with me to address language barriers between me and the participants. Additionally, with permission of THs and their clients, I observed the study population at their practicing places.

6.6 Methods of Data Analysis

I analyzed the data using a descriptive thematic approach, a systematic qualitative research methodology emphasizing describing the main themes extracted from data in the process of conducting research. The audiotaped data was transcribed. I made myself familiar through reviewing, reading and re-listening with the help of a translator. I then loaded the translated data into ‘open code’, a computer software for analyzing qualitative data. I read the data carefully, line by line, and divided them into meaningful analytical units. Each meaningful segment was coded with descriptive words. Then I grouped similar codes to form categories. Finally, I ended categorization when no additional significant categories emerge. I identified common themes on the bases of practice, type of service and linkage with modern eye care providers.

6.7 Ethical Consideration

I have respected the privacy and confidentiality of participants and various health organizations. Unless participants choose otherwise, all information supplied during the research was held in confidence. To accurately record participant's thoughts, I audio taped the session and took some notes during the session. All responses were kept confidential. This means that participants interview responses were not shared with anyone. I ensured that any information I included in my report did not identify participants as the respondent. Instead, I used a pseudo name of their choice. Participants did not have to talk about anything they didn't want to and could end the interview at any time. The data was safely stored in a password protected storage space (e.g. google drive). No one had access to this information except for me. Following completion of the research study, the data will be kept for three years and later destroyed. Confidentiality will be provided to the fullest extent possible under Ethiopian and Canadian law.

7. Results: Traditional Healers and Birth Attendants

A total of 10 key THs and experienced birth attendants were included in this qualitative study. Table 2 shows the age and sex distribution of THs in this particular study. The age range was between 34-69 years, with a mean population age of 49.6 years. Five of the participants were Muslims by religion, and 9 of the participants were Gurage by ethnicity and one of them was Amhara. The age group between 41-69 years was the highest frequency for participants that are traditional healers. There were more male participants (6) with a male to female ratio of 1:1.5. Participants with no formal education were predominant (9) followed by participants that have completed elementary school education (1). Eight of the participants are self-employed (farmers), two of them are considered unemployed. Six of the participants live in urban region of Gurage zone in which 4 of them have limited access to media whereas two of them have no access to media what's so ever. Six of the THs earn an income between $1000-1500, two of them earn between $500-1000 and another two of the key informants has an income less than $500 per month (Income per month)

Table 2. Age and sex distribution among traditional healers of Gurage Zone, Southern Ethiopia, December-February, 2017/18.

		Sex		Total
Age Group	Age Group	Male	Female	
	20-40	0	1	1
	41-60	4	3	7
	>60	2	0	2
Total		6	4	10

7.1 Utilization of Traditional Eye Medicine among Traditional Healers

Six of the participants among THs mentioned that they have mostly given herbal medicines while 2 of the participants gave some sorts of animal products in addition to herbal drugs for clients that visited them in the past year. Only two out of the 10 participants had given a Holy Water for treatment of various illnesses. Direct implementation of the herbals/animal products to the affected area was the commonest route of treatment administration by traditional healers. All THs (10) had practiced self-treatment by using traditional medicine of their own or some other TH that they perceived have a better knowledge and recognition than themselves. Self-

treatment was found to be more frequent among THs themselves that have little education no access to health information. Key informants that used self-treatment were also found to be more common for those who are in the older age group (above 40 years), and female participants. In addition, participants living in remote rural areas (5) with little/no access to modern eye care were found to have strong association with utilization of traditional eye medicines.

Eight of THs used traditional eye medicine within the last one year for the treatment of different types of ocular complaints. Out of the ten participants, 7 of them used traditional eye medicine for ocular redness and irritation. "Funafua" was a type of herbal medicine which was utilized commonly to reduce redness and irritation by gently rubbing it on the affected eye. After being prescribed with traditional eye medications, 4 participants claimed their patients were back for worsening of the presenting eye symptoms. Half of THs who used traditional eye medicine to treat their clients, pointed out that the presence of stigma among healthcare providers, the cost of modern medical treatment and distance of health centers as a major reason for their clients to frequently seek their services. Two other participants mentioned other cultural and societal beliefs for clients utilizing the TEM.

7.2 Traditional Healers and Traditional Practices

7.2.1. Background of Traditional Healers

Ten traditional healers participated in this study; 6 males and 4 females. They had been working as THs for between 8 years and more than 40 years. According to the cultural and spiritual practice of the region, THs are classified into three groups based on their experience on traditional medicine practices and treatment approach. The first group that consisted of two THs belongs to those groups that are believed to practice TM based on some type of supernatural power. They are called "Shegore" (literally meaning Witch doctors). The second group consisting of five THs are those groups that practice TM with reference to various religious books, are called 'Weliye' among the Muslim population (meaning friend of Allah) or 'Holy Water' for Orthodox Christian followers. The third group belongs to three THs who are experienced birth attendants.

These first two groups claim that God choose them to serve and help their community. The Shegore's and Weliye's are very much respected and sometimes worshiped by the community since they are considered as "a mercy from God to the people". They are also not just THs with supernatural power but also are the law and order of that specific society. They are the leaders of

the community in every aspect in which each and every member of the community should follow and obey their rules. If any one of the community members went astray and disobey the leaders, they have the power to curse and punish members. The cursing and punishment might extend from excluding the member from any type of social activities and gatherings, curse their offspring's (born and unborn), and if they are farmers (or traders), no one from the community is allowed to buy their product. Finally, they will be forced to leave the community and migrate to a different location. When a respected community leader pass away, a common ritual ceremony to cherish the work and legacy of that person will be held. After the funeral ceremony is completed, although many people believe that the person's soul will be going to paradise, a prolonged prayer for at least three consecutive days (depending on the leaders' religion) will proceed. A yearly memorial, where thousands of people gather and remember the leader's legacy as a TH and community (religious) leader will then follow every year.

7.2.2. Training and Experience on Traditional Medicine

The former two groups of THs (Shegore and Weliye (Holy Water)) did not receive formal or informal training from any party on the safe use and practice of traditional medicine. They are the 'all-knowers' of the community with a supernatural power to cure most diseases. Most people do believe their potential in curing diseases such as HIV/AIDS, paralysis, cancer, mental disorders and others. Because of this, they become famous even outside of the region they reside. People will travel from a very distant and remote locations to find cure for their physical and mental illnesses. Although many Shegore's and Weliye's genuinely believe they have been given supernatural power to heal diseases, there are others who just use their name for the benefit of gaining profit and personal fame. They trick people into believing that they can cure anything and everything under the sun and make them pay beyond what they can afford. Some give their homes and others give themselves as a slave to the master because they have nothing to give. Because such types of cheating and stealing are becoming a common practice in recent days, the state is putting more and more of these people in jail. Because there is no clear evidence which Sheroge's and Weliye's are genuine and which are not, it's also negatively affecting the community which can benefit from their service.

Birth attendants are also huge contributors of the community by helping mother and children with their expertise. Because there are no nearby health centers in many parts of rural Gurage, the demand for birth attendants is very high. According to USAID (2007) report, "Ethiopia has one of the world's highest rates of maternal deaths and disabilities in the world. Women have a one-in-52 chance of dying from childbirth-related causes each year. More than 60 percent of infant and 40 percent of under-five deaths in Ethiopia are neonatal deaths". The reality of birthing mothers in rural regions of Gurage zone is even worse. If any kind of emergency arises during labor or birthing such as excessive bleeding, placental abruption, or uterine rupture, because many of the birth attendants are not trained by health officials, they have little control over these situations. In addition, because there are no nearby hospitals or emergency centers within short distance to provide assistance, the lives of the mother and newborns are at stake. During the interview, only one of the traditional birth attendant (1) had received some form of formal training through the regional health office. Below are some of the responses from all three groups of THs on their experience of traditional healing.

Sekunna is an 80 years old male Shegore TH. In an in-depth interview, he said:

… after the death of my husband, I used to cry day and night. There was no one with me to help and take care of my children. One night, I saw a dream where an unknown superpower came to me and said you will be called 'Emet' and you will be able to heal yourself and your neighbor's whenever there is a problem….

Tekle is another well-known Shegore who lives in Mareko region, explained himself in the following way during an interview.

.... I'm just doing what I was taught to do after my grandfather passed away. God gave me the wisdom and the power to heal myself and my neighbors and be peaceful, balanced and centered. An angel (supernatural power) used to come to me almost every night while I am asleep after few weeks of my grandfather's death. The angels revealed the secrets of healing that my grandfather had used before he passed away. Sometimes when I indulge myself in some kind of sin, the angels won't come to me for few days. When that happens, I ask sincere forgiveness to my God and the angels will continue to come to me to reveal the secrets afterwards.

The second group of THs that practice TM with reference to religion believe that their knowledge is acquired from God through religious books by means of their forefathers and

believe that their knowledge will be transferred to the next generation after the death of the practitioner. On an in-depth interview a "Weliye" named Tuba, who has been working as a TH for more than 40 years, said:

… I have inherited this wisdom of TM practice from my father who in turn was rewarded by his grandparents who are descendants of the Prophet Mohammed. I am the 30th descendant and my son will maintain the trend as the 31st generation.

Murida is a 57 years old female Weliye who have been practicing TM for more than 11 years. She claims that she inherited her power of healing from her mother who herself used to practice TM for over 25 years.

...My mother was a very good and well-known healer for many years. She was loved and respected for her magical power of healing diseases to everyone who sought her help. Because I was very respectful and well-mannered child of hers, I think, my mother chose me among my siblings and decided to teach me the secrets of healing. After few years of her death, I replaced my mother's role in curing people. Since then, I took the responsibility to stay very close to my family, help around the house, clean up the grounds, and talk with elders when need arises in the community in addition to my practice of TH.

Mary is a traditional birth attendant. She has been helping birthing mothers for over 9 years. She said;

...I really enjoy my job as a birth attendant. I have been doing this for nine years and I got my experience from my mother. My mother taught me every step of child birth while I was very young. After her death, I took over her and now am helping a lot of women every day. I take pride in what I do but sometimes, when series complications happens, I still get anxious and helpless. But the good part, it doesn't happen so very often...

7.3 **Diseases Treated**

The study of the practice of TM in Gurage zone was mainly focused in the Eastern part of the region mainly in 'Mesqan' and 'Mareqo'. These villages are believed to practice TM as their primary mode of eye treatment with no access to modern eye healthcare within a reasonable distance. Patients with all kinds of diagnosis including HIV, psychiatric illnesses, and patients with seizure, hemorrhoid, eye, and internal medical problems visit THs such as Shegores, Weliyes, and Holy Water in the region. The common ocular disorders include ocular redness, irritation, eye

discharge and tearing, trachoma, strabismus, cataract and poor vision. Six out of the ten of THs provide herbal treatment only; two of the THs provide herbal treatment and animal products. Two of the healer's give holy water as a treatment for most illnesses. Eight of the traditional practitioners use their living room for consultation with clients and the holy water was given in the church or mosque.

At the time of observation during the study period, 5 to 20 patients were being seen, seeking medical and spiritual help from the healers. Patients experiencing all sorts of pain come to visit THs in the hope of alleviating their suffering. I observed that some patients are overly respectful to THs (mostly Shegores and Weliyes) that they will be crawling on their knees when they enter the home of a TH until the visit is over. It is considered as a taboo and disrespect to just walk and enter their house without their permission. Some of these THs uniquely isolate their personal space from the crowed using a curtain and not everyone is allowed to meet face to face with the TH. From the back of the curtain, the patient will start to explain their problem to the TH. Then the healer will affirm that he/she knew that particular patient was coming to visit him/her with the said problems through his gift of power given to him from God. After that, he/she will start to prepare the medicine right way or will ask the patient to come after few days. The TH will then explain about the drug and how and when to apply the medicine. I witnessed that some patients give a gift to the TH before they leave. I have also observed that a patient who was being treated at Menelik II hospital, tertiary teaching hospital in Addis Ababa, with a diagnosis of retinoblastoma for whom enucleation surgery was suggested instead chose herbal treatment with one of the Shegore traditional healers.

7.4 Method of Evaluation

The results showed that all traditional healers use history taking as the primary way of diagnosing patient's problems. They all considered histories of the patient to be more important than physical examination. Only two of THs examined patient's status of vision or performed physical examination in addition to history taking before initiating treatment. One of the participants among THs called Abba Amole mentioned;

> *.... We examine our patients by way of interrogation. We ask them what their complaints are and how long they have experienced the problem. Then we identify the problem based on their history and we will give them 'proper' medication*.

Patients who visited THs, such as Shegores, consider them as 'know-it-alls' when it comes to treating their illness. In an observation, a young man, Tekele, who visited a witchdoctor for his son's eye problem said:

…. There is a saying in our culture that the traditional healer has a power of mind reading (telepathy) and she would know if any one of us doubt her potential to cure or to think something negative might happen on the treatment she provides. If you do, the medicine will not be as effective and she might even curse you and never recover from your illness…

A 47 year old father, Abera, strongly believe in the practice of TM especially by those of Shegores. He thinks that although they ask for the symptoms and timing of a disease, they have some supernatural power to know what's going on with a person before the person starts to explain. He testified that:

I witnessed a miracle performed by a Shgore man when a patient presented to him was unconscious. The family of the patient knew nothing about the patient's problems and they told the TH that he was perfectly healthy two days ago. Because Shegores knew the untold, he gave the patient a medicine to rub all over his body for as long as required, and gave some more medicine to give the patient to drink when he was able to swallow. After few weeks of applying the medicine on the body, the patient was able to regain consciousness. Once he was able to swallow without difficulty, he starts to drink the medicine given to him by the Shegore, and he was completely cured.

A relatively young TH (Yoseph, 42 years old) also explained the importance of traditional healing practice in his community,

I think with [traditional practices], it would help us to better ourselves, our tribe, our culture, because I think by pulling away from our culture, it's making it worse on us in the long run.

7.5 Terms Used among Traditional Healers

Different types of terms are used by THs for naming various types of ocular disorders. These terms describe only the signs and symptoms of the disease not the pathogenesis. According to the participants, ocular disorders are classified into three major groups based on the presenting compliant. One, when patients present with ocular redness, irritation, eye discharge and tearing, THs call them 'mich', 'ye'ayn Mich' and 'Ayne Mochmacha'.Trachoma which is a common ocular problem in the zone is labeled as 'Enfush'. Second, when patients present with blurry vision,

or poor vision, its termed as ‘ye’ayn mora’ to refer to cataract whereas poor vision generally labeled as ye’ayn Tenema (‘ye’ayn girdosh’, ‘ye’ayn megared’). The third category is when patients are presented with ocular misalignment, THs refer them as “oumusubia” and ‘kendassa’.

All the THs have the right knowledge when it comes to the causes and risk factors of red eye. They believe lack of personal and environmental hygiene and exposure to animal dung are the risk factors for red eye and trachoma. Nevertheless, staring at the sun rays for prolong periods of time and evil spirit were considered as a major cause for strabismus.

One Weliye who served as TH for more than 22 years said:

…. We call it “oumusubia”. It (strabismus) is the work of the devil….

Traditional healers that practice TM based on religion and “supernatural power” believed that two factors determine the cause for the presence of cataract and poor vision. According to them, God will make you sick for some sin committed before (that won’t be revealed for humans except for those who possess supernatural power) and also poor consumption of diet might cause eye problems. A priest called Aba Mulat, who practiced TM in one of the churches, when explaining the cause of cataract, said:

...Only the Lord knows. It is due to changes in the composition of our blood…

A Holy Water practitioner, Alemu, described the cause of many eye diseases as;

...I think it is a curse from God as are other types of illness such as HIV/AIDS, mental disorders and other genetic disorders. The curse might have happened because of a sinful act that the person did, or his families did. Either way, we would not be able to identify the cause unless the person told the sin he /she has committed. What we can do is ask forgiveness on behalf of them and give them the holy water so they will be cured.

Various types of causes for different diseases are attributed among THs. Kasech is a Weliye TH practicing TM for over 14 years. She explained the cause of strabismus or blindness as:

...I believe diseases that cannot be cured such as strabismus (‘menshewarer’ in the language of the region) or blindness or any kind of incurable disease for that matter, are caused by possession of the devil. People are advised not to walk outside of their home after midnight because that’s the time for the devils to be free. And anyone going outside after that time may be possessed by the devil and can be sick forever...

7.6 Treatment of Ocular Illness

Traditional healers more commonly treat systemic problems such as psychiatric illness, gonorrhea, herpes zoster, than eye problems. Yet, all participants had treated patients with ocular diseases at some point in their life. The treatment of ocular diseases varies according to the presenting illness signs and symptoms and among the three groups of traditional healers. Only four out of ten THs refer patients with cataract and strabismus to modern health care providers. One of a famous TH, who is a witchdoctor called Alemnesh, replied in the interview that she will not see a patient with cataract and/or strabismus:

... I can't treat cataract because it requires extraction surgery. I refer them to the city hospitals to treat them. I myself had cataract surgery done on my both eyes a few years ago in one of the hospitals in the nearby city….

Unlike the above TH, Kasech, refused to refer patients presenting with cataract or strabismus to health centers. She said;

...Because I strongly believe that people contract those kinds of series and incurable diseases (strabismus and cataract) from a devils possession, I don't think anyone can help them better than Sheroge THs. Therefore, I will not push away any of my patients to health centers.

Another traditional healer who is a priest by the name kebede, refused to refer patients to hospitals. He treats all patients (with all kinds of ocular problems including cataract and poor vision) with holy water. He said:

… When patients come to me with 'ye'ayn megared' (cataract), I believe this is an internal problem. I will treat them with Holy Water to get rid of the harmful substance from their body in a form of diarrhea or vomiting…

When patients bring babies for treatment of ocular redness, all but one TH, recommended that mothers apply breast milk directly into the eyes of their babies. Trained traditional birth attendants tell their patients with ocular redness and trachoma to wash their hands and their face with water and soap frequently and refer them to nearby health centers if the problem did not subside after few days. Surprisingly, even one of the trained birth attendant did not know about eye care treatments for new born babies and have never applied topical eye medications immediately after attending deliveries.

Meseret, is a traditional birth attendant discusses the treatment of patients with ocular redness. She said:

...If it is 'Mich' the eye gets red. There was once a person in the neighborhood whose baby daughter's eyes were both red. I advised him to take the child to the nearest hospital. However, the daughter didn't respond to the treatment given at the hospital. In this case I went to her father and asked him to give me a chance to treat her. I saw that the baby's eyes were red and I cleaned both eyes with "Fuanfua" and exposed the eyes to a leaf that I know will cure her. The redness of the eyes disappeared and the eyes got cured after few hours.

Similarly, Tekle explained the process of his treatment as:

...Eye disorders require special attention and care. I cannot just give a random medicine to treat a patient with eye disorder. First of all, I only give medicines that I know of for sure will provide cure. Second of all, if the eye disorder appears to be different from what I have treated in the past, I make sure I pick up the best and safest plant products. Then I will apply it to my own eyes or anyone who volunteers to try the medicine. If there is no adverse reaction to the healthy eye, then I give it to the person whose eyes are sick. That's why, it takes two or three visits to make everything ready and cure the eyes.

Many of traditional healers claim that the government is "defaming" their name by saying that their medication and treatment are harmful. Meriem is Weliye TH, shared her story as:

...Prior to giving the medications to our patients, we test it in front of our patients to see if it is lethal or not.

... For an evil spirit ('dorora'), first I taste it myself, if it is lethal, it will kill me first.

Semira has been a traditional birth attendant for 7 years. She has never encountered complications after giving medicine for a new born baby. She said:

All pregnant mothers in my village come to see me when they are in labor. I help them safely deliver their baby and will take care of the mother during delivery. If the baby's eyes appeared to be red or if the baby is unable to open their eyes, I apply homemade ghee to the eye which has a soothing and therapeutic effect for the baby's eyes. Not only will the baby be relieved but also will have a very pretty eyes as they grow older.

7.7 **Cost of Treatment**

In the rural areas of Gurage region, one sometimes travels for several days before finding the nearest dispensary and pharmacy or health clinic for consultation. In addition to loosing working days, high transport fares coupled with the high cost of medicine must be taken into consideration. It is obvious that the lack of health care systems in rural areas forces local people to treat themselves, either by using medicinal plants and homemade medicines or pay a visit to local TH. Sometimes, people borrow and share medicines that was given to one person for a specific diagnosis to other members of their family, neighbors and villagers, predisposing themselves to health dangers. This is further exacerbated by not knowing the right dosage, pre-existing health conditions that may counteract with the drugs, adverse reactions and the unknown source of these some medications (Ndhlala et al., 2009). In the rural areas, as a whole, people begin by treating themselves before going to a traditional practitioner or a modern doctor.

Over the years, the types and methods of payments for traditional healing have changed. I have observed that in urban settings, practitioners are increasingly demanding monetary payments. In rural settings, it's more common for patients to bring gifts of their choice when they visit THs. None of the traditional healers who participated in this study had a formal or fixed cost for the type of service they provided. Patients pay practitioners based on their "Neya" (meaning, wish). When THs were asked how they charge fees for their services, most respondents (witchdoctors and traditional birth attendants) said that people seeking their help are poor and they do not ask for any money or gift. THs offer the service free of charge, hoping God will pay them back.

Tuba, one of the THs, said:

...Although we don't ask for money or any kind of gift from our visitors, people bring different kind of valuable gifts most of the time.

Getachew, another well respected TH also said:

...People are really poor in our community. Some of them don't have food to feed themselves and their families. Some of them, don't have clothes to wear. How can we ask these people for money when they are sick and vulnerable while many of them don't even have food to eat?

Alemu, also said:

...We want our patients to pay us for our healing practices. Our life depends on it and we would not be able to afford to buy food for our family if we cannot get enough money from our

visitors. Unfortunately, our community is very poor and I think it's unethical for us to ask them money knowing that they have nothing. At least, we have a means to treat ourselves and our family if we got sick but they don't.

Unlike other participants, one TH mentioned his expectation for a monetary or gift for his service.

...Although I do not say it out loud, I expect people to pay me for my services. I spent hours and sometimes days trying to find the best cure for a disease. If I am not paid well, I am not able to sustain myself and my family. Which means, I can no longer serve as a healer for the community. So I expected some kind of monetary prize or a gift from my patients so I can continue to serve my people.....

7.8 **Patient Referral and Perception to Modern Medicine**

One of the main problems that have caused a slow collaboration between biomedical healthcare and traditional medicine is the lack of legal framework. In Gurage region, there is no official recognition of TM and THs by the Western model of healthcare. Generally, THs are not accepted but tolerated because, WHO and the Ethiopian Government has signed a convention to draw up a strategic plan for the validation and integration of TM in Ethiopia. However Ethiopia signed the convention, there are no laws guiding the TM practice in Gurage region. The TM sector is still isolated and uncensored, and anyone can enter the trade. Although there is lack of proper integration of traditional medicine in health care systems, there are signs of visible drawbacks of traditional medicine practice in this region. These include, incorrect diagnosis, improper dosage, and low hygiene standards, the secrecy of some healing methods and the absence of written records about the patients (Teklehaymanot, 2009). According to Fokunang et al. (2011), "most of the time, the practitioner are unable to have a limit on what they can cure. There is a hit and miss operation going on most of the time. They have very little knowledge on drug-herbal interactions". This had led to uncertainty and cause for concern, it is unfair to discriminate and pass judgement without even considering the potential benefits of TM for many societies.

Accordingly, all the traditional healers in this study (witchdoctors, religious leaders and trained birth attendants) blame zonal and respective health offices for not recognizing their contribution in helping patients in their community. Nevertheless, religious leaders (Weliye and Priest) have shown zero interest in receiving any form of assistance (be it financial or

informational) and showed little to no interest to working in collaboration with zonal heath offices and modern health system. In an interview, one participant named Tuba (Weliye), said:

...I am a farmer having enough to feed myself and my children. I don't need any support from anyone. I need the support to come only from Allah the Almighty. If I seek help from creations not the creator, famine and other problems will prevail.

Another participant, Getachew, mentioned that he doesn't want anything to do with government officials and neither health care providers. He mentioned:

... these government people are not honest with us. Either they want to steal our knowledge and curative medicines from us or they want to accuse us of harmful practice to our patients. They are not interested to hear our achievement in helping out our poor community for many years.

Another key informant discussed how healthcare providers have discriminated and stigmatized them just because they practicing TM. He said:

...I don't go to health centers very often. But if I do, it's because I have a family or community member who has a serious disease that needs health practitioner's attention. After long hours of travel by foot, when we get there, they treat us different and rude. They don't want to treat us like any other human being because we are traditional. They make us wait till the last moment and sometimes will tell us to go back and come back another day...

Similarly, another participant describes health practitioners as un-empathetic:

...We don't have the means of transportation to arrive early at the nearest health center. We walk for hours on foot and arrive late in the day because some of us are elders and some others are seriously sick. After we travelled all those miles, the practitioners will tell us to come back another day because it's almost time for them to leave or if we insist, they treat us like a garbage...

Participants were also asked about their referral systems (i.e. suggesting patients use modern health institutions). Four participants responded that they refer patients with cataract and strabismus. By contrast, all of them treat red eye themselves.

Shenkore said:

...I will never refer my patients to health centers. I know they treat us different and bad. I would rather exhaust all my resources trying to cure a patient than sending them away for these people to treat them like garbage....

Tekle also said:

...I do not see the need to refer my patients to health centers that are very far away from here. I believe we [Traditional practice] have all the means to cure majority of the diseases. They [health practitioners] don't know any better than we do. Our treatment is cheap and mostly natural...

8. Results: Healthcare Practitioners

A total of 7 participants were included in this qualitative study. Table 3 shows the age and sex distribution of the participants. The age range was between 22-49 years, with a mean population age of 36.71 years. Four of the participants were Muslims by religion, and 3 of them were Orthodox Christians. Five of the participants were Gurage by ethnicity and 2 of them were Amhara. The age group between 20-40 years was the highest frequency for participants. There were more female participants (5) with a female to male ratio of 2.5:1. There were no participants among healthcare practitioners (HP) with no formal education. All of participants have diploma and above. None of the participants were self-employed, and all seven of them are employed. Most of the participants live (5) in urban region of Gurage zone in which they have limited access to media. Four of the HP earn an income level between $2000- $2500, two of them earn $3000-3500, and one person earn an income level more than $5000 (Income per month, Birr).

Table 3. Age and sex distribution among healthcare practitioners of Gurage Zone, Southern Ethiopia, December-February, 2017/18.

		Sex		Total
Age Group	Age Group	Male	Female	
	20-40	1	3	4
	41-60	1	2	3
	>60	0	0	0
Total		2	5	7

8.1 **Level of Coordination between Health Practitioners and Other Stakeholders**

ORBIS International Ethiopian is one of the major stakeholders that work to make a difference in reducing eye health problems in Gurage region. In collaboration with the local healthcare administrations, it is implementing a model for comprehensive rural eye care to address critical gaps through capacity building, healthcare technology development and advocacy. In particular, ORBIS is addressing the widespread challenge of blindness caused by trachoma and cataract by implementing World Health Organization's SAFE strategy (eyelid surgery, antibiotics, face cleanliness and environmental improvement). Although ORBIS Ethiopia is training both community and healthcare workers in all aspects of eye care, with awareness of services, identification, diagnosis, referral and treatment, THs have not been the area of focus for any of the trainings provided by the organization. The non-profit organization have built a longstanding partnership with the Ethiopian Federal Ministry of Health, through which they work to develop and strengthen the capacity of existing government health providers to deliver eye-care services at the primary, secondary and tertiary level. According to the findings, no identified relationship is built between this organization and THs of this region. Moreover, although effective referral networks have been set in place between primary, secondary and tertiary services to ensure that people are appropriately treated at the right level of the healthcare system, no clear referral system exists between THs and Modern healthcare centers.

8.2 Level of Coordination between Traditional Healers and Healthcare Practitioners

Despite progress to expand healthcare at primary, secondary and tertiary level, Gurage region's biomedical health care system continues to face profound challenges. A primary challenge is its accessibility, particularly in smaller rural communities. Recent surveys show that 70% of the Gurage population lives in areas with insufficient access to biomedical healthcare. Considering the vitality of TM in Ethiopian health system, integrating traditional healing and biomedical health care, as an effective and sustainable way of expanding the reach and outcomes of health care in Gurage region is crucial. Although WHOs (1978) commitment to promote the inclusion and integration of traditional practitioners in national health programs across sub-Saharan Africa, collaboration between THs and modern healthcare has been complex and ineffective in Gurage region.

Lack of interest to collaborate with THs doesn't always come from health practitioners. Some THs maintained that they don't want to disclose their traditional medical knowledge for the sake of training or scientific research. Some THs said that they don't want to mix their traditional medicaments with modern drugs and they were not interested in combined therapy. Collaboration between the two parties is pervaded by mistrust and negligence. Only two THs were agreed on the idea of collaboration between modern and traditional medical systems. I have learnt that the Gurage regional health office has no delegated person or assigned department to address issues related to traditional medicine practice and does not provide any kind of training to THs. The exact number and distribution of THs in the region was also not known by the office. The office does not give license and/or accreditation to THs and traditional practices. The regional health office delegate department lack both formal and informal knowhow on how to implement WHO's African traditional medicine initiative. The health administration office have not conducted any type of formal scientific research on the prevalence and utilization of traditional eye medicines. These organizations maintain misconceptions on the utilization of traditional eye medicine and its effectiveness in the region.

One of the health administrators of zonal health office, Akmel, said:

… If you go and ask people about what we have been trying to achieve on the practice of traditional eye medicine in the region, they might tell you that nothing has been done so far and it's true. We are becoming obsolete in this regard and we haven't planned on integrating THs to the existing health system so far….

A nurse working at one of the health centers also explained the lack of integration of THs as:

...It would be something really new for us to work with THs in this region. They [Traditional healers] practice medicine based on their native ways of knowing. We practice medicine based on Western model of healthcare practice. I do not see any connection between the two and honestly, it would be a challenge to our system.

The medical director at one of the urban centers explained the difficulty of integrating TM with biomedical practice as:

...I think anything that has to do with health, it has to be scientifically proven. That's what we were instructed to do as medical doctors. Although I know so many people use traditional medicine to treat various types of diseases based on ancient teachings, it does more harm than good unless proven otherwise...

Tibebu, is a male nurse who has been working for over 12 years within the healthcare industry states his perspective as:

...Yes, it would be beneficial to integrate THs with modern healthcare if THs are willing to cooperate with the biomedical model of health approach. I don't think we should push it on them but we could maybe ask them if they want to work with us. It all depends on how these THs perceive us and if they want to do it their way or our way.

Another healthcare provider states:

...I think it would be really important to include some of our spiritual and cultural things in the Western program so it becomes a whole package to address health...

Most healthcare practitioners (5) consider TM as harmful. They believe that many people have been devastated and lost their eye sight as a result of TM malpractice. These healthcare practitioners consider expansion of modern eye heath care as the only means of addressing eye care in the zone and currently, they have not designed and implemented a strategic plan to work with any traditional practitioner. A nurse working at one of the health centers, Meron, found no good reason to collaborate with THs. She thinks collaboration with THs is a waste of time, money and other resources, as it takes a long time to change the perception of THs and traditional medicine users. Instead she recommended spending the budget, if any, to expand health centers into remote parts of the region in which people have little/no access to healthcare.

... as far as there are abundant trained eye health care workers in the zone & these eye health practitioners are trusted and accepted by the community , why do the community has to go to traditional practitioners? Right now we don't have the budget to strategically plan and train more modern health eye care workers let alone change the long standing perception and practice of THs and traditional practice.

Seniya, a health practitioner in one of the health centers also sees no benefit in collaborating with THs of the region. She mentioned that:

…majority of their patients come to health centers with complicated eye and other health problems and sometimes become blind, all because of harmful traditional practices. We need to monitor the so called THs and held them accountable for their action. Otherwise, they do more harm than good.

9. Discussion

This qualitative study was one of the first to examine the role of traditional medicine in the eye health care by investigating the utilization of TEM, the practice of THs and examining the level of coordination between modern and traditional health practices. In-depth interviews were used in addition to lengthy hours of observations (using guides who are health workers in the zone) in the working places of traditional healers. This investigation is an independent study and not a monitoring and/or evaluation activity within the TM practice in the region--Gurage zone. This study has explicated that among traditional practitioners, there are categories –witchdoctors, religious based practitioners and trained traditional birth attendants. The identification and the categories are given by the community as Shegores (meaning "witchdoctors"), those who practiced based on a super natural power given by God and Weliye (those who refer Quran as method of treatment guide) using Holy Water and trained traditional birth attendants. The identification and distinction of THs as Shegores, Weliye and birth attendants is important for the community to identify THs way of healing mechanism and healing power to cure ailments. One group might have a specialized skill to treat specific types of diseases or afflictions and might have gained a reputation in her/his own community or elsewhere than the other group. Another group of TH may base their power or practice on religion, the supernatural, experience, apprenticeship or family heritage which is more relevant to some people who strictly follow a specific category of their choice as their way of life.

Effort was made to explore the role of THs and traditional medicine in eye health care delivery for those living in the rural part of the region where accesses to health care (especially eye care) is very much limited. Because access to resources such as healthcare is limited, the practice of TM is prevalent in this region. Correspondingly, Gupta's et al. (2017) recent population-based study in rural India have shown the extensive use and prevalence of TEM in rural regions of India. Because these regions are located in rural areas where access to healthcare and/or health information was limited, the commonest sources of eye-related health information were villagers themselves that included neighbors, relatives and traditional healers. This study climaxes the importance of establishing accessible primary eye care services and the need to create a collaborative network between these remotely located populations and TM practices. Also, Prajna and colleagues study in 1999 performed to assess the nature and frequency of the use of TEM in

patients from predominantly rural background yielded a similar outcome. They documented the use of TEM by corneal ulcer patients presenting to a tertiary eye-care center in South India during two months of 1996. The study findings showed that 47.7% of the participants used TEM. They found no age or sex difference in patients using TEM. Interestingly enough, the use of TEM was higher among participants who live in remote areas where awareness of primary eye care and access to healthcare was very much limited.

By the same token, the results in this study suggest that utilization of TEM and visiting traditional healers is still a common and accepted practice in the region that may run counter to prevailing assumptions. TM has been recognized for its widespread importance for the development of various treatment regimens as well as blamed for delayed or complicated presentation of eye problems. Eye problems presented might include corneal ulcer cases, active conjunctivitis and delayed treatment of trachoma which might result in reduced vision and sometimes blindness. To the best of my knowledge, there has been no population-based evaluation of the use of TEM and self-medication done by any party in this region.

This study highlights that the rural Gurage population utilizes various traditional, and home-based remedies for relief of ocular symptoms through THs without consulting the health care system. Although a broad range of products were used to promote healing and for pain relief, home-based remedies prepared by THs that included the use and application of honey, ghee, and other plant, dairy and animal products were offered to patients to apply directly to the affected eye. Patients might also be required to take these remedies orally for a prescribed amount of time. Likewise, the study of Carvalho et al., in 2009 investigated the practices of self-medication and the use of home-made herbal products by THs for the treatment of ocular diseases comes in handy here. Their study suggests that traditional eye practices are being widely used by the Indian population. Similar results were reported from Sao Paulo in Brazil. As population-based studies provide more accurate data on TEM use, this study reflects the actual burden of use of TEM in this rural Eastern Gurage population.

It is also necessary to examine the social conditions that has gravitated these populations for the use of TM. Since social conditions (SDOH) are not constant throughout time, space, and place and this needs to be understood and accounted for when studying, or conceptualizing health inequity. Our argument should also be centered on fundamental social causes that

encompass not just resources but access to resources, helping people to avoid risks for morbidity and mortality, through a variety of mechanisms (Link & Phelan, 1995, 81, 88). Effective intervention is the one that does not merely address the "mechanism" linking the fundamental social cause of disease, as it only identifies the "proximal causes" (Carasthathis, 2015, 88). Rather, it must tackle the fundamental social cause itself (distal cause), and the inequality in the distribution of resources that causes necessitate populations to choose one resource over the other (in this case, TM over Western treatments) (Carasthathis, 2015, 89).

Having said that, the use of TEM was found to be significantly higher among participants in the lower socio-economic class who have no access to health promotion and media access. Upon my observation in this study, traditional eye practices are not dependent on the participants' age, gender, religion or marital status. Yet, most ocular complaints were predominantly common among children and the productive age group within the lower socio-economic status group. The high incidence of eye diseases observed in these two age categories has an adverse economic and social implications for the patient, the family, and the country in the long run. The findings of Maregesi, & Kauke (2016) in Tanzania among traditional healers as well as individuals with knowledge in medicinal plants indicates that little awareness of the health risks associated with poverty was discovered. This means that, with little knowledge of the side effects and adverse effects of herbal and animal products offered by THs, young children and people in the productive age group have a greater chance for their health to be compromised. Besides, little/no follow-up was performed by THs following their treatment, and in terms of managing patient's pain.

A similar finding was observed in Enugu State by Stella et al. in 2013 that studied the relationship between lower SES such as safety, reliability, effectiveness, availability, cost, and other factors influence use of TM. The study showed that 19.1% of the respondents without formal education and 79.9% with at least primary level of education use TM. Like the previous study, they found that there is a significant relationship between TM use with age, occupation, educational level, family setting and religion. The researchers concluded that socio-economic factors such as cost, effectiveness, availability, safety of the product, educational level, income, age and sex affect the use of traditional medicine. Another important connection between the use of TM and lower socio-economic status (SES) was established by Shih at al., in 2012. The study was carried among children and adolescents of Taiwan to determine the association between SES

and TM use. The study found out that there was a high use of TM among the participants that are under the category of lower SES. I do agree that both material and relative poverty should be seen as important determinants of health that would each be distributed in various ways among different communities. The shift needs to be made from discussing the various social determinants of health to implementing change to create improved circumstances for the people that are in need of health policy changes.

Limited access to modern healthcare centers were also prevalent in this setting. Access to healthcare and healthcare-seeking behavior were limited by long distances to the health post and long waiting times on arrival. A study carried out by Williamson et al., (2015) using a descriptive method yielded a similar outcome. They analyzed the health, health knowledge and healthcare access of 13 remote communities of Manati and Amazon rivers in Northern Peru. They interviewed 85 participants attending a medical boat service on socioeconomic position, health, diagnosed illnesses, pain, healthcare access, and traditional versus modern medicine use. They found out that participants preferred modern over traditional medicine if it was not for the limited access of modern healthcare. They also found out that participant's health knowledge and education were predominantly poor. Similarly, the study of Balcha (2014) that used both qualitative and quantitative research methods in the rural areas of the Oromo people, Ghimbi District, generated a comparable result as this study. The researchers showed that, as a result of poor accessibility to health services, more so in the rural parts of Ethiopia, there is a high dependence on TM for the purpose of primary health requirements. However, they pointed out that traditional medication has been neglected in terms of therapeutic capabilities while adverse conditions have not been fully studied scientifically.

This paper elucidates some of the reasons why people choose TEM instead of Western treatment despite the remotely accessibility of health care centers in this region. The study was largely conducted in the relatively urban part of Gurage zone. In this study, all of THs (10) and 5 of the participants among healthcare practitioners were found to use TEM of some sort in the last one year. The possible reason for the exaggerated prevalence of the utilization of traditional eye medicine could be because; (1) more than half of the participants are THs themselves that have easy access to all sorts of TH treatments; (2) because of the widespread acceptance and recognition of TM, majority of the participants may not be able to see the need to visit a nearby health center.

(3) The cause for higher prevalence could be also be attributed to a smaller sample and (4) the less accessible nature of health care centers in the region. In comparison with other studies done in different parts of Africa, the prevalence of TEM utilization in this study was higher (15 out of 17 participants) than a report from Dares Salaam which was 49%; this finding was also much higher than other cross sectional studies. For example, a study in Malawi carried out on 583 patients presenting with corneal ulcers at two rural district hospitals, showed a 33.8% TEM utilization. Another study indicated TEM utilization of 17.9 % on 465 subjects attending Bukavu ophthalmic district, Democratic republic of Congo (Theodore, 2008).

The assessment's of my observation also confirm that, utilization of TM was more common among THs themselves, the elderly, people living in the rural part of the region that have little/no access to information as well as to modern eye healthcare. Majority of THs (6) got feedback from their customers why they preferred to use their service (THs service) over health care centers as; (1) the strength of their service and efficacy of the treatments, (2) fees of treatment of herbal medicine was cheapest or non-existent (3) lack of access to the health facility (cost, distance, quality of service) for modern eye care. Because traditional medicine is culturally entrenched, accessible, and affordable, majority of the Gurage population relies on traditional remedies as a primary source of health care (Kassaye et al., 2006). Moreover, Western medicine has become less focused on preventative measures and more on people seeking curative practices, these people still rely on indigenous medicine as the primary source for health care (Pankhurst, 1990). In countries with substantial lower socio-economic status--Gurage populations, traditional herbs, and traditional practitioners are readily available (Papadopoulos, 2002).

During an in-depth interview, history taking was found to be the commonest method of assessing the type, extent, and severity of eye problems presented to THs. Almost all (8) of the THs agree that asking the right type of question will help them identify the problem without the need to perform physical examination on the patient. Very few of THs suggest that it will more accurate to perform physical examination in addition to history taking when the problems presented appears to be more complicated. A study carried out on TEM in Nigeria, Benin-City, Edo state in Nigeria by Ebeigbe, (2013), also found similar result as above. Forty-six percent of THs used the history of patients as an important means to diagnose patients as opposed to using physical examination of the eye (Ebeigbe, 2013). On the other hand, about 50% of the participants

considered both physical examination and history as important. Among them, about 30% used the inversion of the upper eyelids to conduct physical examination.

A variety of patients presenting with various symptoms visit THs. According to this study, the method of evaluation and treatment approaches among different traditional healers vary. In addition to patients with eye problems, patients suffering from psychiatric illness, HIV/AIDS, or other chronic illnesses visit THs regularly. All THs manage red eye with herbal medications. None of these THs practiced couching or other types of surgical interventions on the eye. This finding contrasts with a population-based survey done in a rural district of Mali in 2000 by Schémann and his colleagues. The study found couching and surgical practices by traditional healers to be a relatively expensive, potentially dangerous and ineffective way of cataract extraction. Additionally, in 1997, 22 cases of couching practices on patients' eyes were identified in the regional hospital of Zinder, in Niger (Mariotti &Amza, 1993).

Interestingly, THs had misconceptions about the pathogenesis of cataract and strabismus, even though they treat red eye well with herbal treatment. Similar findings were documented by Solomon and his colleagues (2000), where less than one fourth of traditional healers reported age as the major cause of cataract. This study found out that some THs refer patients with cataracts and strabismus to the modern health institutions. The referral tendency of trained traditional healers and witchdoctors was more commoner than religious-based practitioners. Remarkably, except for trained traditional healers, the rest of THs did not want any form of support and cooperation with the modern health care providers. Lack of recognition from responsible agencies and a kind of prey and predator relationship with the zonal health office could be the reason for lack of interest in collaborating with the modern health institutions. A similar finding was observed from a study carried out by Ebeigbe (2013) on the knowledge and practice of THs in Benin-City, Edo state, Nigeria. Sixty-eight percent of traditional medicine practitioners (TMPs) that treated eye conditions participated in this study. The results revealed that THs manage eye diseases based on their concept of the disease causation without the support of any formal education or training. Many of the healers failed to give a clear distinction between various eye conditions, causation and its outcome: cataracts, for example was described as a clouding or whitening of the eye. Foreign bodies and injuries were recognized easily by description.

A different outcome was reported by Poudyal and his colleagues (2005) after providing the necessary training to THs. The authors found that training yielded a significant change in the number of THs with accurate perceived knowledge about trachoma and cataract. As well, Courtright and his colleagues (2000) reported that after providing an interactive training program with THs in Chikwawa District, Malawi, blindness among patients reporting the use of TEM decreased from 44% to 21%; bilateral corneal disease in patients using TEM decreased from 31% to 10%. Unlike some regions of Africa where training is provided to THs, the practice of utilizing traditional medicine in Gurage Zone seems to have been practiced without any attention from zonal health offices. Traditional healings (especially witchdoctors') are considered illegal and culturally stigmatized which may have contributed to it being practiced covertly. The zonal health office did not have any pertinent information on the extent of knowledge of THs and utilization of traditional practices in the region. Not one of THs were licensed and recognized by the office locally or nationally.

Although ORBIS INTERNATIONAL Ethiopia, a non-governmental organization, is working in collaboration with the regional office on eye care services in the zone, it considers expansion of modern medicine as the only means to address the need for coverage and quality of eye care in the region. Because the organization and some health practitioners consider the practice of traditional medicine as backward, harmful and causing catastrophic side effects to patients, they have no real strategic plan to collaborate and work with THs to reverse the situation. This reality stands in contrast to Ethiopia's national commitment to improve synergies between Western and traditional healers. Ethiopia was accepted in the African Traditional Medicine (ATM) plan, which focusses in developing laws, policies and/or regulations on TM and also establishing scientific research institutes to help make traditional medicine safe. Gambia established a research institute in 2001, South Africa launched a center for research into African TM in Pretoria in 2003 (Abdullahi, 2011). However, realistically speaking, little has been accomplished in terms of providing training or integrating THs to Western model of healthcare in Ethiopia specifically in Gurage region (Federal Democratic Republic of Ethiopia Ministry of Health, 2004).

In a similar study by Kaboru et al, in 2006 in two Zambian urban sites, confirmed the above findings. The authors explored biomedical and traditional health practitioners' experiences of and attitudes towards collaboration and to identify obstacles and potential opportunities for them

to collaborate regarding care for patients. As a result, their study found out that there was a very low level of experience of collaboration between HPs and THs (mostly traditional birth attendants) on issues of safe delivery and other disease treatments. Although there is a growing indication that both parties want to collaborate and work together, the lack of a real collaborative framework integrating THs with the healthcare system was at odds with the needed comprehensive approach to disease control. Also, considering the stigma reported by THs, HPs should provide an adequate understanding and acceptance of the roles of THs for a better outcome.

When people are being stigmatized for practicing traditional healing, they are seen as being reduced in the minds of HPs from a whole and usual person to a tainted, discounted one. In understanding stigma, there is a relation between attributes and stereotypes which come to shape the social identity and interaction of mixed contacts between the stigmatized and 'others.' The stigma coming from HPs could be physical, stigma of character traits, and stigma of a group identity (Goffman 1963). Healthcare providers in fact may categorize THs as discreditable. In the series of interviews done with HPs, the relation between attribute and stereotype was quite visible. The interviews slightly illustrated the different patterns of moral career that the stigmatized goes through. Therefore it is crucial that by forming a more accepting world, the mixed contact issue can be limited or stopped from occurring. The stigmatized will no longer have to experience uneasiness due to the employment of categorization within that social location.

10. Limitations of the Study

This research was a small qualitative pilot inquiry. There are several methodological limitations inherent in the present research that must be considered. Some limitations include; (1) it was not possible to observe the method of preparation of the various medications nor their administration. (2) As the research was cross-sectional in nature, I was unable to determine the effect of utilization of traditional medicine on patients. (3) The practical circumstances of sampling was opportunistic, small, and prone to selection bias. The research would have benefited from a greater number of key informant interviews. Besides, the observational section of the study may be vulnerable to bias. (4) There may be seasonal changes in illnesses and health-seeking behavior that could have influenced the study results. (5) It is important to note that I might have underestimated the lack of healthcare access in the region: although its described that the study site communities as remote because of their distance from public transport (3–5 hours by the most

common form of public transport), there are other more distant communities that I did not reach and therefore, were not studied.

In these very remote communities, the health conditions and healthcare access are likely to be even more precarious and limited than the study communities. Therefore, the results of the study should be interpreted with caution, because they may not be representative of or generalizable to the wider population outside eastern region of Gurage zone. Consequently, the observations from this study 1) may not fully reflect the attitudes and beliefs of all THs and health practitioners within the Gurage community; 2) may not be representative of the study participants because of the researcher's different cultural background and upbringing from that of Gurage region. 3) It may be also be non-generalizable outside Mareko and Mersa regions due to in part, to the level of diversity that exists between these regions; and 4) the study findings may not be applicable outside to those who do not seek traditional health services from THs. Despite the above listed limitations of the study, the novel observations from this study provide critical information about the health practices of an under-studied population of THs and provides insight of healthcare practitioner's perspective in cooperating with local THs.

11. Potential Implications for Health Equity

When discussing population health, one of the aforementioned concerns is about how poor health history impacts MVGs and how it affected their long-term health outcomes (Doyal, 1996). Instead of fully focusing on limitations of access and availability of resources to certain groups, analysing the underlying discourses that created MVGs in the first place will help examine the meanings embedded in various discourses and health policies. These types of investigations aid in reforming inadequate health policies, calls for change in the political arena, create dialogues between governments and the media (Charlton, 1998). Researchers would also get the chance to question and further analyze what often gets taken for granted in social relations.

Therefore, studying TM and the health of populations help improve health disparities and reduce marginalization in the following seven ways. First and foremost, it helps pave the road for future research and policy development that included the health of MVGs. It can lead to more effective government decision making to close the gap in key health, income, employment and other social indicators between various communities within a generation (Busfield, 2017). Furthermore, understanding and integration of the ways of knowing and being of these specific community and addressing systemic and institutional barriers to better health can result in more ownership of decision for their improved health (World Bank. World Development Report 1993). Second, many Ethiopian THs provide treatment for eye diseases, yet there is little published information about eye care knowledge and practices among these healers. This will enable an understanding of TM practice and to collaboratively work with modern eye care practice and traditional healers. It is believed that traditional healers are well accepted by the communities they live in, and with proper support and training, can make a vital contribution to primary eye care services.

Third, there is a wide spread use of TM in Ethiopia. Despite the common use of TM for the eye, there is great concern over the harmful impacts on the eye as a result of using some unproven traditional medicines. For instance, Ethiopia has approximately 1.6 percent of its entire population blind. Moreover, about 3 percent of the population has an impaired vision (Maregesi, 2016). Therefore, the information gained from this study may inform further studies and projects

aimed at supporting safe use and practice of traditional herbal medicine in the region and elsewhere in Ethiopia. Forth, bearing in mind that access to herbal medications and THs in the country is much higher when compared to the modern health practitioners, the government of Ethiopia has showed its commitment in integrating and coordinating TM into the modern health care system as is clearly stated in the health policy of the Ministry of Health of Ethiopia. However, because of lack of adequate research, there is limited implementation and integration practices between THs and modern health science so far. Therefore, this study will aid towards the implementation and integration of TM to modern health care delivery.

Fifth, a single model of Western healthcare model will find it difficult to cope with the healthcare needs of the fast-growing population of Ethiopia. Therefore, by introducing safe traditional and cultural medical knowledge to the existing system, it's possible to catalyze healthcare needs of the growing population and at the same time meeting the health sector development objectives. Sixth, there are obvious cases of TM being a distinguishing element for separating 'us̱' from 'them̱' thus naturalizing people that utilize TM as 'differenṯ'. Thus assigning stereotypes to those health complications that arise from the treatment of TM. What may be considered 'normal' in one region could be seen as a 'bad practice' in another. Similarly, often things about people that have been stigmatized in the past may, over time, become normalized. Although, measuring attitude is not sufficient in assessing the extent of stigma around the practice of TM, it would be useful to account for the level of services available for marginalized members within a community (Specifically, Gurage region), This will help us to accurately gauge the prevalence of stigma and structural oppression based solely on an attitudinal assessment.

Seven, evidence based medical practice has emerged as an important dimension in modern medical care. Despite the two polirized thoughts of modernization as either 'modernize or disappear', traditional medicine is in a challenging process of proving itself through a completely different epistemology (Couze and Featherstone 2006). It is feared that by only imposing evidence based medical practice, absorption of successful traditional practices would result in biomedicalization by further eroding an alternate approach to health. Unlike what was assumed, public preferences are moving in a direction where science is not the starting point for health decision making, hence the study of traditional medicine (Terasawa (2004), Janska (2005)).

Furthermore, the reasons for TEM use are amenable to positive change through enhanced delivery of promotive, preventive, and curative public eye care services. This has implications for eye care planners and implementers. To reverse the trend, it's suggested that strengthening of eye care programs, even distribution of eye care resources, active collaboration with orthodox eye care providers and traditional medical practitioners will make a difference (Ahmed et al., 1995).

12. Conclusion

The consequences of social determinants of health are expected to vary among different groups depending on their level of income, literacy, health and where they lie on social ladders. These factors include an individual's geographical location, race, gender, disability, economic disparity, and age. The uneven distribution of economic and social resources, based on social and geographical locations, renders certain bodies more vulnerable, precarious, and powerless, as they continue to struggle for equity and survival (Solomon et al., 2000). There is an over emphasis on a lifestyle-behavioral model of health and an individually-based system of prevention, treatment, risk assessment, and mitigation -- putting the responsibility on self-regulation and care (DeLeeuw &Greenwood, 2011). This study discussed some of the structural barriers that influenced the health of Gurage people in Ethiopia. The results have indicated that health knowledge and education among the participants were poor. The emphasis within the medical sphere of the lifestyle-behavioral model has left the general marginalized population unaware that health is shaped by socio-economic factors such as how income and resources are distributed, employment and the working conditions they experience (Addis et al., 2002).

Access to healthcare and healthcare-seeking behavior were also limited by long distances to the health post and long waiting times on arrival. Access to healthcare services for Gurage people not only involves the physical presence of healthcare centers but also the engagement of a culturally competent provider, and involves the creation of a comfortable and understanding environment (Kassaye et al., 2007). Essentially, wealth does not equate to equity because the rationality of the invisible hand in equitably distributing resources in a market-based economy is a flawed assumption (Strong, 1979). Moreover, there seemed to be a stigma and discrimination among healthcare practitioners providing local healthcare services to the community. There is a tendency for TEM users to conceal the fact of TEM use or information relating to it, probably to avoid social stigmatization (Mahamoodally, 2013). It is important to explore, not only the

experiences one has because of their illness but all of the elements that intersect to provide each person with a unique experience known only by them (Lewallen, 2001).

. Based on the findings, it is recommended that government officials and non-governmental organizations working in eye care be aware of the extent of utilization of traditional medicines. If the health of the community ought to be improved, health extension workers should educate the public not only on the negative aspects of utilizing traditional medicine but also should be able to train THs on safe practices and create a link for referral (Mesfin et al., 2014). Traditional healers should be recognized, and licensed, and there should be a regulatory body to control the practice. Furthermore, traditional medicine should be researched for potential benefits and side effects. Traditional healers should work hand in hand with modern healthcare and a clear referral link should be demarcated between the two parties. The best health outcomes occur when there is an opportunity to be treated through a comprehensive health-care plan that includes both traditional and biomedical practices. By doing so, resources will be directed not only for curative purposes but also to preventative health activities. Likewise, THs collaborating with biomedicine would facilitate more efficient use of domestic medical resources, and enhance self-sufficiency in health development of resources where it's needed the most. Doing so, will benefit THs, biomedical practices, and improve population health outcomes.

Policy and regulation changes should not only focus on the healthcare access and delivery, healthcare cost and population health, but also implementation and regulation of safe traditional eye care practice. This is the manner through which majority of MVGs could be reached out to address the various health issues they have to deal with (Hur & Lee, 2013). Moreover, the state should be able to decide the determination of how well the healthcare system defines the level of quality healthcare services offered to the MVGs in comparison to the instilled healthcare standards. By doing so, it is possible to develop effective health promotion and integration as well as response strategies that is pertinent to the population under study. In addition, understanding the key constituents of health and illness in different perspectives, cultures, religion and public health & safety should be well studied. This will further allow to more effectively manage better physical, psychosocial and mental well-being of the MVGs which are part and parcel of the bigger picture.

In conclusion, I believe a more reflexive approach needs to be taken, especially by health care policymakers. While economic growth will act as a panacea for illness and disease, recognizing the contribution of TM towards expanding the scope for policy analysts and health researchers beyond the curative medical system is vital. Although the medical model could be accused of being overly formulaic while not adequately representing the dynamic and holistic relation between these variables, the expansion of scope to include the aforementioned factors would have been considered pioneering work at the time. For sure, beginning with this task and then moving towards an intersectional approach, change in health-related policies can be explored and implemented within contemporary society (Naidoo, 2007).

13. Glossary

Trachoma

Trachoma is a contagious bacterial infection of the eye caused by the obligate intracellular bacterium called chlamydia trachomatous (Roba et al., 2010). Trachoma can be spread by either direct contact with an infected person's eyes or nose or indirect contact, such as through contact with clothing or flies that have come into contact with an infected person's eyes or nose. Poor sanitation, crowded living conditions, and insufficient clean water and toilets can also increase the spread of trachoma (Lasker, 1981).

Cataract

WHO (2005) defined cataract as "clouding of the lens of the eye which prevents clear vision. Although most cases of cataract are related to the ageing process, occasionally children can be born with the condition, or a cataract may develop after eye injuries, inflammation, and some other eye diseases". Research findings have shown that most of the blindness in Africa is caused by cataract. According to WHO's latest assessment, cataract is responsible for 51% of world blindness, which represents about 20 million people (2010). Blindness that results from cataract is mainly as a result of the lack of accessibility to treatment.

Strabismus

Strabismus also known as lazy eye is a condition in which the visual axes of the eyes are not parallel and the eyes appear to be looking in different directions (Fraunfelder, 2004). As stated by WHO (2001), "in divergent strabismus, or exotropia, the visual axes diverge. In convergent strabismus or esotropia, the visual axes converge". Severe strabismus may require surgery (Goyal & Hogeweg, 1997).

14. Bibliography

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