Original article

Traditional healing and primary care: A socio-cultural study in a rural *Tehuledere* community, North-Eastern Ethiopia

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Abstract

***Introduction*:** This study explored the traditional healing practices among *Tehuledere* communities of North-eastern Ethiopia with an objective to construct a rural primary health care model.

***Methodology*:** A qualitative ethnographic method was used for this study. Using Kleinman's Cultural Systems Model, we conducted participatory observation (5 months over a one year period) supplemented by ten focus group discussions (n=96) and 20 in-depth interviews with purposefully selected knowledgeable community members. The focus group and in-depth interviews included questions about the traditional healing as a health care option, relationship and referral patterns between traditional healers and biomedical care and factor influencing the decision to seek health care options. In addition, the PI observed 7 traditional healers (2 female and 5 male) and 3 health extension workers while in action and interviewed informally. The notes were expanded, read and re-read to develop themes and interpretation and narration of findings followed.

Findings: It was found that in *Tehuledere* pluralistic health-care resources were used either independently or concurrently with biomedicine. Three categories of traditional healers in the study communities were identified: *Kitel Betash* or Herbalists, *'Awalaj'* or traditional birth attendant and *'Wogesha'* or local bonesetter. Major reasons for the use of traditional healers included: perceived etiology of illnesses; the availability and acceptability of health-care services; the relationship between the health-care practitioners and the patients; socio-economic factors (cost of health care service); and the influence of social network and/or social relationships. It was also found that traditional healers have interest to collaborate with bio-medical health-care practitioners.

Conclusion: Members of the study community considers traditional healing by *Kitel Betash*, *Awalaj* and *Wogesha* as a health care option in a multiple health-care resources. In view of this a successful rural primary health care strategy would have integrated these into the strategies of rural health care. [*Ethiop. J. Health Dev.* 2015;29(2):127-136]

Introduction

In Ethiopia, people use traditional medical systems as an alternative primary health care service along with the biomedical health service for centuries (1). Despite its persistence and continued use in Ethiopia, traditional healing practices were not officially recognized or regulated in the country. Though previous studies have provided useful insights into the understanding of traditional healing in terms of the therapeutic value of medicinal plants, the numerous socio-cultural and symbolic aspects of traditional medicine have not been explored in-depth (2,3). The contribution of traditional medical beliefs and practices to primary health-care is fundamental serving as a "safety-valve' for many Ethiopians who do not have access to biomedical health-care facilities, or cannot afford the costs involved (1, 4, 5)

Integrated into biomedical health services, indigenous knowledge and skill could contribute to primary care services. The primary purpose of this study was to explore and describe indigenous traditional practices in the management of health problems. Besides, it intends to propose a rural primary health care model that considers integration of traditional health resources to enhance primary health care services. Kleinman's Cultural Systems Model which recognizes the existence of more than one type of medical tradition in a society was adopted (6).

Methods

Design and setting: A qualitative ethnographic method was conducted in *Tehuledere Woreda*, an administrative unit in northeast of Ethiopia (7) (see figure 1). The capital of the *Woreda*, Haik, is situated 430 kms away from Addis Ababa, the capital of Ethiopia. According to the *Tehuledere Woreda* Information Office (TWIO), the *Woreda* covers an area of 45,800 hectares with a population of 152,107. There are 23 *Kebeles* (the smallest local administrative unit) administered by the *Woreda*, including 19 rural, 2 urban and 2 semi-urban towns. Residents here are members of the Amhara ethnic group and are largely Muslims. They speak Amharic, Ethiopia's official language. As predominantly rural *Woreda*, most inhabitants rely on farming. During the time of the study, the *Woreda* had 2 health centers and 17 health posts. In 2014, communicable diseases including malaria, lung infections, diarrheal, intestinal parasites, eye infections, skin disease, and rheumatism were the major public health problems in the area (8).

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Getting into the field: Given the large geographical area, the number of small communities in the region and uniformity in socio-economic and geographic characteristics, decision was made to focus on five communities for in depth study. The investigators consulted the *Woreda* health extension workers on selection of study communities. The accessibility and geographic distribution of the five *Tehuledere* sub-districts (`*ketena*`) were primary basis for selecting the study communities. Besides, the interest shown by the health extension workers to collaborate in the study was considered as an added value to select study communities. Accordingly; *Gobeya, Godguadit, Bededo, Jari and Muti-Belg* were selected as the study setting. Study participants of focus group discussions and individual interviews were selected in collaboration with HEWs and local opinion leaders.

Data Collection and Analysis: This ethnographic study was grounded in a participant observation by the principal investigator for five months between June and November 2013. This participatory observation helped to access research participants and health extension workers. The researcher was also able to participate in local activities such as rituals, festivities, public gatherings involving health practices, and converse informally with community members. Data obtained from observations and conversations were captured in the form of field notes, photographs and audio-records.

Following introductory discussions with community leaders/representatives, ten focus group discussion sessions: all male and all-female were conducted in each *kebele*. Study participants were adults over 30 years of age identified in consultation with health extension workers based on their knowledge about local health traditions and willing to participate in a conversation. The women's focus group discussion was meant to allow women to freely discuss– with no inhibitions. The focus groups lasted 1.5-2 hours and were moderated by the PI. The focus group included questions about the traditional healing as a health care option, relationship and referral patterns between traditional healers and biomedical care and perceived factor influencing the decision to seek different health care options.

Semi-structured interviews were conducted with 20 participants following the focus groups to obtain more detailed understanding of the traditional healing systems. Interviews lasted 1–1.25 hours at the participants' home or in public spaces in the villages. We also conducted informal conversations with healers (n=7) and 3 health extension workers on beliefs and roles played by traditional healers in the healing process. The number of focus group discussions and interviews was informed by data saturated (7, 10).

All focus group discussions and interviews were audio-recorded and transcribed verbatim in Amharic. Texts were read independently by the PI and another professional who speaks the local language and codes were developed in reference to the research questions. Each of the codes were organized into higher-order conceptual themes. These individual codes and themes were discussed at group meetings until consensus was reached on basic themes and subthemes across the focus groups and interviews. Finally the themes were incorporated into a conceptual model of the participants and their beliefs in traditional healing system and rural primary health care (10).Sections of original transcripts and key quotes considered to be illustrative of the emerging themes were translated into English to facilitate discussion with the full research team.Data analysis was supported by the use of NVivo 10 computer software.

The researchers shared findings with research participants and the local research assistants to confirm interpretations are accurate and reflect evidences believed to reflect the community. The findings from different methods were triangulated (7).

The key findings are organized into three major themes. First, an attempt was made to describe cultural beliefs and perceptions surrounding traditional healing as a health care option among multiple health-care resources. Second, relationship and referral patterns between the traditional healers and biomedical practitioners are presented. Third, the perceptions of the *Tehuledere* people about factors related with decisions to seek different health care options, with particular emphasis on traditional healing are described. Finally, the emerging model of the traditional healing system and practical implications for primary health care are articulated.

Ethical clearance: Approval of the study was obtained from the Ethical Review Committee of Addis Ababa University, College of Health Sciences (#037/13/PSP). All participants who participated in the focus groups and interviews gave informed consent and their anonymity was maintained.

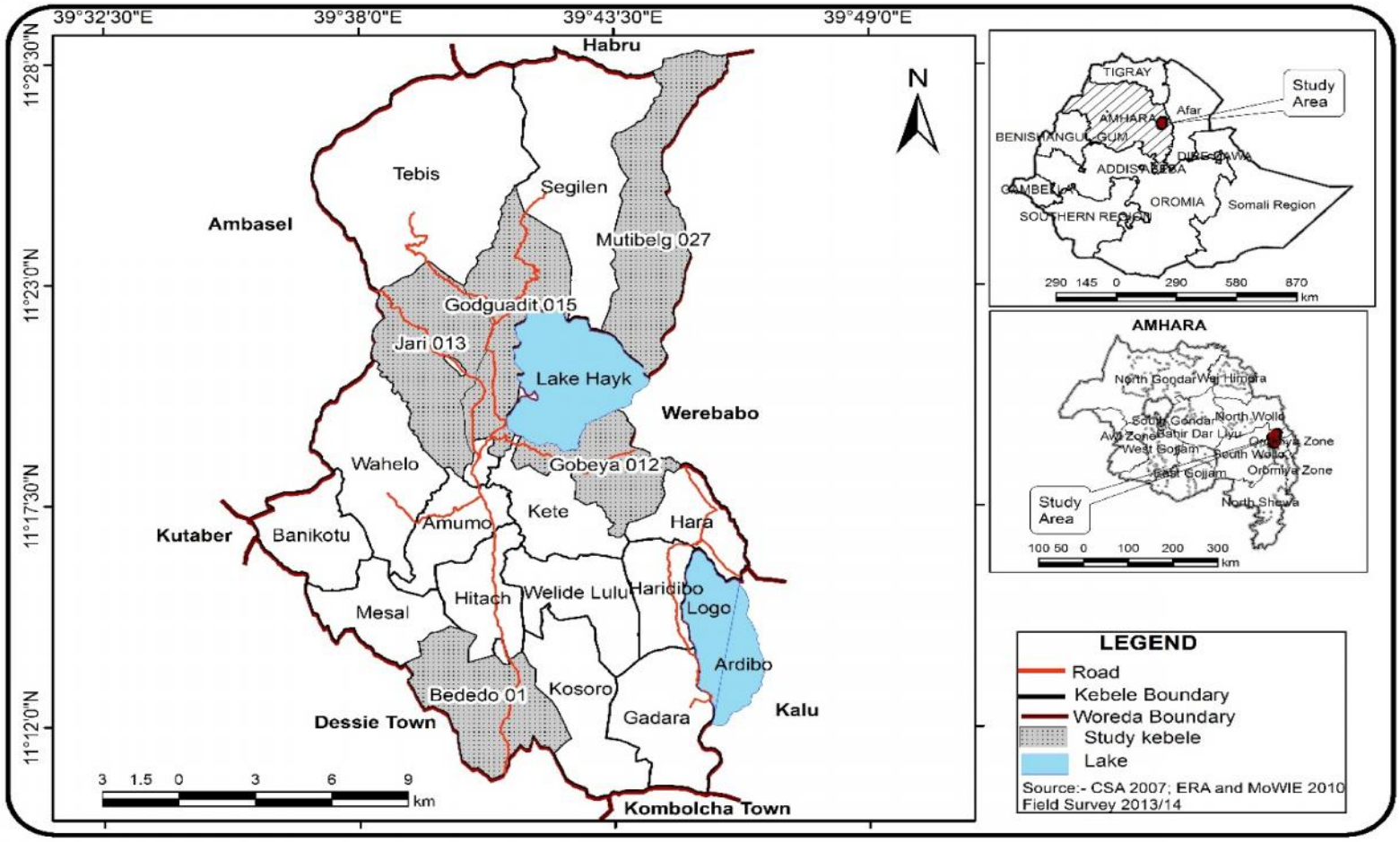
The first author's "native" status offered both opportunities and limitations for the study (11). He approached this ethnographic work as an "Amharic" speaker, member of the "Amhara" elite and senior pharmacy professional. He was able to use his networks and contacts within the indigenous institutions, including traditional leaders and local health officials, thereby gaining access to cross-section of population. He carefully reflected on how the data collection process influenced his own perceptions, and how other people respond to him. He faced with the challenge of being perceived as a powerful individual due to his position as a member of the elite and a senior university lecturer. All of these issues concerning competing roles and social perceptions relate to the concept of insider bias. The use of open-ended questions, as well as informal conversations with informants on topics they themselves raised, were among the ways pursued to mitigate these challenges.

Table 1: **The health problems that the respondent from focus groups and in-depth interview managed by herbalists, Tehuledere, North-eastern Ethiopia, May 2013- April 2014**

S.N.	***Health Problem (Local Name)***	***Biomedical equivalent***	***Perceived Causes***	***Management steps/strategies***	***Rationale for referral***	***Referral source***
1	*Yewef beshita*	Jaundice	Caused when the bird */an owl/* that sees a woman's blood from the menstrual cycle, goes around a person 3 times; *Caused by an owl* ***(yelelit wef).*** *There might be something that this bird infected/touched.*	a) Give the patient mixtures of water and peelings of leaves or macerate this mixture and give as drunk. Then when the patient sees the water, the disease comes out in the form of vomit and diarrhea b) Prepare one can of red teff and grinded it; baked grinded *teff* after mixing with the medicine prepared from the leaves of *sensal, panoalal (Dasminum abyssinicus),digita (Calpurnia aurea), atuch (Verbena offcinalis)* and the leaves, barks or resin of zigba (Podocarpus falcatus). Contraindications: 'don't eat cattle's meat and milk and sexual intercourse	Dealt with healers	Unnecessary
2	*Kintarot*	hemorrhoids	Strong heat; for instance, if a person sits on heated soil or stone, or if a person uses heated stones as toilet paper	a) rubbing with the leaves of hulagab or chifreg b) poulticing with the stem of embacho and rubbing with its leaves. c) applying the sap of antarfa (Euphorbia longi-petlata), or qinchib (Euphorbia triucale) d) Cut the *Kintarot* using a razor and wash the blood with water; put an ant's egg on the wounded part and wrap with a scarf (cloth). Contraindications: avoid eating beef and drinking alcohol for about one year; moreover, refrain from sexual intercourse for about five months.	If get worsen	Health center
3	Yelij-t'ilat[literally means enemy of the child]	herpes zoster	The perceived cause was said to be a lizard-like animal which is found mainly in the study areas.	a) The medicine is a leaf, it's squeezed and mixed with water or butter and applied on to the affected area. It will stop burning immediately after application. It could be applied on the mother or the child first. Once he/she gets a relief from the first medicine another medicine will be dried and powdered. Then it will be applied on the affected area. It's given for three days and before application you have to wash the area with soap and water. It will heal after three days. b) There's a leaf that will cure it. They mix it proportionally and drink it in a sufficient amount. It will totally cure the disease	Dealt with healers	Unnecessary
4	*Sireyet* or '*ije-seb'* (lit. 'The hand of [another] human')	[Digestive disorders associated with food intake]	Causes: 'evil-eye' inflictions; poisoning once food intentionally by enemies and if a snake's licks a stirrer and if its saliva gets into the wot/sauce	a) The chicken preparation, has a medicine as well, is made as a soup/sauce and taken by the patient to take out the creature on the abdomen through vomit and diarrhea; It is a one day treatment. *b)* The herbal medicine mixed with Tela, local alcoholic beverage, will be drunk and then a jar is also kept there. After they finish drinking, they throw up and you can see what comes out. Something like the head of lizards or frogs comes out while vomiting. There are people that took it up to 7 -14 days	Dealt with healers	Unnecessary

Table 1: cont.

S.N.	***Health Problem (local Name)***	***Biomedical equivalent***	***Perceived Causes***	***Management steps/strategies***	***Rationale for referral***	***Referral source***
5	*Chief*	Eczema	Washing the body on polluted water or pond/ also perceived as caused by washing the body with water infected with Jinn or Satan.	a) Washing the sore with the crushed leaves of *astenagirt* (Datura stramonium). b) Applying the pounded leves of waginos c) Rubbing the sore with the pounded root of *samma* (urtica simensis) or yameder embway. d) Smearing the affected part with *dinne* (Yellow sulphur)	Dealt with healers	Unnecessary
6	*Sinfete wosib/ I*	Importancy		a) Drinking a potion of the pounded rot of busqe with milk or honey. b) Taking an infusion of the pounded root or marenz (Acokanthera schimperi) c) Chewing the root of chifreg (side ovate) and sucking the juice D0 Drinking a concoction of the pounded root of labit (Tragia pungens) and zrch embway (Solaum sp.) with milk	If get worsen	Health center
7	*Neqersa*	Scrofula	Washing the body with water in which the jinn/Satan/ used to wash	a) Applying a paste of the sap of qulqwal, the pounded leaves of ese menahi and tult. b) Plastering the sore with the bruised leves of embacho, or ese seol. c) applying the sap of qulqwal d) applying sumanfar (?) kebra seamy or some gunpwder	Symptoms growing Worse	Health center
8	Ebab sinedif	Snake-Bite	Caused by bite with snake	a) Lngesting the pulverized root of ese amera or ese lebuna (Stureja biflora) with honey. b) Chewing the root or digita (Calpurnia aurea) and sucking the juice c) ingesting the pounded root of kafato (?) with honey d) chewing the root of chifreg e) Making an incision and sucking out the poison by mouth.	Dealt with healers	Unnecessary
9	*Rih*	Gout	Caused by contamination of the blood due to environmental pollution	a)Drinking a cold infusion of the boiled leaves of ese amera (Plumbago zeylanica?) with milk or honey. b) Taking the jice of the leves of semanak with fat. c) Hydrotherapy or repeated immersions in hot springs	Not improving	Health center
10	Lemt	Vitiligo	Caused by curse by elders or religious clergy	Rubbing the affected part with the leaves of *tenjut* and *waginos*	Dealt with healers	Unnecessary



Source: TWIO, 2014

Figure 1: **Map of *Tehuledere* Woreda, South Wollo Zone, Amhara Regional State, North-eastern Ethiopia, 2014.**

Findings and Discussions

Demographic Characteristics of Participants: In total, 96 people participated in the focus groups. Number of participants in each focus group ranged from 8 to 12, with a mode of 9. Participants ranged in age from 35 to 79 years, with a mean of 42 years. Most participants identified themselves as Muslims (n = 92) and others belong to the Ethiopian Orthodox Christian. Most of the participants were married and a few described themselves as widows/widowers. More than half reported that they cannot read or write (n = 53). Twenty individuals, selected from among focus group participants participated in in-depth interviews (Male=11 and Female=9). They were very similar to the focus group participants in their demographic characteristics. Those who were observed and also conversed with us has age range from 37-75 years while age of the 3 health extension workers ranges from 30-35 years.

Traditional Healing as a Health-Care Option: Medical pluralism as described in Kleinman's Cultural Systems Model was found to prevail among the *Tehuledere* community. The community was found to use multiple health-care resources either side by side or simultaneously. Most of focus group participants (n=9) stated that they are consulting traditional practitioners such as herbal healing, bone setting and traditional birth attendant as the first entry for perceived ailments or seeking bio-medical care.

Traditional practitioners are believed to be helpful in the prevention and treatment of variety of illnesses that cannot be cured with modern medicine:
If you go to a doctor seeking treatment for Yelij Tilat [Herpes Zoster] and Yewof Beshita [Jaundice], he will only take you to death….rather we use Kitel Betash, herbalist, in our village [Male ,59].

Similarly, there is a widespread belief among the *Tehuledere* people that Traditional healers are more effective, faster and less expensive than the biomedical professionals for fractures and attending births.

We found three categories of traditional healers in the study communities: *Kitel Betash* (Herbalists), *'Awalaji'* (traditional birth attendants) and *'Wegesha' (*bone setters). Details of these healers are further elaborated below.

***KitelBetash (Herbalists*)**: In this paper, the term herbalist refers to all practitioners who use only herbs or combine herbs with 'invocation or an act of supplication in Muslims' remedies such as herbal remedies and *"Dua"* (a prayer ceremony).

We observed that *Kitel Betash* play important roles in tackling some of the key health problems of the community. A list of ailments commonly treated by herbalists is provided in Table 1.The prescriptions, which constitute the concrete relationship between a specific ailment and the plant together with incantations are considered to be essential and the most valuable part of the healing tradition.

Acquisition of knowledge about medicinal herbs and healing skills were thought to be God (*Allah*) given. This knowledge was often passed down from generation to generation through families. Apprenticeships and verbal transmission of knowledge were commonly described.

***Awalaj (Traditional Birth Attendant*)**: *Awalaj* had a very important role in practices related to child birth and post-partum care. *Awalaj* attend expectant mother during labor and child birth.

Most of the focus group discussions (n=7) identified important roles for the *Awalaj* in delivering health care messages, providing spiritual support and healing, counseling female patients, and pregnant women. The counseling and prenatal and postnatal care by *Awalaj* sometimes is a substitute for midwifery nurse professionals. According to study respondents most women preferred home deliveries rather than delivering in a nearby health center. It was believed that they will not get the psychological treatments or comforting in the health center that *Awalaj* provide. *Awalaj* were found to be women and the new mothers would feel more at ease with their peers than with the largely male obstetricians in health center.

Respondents described the *Awalaj* as a counselor for moral supports of pregnant women and as someone "in whom everybody confides," because "sometimes pregnant women do not want to go to the health professional," and they "go to *Awalaj* who are knowledgeable." The knowledge of *Awalaji* was handed down from generation to generation within families or through informal apprenticeships.

***The 'Wegesha' (Bone setter)*:** The word *Wegesha* literally means 'to relieve' or 'to effect cure' (9). Their activity focuses on curing largely through physical examination and manipulation of the human body in the management of bone fractures and dislocations. Even though their knowledge of the anatomy of human body appears crude, the *'wegesha'* have some knowledge on the movement of blood vessels, bones, tissues, and arrangements of muscles, joints and ligaments. According to focus group participants, *Wegesha* intervened in cases of compounded, closed simple or complicated fractures, violently rotated limbs and broken skulls. They also handle cases like dislocated jaws and used catgut as a suture for sewing wounds.

Skills of *Wegesha* were usually acquired through very long practical experience, which serve as a source of respect and pride for many practitioners. Those families with long history of service were respected in their communities.

Relationship and Referral patterns between traditional healers and modern health care providers: Our findings show that community members use multiple health-care resources independently and concurrently. Both traditional and bio-medical health-care professionals expressed concern about patients using both systems simultaneously. Both groups agreed on the use of the other health care option under specific circumstances. However, the finding didn't show specific referrals or collaborative experiences despite evidences of interest for collaboration by traditional healers. A traditional healer reported that she is interested to collaborate with modern health care practitioners:
I am great at healing 'sire yet' [Lit. illness caused by poisoning once food intentionally by enemies*]. At times, however, my medicine may not help for this health problem. Likewise, above all, I am not experienced on how to treat tuberculosis, HIV/AIDs, diabetes and some other health problems. I would have then refered such clients to modern health centres [Female Herbalist, 80]*.

Another male participant stated that in his opinion modern health care practitioners could not understand the causes of "Jinn" and do not always "give the patient enough care and attention". Thus, he further pointed out that "*….it would be decent to refer such clients to us. This is because it is not necessary to compete with one another. We...together need to impart our insight to each other for an improved health service delivery..." [Male Wegesha, 65]*.

It is worthy to emphasize the fact that throughout the course of the discussion, tensions and contradictions were evident between indigenous healers and modern health care practitioners. The contradictions were based on differences beliefs about causes of illness/disease and diagnosis and management of such problems. Modern health practitioners do not endorse traditional healers and are skeptical about the efficacy of indigenous medicine (11).

Contrary to this, four of the traditional healers reported that they have been referring patients to modern health facilities for ailments which are perceived to have natural causation, such as HIV/AIDs and tuberculosis. Similarly, modern health-care practitioners refer clients to indigenous healers for cases of snake bites, *yewof beshita* (Jaundice) and *kintarot* (haemorrhoids). In line with this one of the health extension workers has pointed out that:
We should consider using both health care options by differentiating ailments that can be cured by traditional and modern health care. Local government should create awareness on indigenous health care practices and the traditional healers should work together with doctors who work in modern facilities. If traditional and modern health care are integrated, our community would get good service. When the government recognizes the traditional practice, knowledge associated to it can be passed on to the next generation easily [Female HEW, 37]

During our field observations, we learnt that health extension workers recognize traditional healers as helpful in healing *kintarot* (hemorrhoid), *sireyet* and *sibirat* (bone fracture). In view of such recognition, health extension workers provided traditional healers with training and medical supplies such as examination glove, cotton, jugs, gauze bandage, adhesive plaster, forceps, and scissors. They train particularly the *Awalaj, herbalists, and Wogesha* on how to use what they are supplied with. Traditional healers on the other hand assist health extension workers to mobilize community members on various community based health activities including campaigns for personal and environmental hygiene. A female traditional healer, who used to receive many clients in her home for herbal treatment indicated that:
When a patient has HIV/AIDs, tuberculosis, or malaria, for example, I send him/her to the modern health-care center, but there are problems because the modern doctors don't understand us. For ailments like yewof beshita/jaundice/, sireyet/Digestive disorders associated with food intake and jinn/evil attack, we are better prepared to treat such diseases with herbs [Female Herbalist, 74,].

Traditional Healing and Factors influencing decisions to seek Health-Care Options: Preference for the use of health care resource is found to be influenced by beliefs on etiology of ailments, availability and acceptability of health-care services, relationship between service practitioner and patients and the influence of social network or social relationships. This is similar to previous studies in Africa (13), which have described treatment-seeking behavior as determined by a range of factors including what was generated in this study.

The study has found that in *Tehuledere* belief about causes of ill-health was one of the most important factor in the preference of health-care options. Participants argued that traditional healers were sought for ailments that are caused by supernatural causes.

Availability of health-care service was another factor related to choice of health-care options. The absence of drugs in the local health post, government health centres and cost of such drugs when/if available were identified as an important reason for seeking care from traditional healers. In addition, modern health care was often not accessible due to distances which make traditional the best choice in many cases. One of the participants argued that:
There is lack of transport to go to the health centers that we mostly rely on traditional medicine as it is the only option we have[male, 63]

The cost of treatment was another factor, which determines the choice for traditional healing among those

in the study community. The cost of traditional medicine was reported to be much less than the cost of modern health care. Some of the participants shared their concerns over limited discussion with the biomedical provider about their problem that they don't understand what was wrong with them or why and how to use the medicine that has been prescribed:

Traditional healers are regularly giving extraordinary time to discuss with us and they are much closer in and treating us like their relative. They are talking and amusing us. Be that as it may, the bio medical specialists are not talking and drawing closer well. Contrasting with the traditional healer, they don't have great open conduct [Female, 64].

This story portrays that traditional healers are good in communicating with their clients as compared to modern health care providers.

We likewise found that social relations and social networking play an important role in shaping individuals' preference of health care options. Participants have also pointed out that they chose traditional healing based on advices from the elders within the family or the community. In the study community, advice and guidance from the elderly is respected and observed. It was found that individuals prefer traditional health-care institutions in respect for guidance from the elderly no matter what the person believes is the right choice.

… Once in a while, our parents and elderly individuals even from neighborhood may advice and guide you to take treatment from the traditional healers. Bridging their advice may bring bad omen and condemnation that may bring about another ailment [Male, 45,].

Functioning Model of Traditional Healing System

Despite the established power differences and marginalization by biomedicine, traditional and modern health care systems coexist in the study community as would be predicted by Kleinman's Cultural Systems Model .People may use treatment provisions exclusively from one option or use medicines from both options concurrently. It is important to address some of the ways in which traditional healing and modern health care can benefit each other resulting in a more balanced exchange between the two (13).

One way to provide a bridge between the traditional healers and modern health care providers appears to be the health extension workers. Among the roles of health extension workers facilitating integration of the beneficial aspects of traditional and modern health care resources is critical for improved health of the local community and optimal use of limited resources in the primary care. We observed that this cooperation of health extension workers, traditional healers and modern health care practitioners was working well in *Tehuledere* communities.

It was evident that *awalaj* provides health services to mothers and health extension workers provide important materials to the *awalaj* so that they may provide safe healthcare services to the community and protect against infections. The health extension workers use the traditional healers as intermediaries to facilitate interactions with community members since they are more accepted and respected. So, the health extension workers provide education and some community based activities in collaboration with the traditional healers. For example traditional healers are often responsible to disseminate any information and socio-cultural issues to the community during the bimonthly meetings held in the villages.

Finding from this study indicate the functioning rural primary health care model is best with all health care options working together.

Practical Implications for a Rural Primary Health Care ModelIB: Based on findings from this study, this section describes an integrated rural primary healthcare model. More advocacy and community mobilization on the need for cooperation between the two medical systems is recommended. The proposed model recognizes that both resources are equally important. Some herbs used by herbalists are effective, although others may not be and much research is needed to build an evidence base in this area. Much of the bone setting work of the *wegeshas* is clearly helpful, although conventional medicine may be needed in more complex cases. Similarly, the activity of the traditional birth attendant (or *awalaj*) also fulfills a very important need within the community especially for uncomplicated labor and delivery.

Currently the Government of Ethiopia is developing primary health care through its Health Extension Program and Primary Health Care Units as the principal strategy to achieve service coverage. It is investing to reduce disparities and improve equity and access through new strategy for community-based services focused on teamwork (14).It is in this part of the plan that the findings from this study are most applicable.

Buhrmann explains the importance of not only linking health to an individual but to the whole community, especially in preliterate communities where health information is shared by word of mouth from generations to generation (15).A situation analysis by Federal Ministry of Health of Ethiopia pointed out a number of challenges to implementing primary care including: inadequate capacity to implement a decentralized health system, weak referral network, low effective coverage of high impact interventions, inadequate biomedical drug supplies at health facilities, and lack of human resources (16).

Many scholars who conduct research on the area of community participation and primary health care in developing countries pointed out that health

improvement depends on more than just one health care resources and centrally imposed public health solutions may be counterproductive (17-21).The essence of Alma Ata declaration was a shift in power from the providers of health services to the consumers of the health services (22).The community approach to health care sees home and traditional healers as the first entry point to primary health care, and the indigenous healers from rural villages like *Tehuledere* as first-line healthcare practitioners for perceived ailments.

Our findings revealed that decision-making on treatment seeking for ailments is complex and influenced by cultural and personal beliefs, individual experiences, and socio-economic features. Besides, the rising cost of modern health care, the shortage of health professionals in the rural areas, poverty and personal and spiritual beliefs on the cause of illnesses, social relations and social networking tended to increase the utilization of traditional medicine among the *Tehuledere* community. This is the basis for a functioning rural primary health care model that is currently in operation in the study community as well as similar settings elsewhere. A bridge of caring was built between traditional healers and the primary health service (i.e. the health posts) in the management of perceived common ailments, such as *Yew of Beshita* (jaundice) and *Yelig Tilat* (Herpes Zoster) in the village. Another bridge of care was between the health posts and the health center for the management of the other health problems, such as HIV/ AIDS and Tuberculosis, which the study communities experience as critical. The role of health extension workers was very important for this integration.

Conclusion:

This study found that community of *Tehuledere* enjoys pluralistic health-care resources that they use either independently or concurrently. The study identified that, people turn to traditional healing systems (such as herbal healing, bone setting, traditional birth attendant), and modern heath care options when they encounter health problems.

The findings of the study indicated that the *Tehuledere* community's choice of health-care options have been influenced by the socio-cultural and economic conditions such as: beliefs of illness causation; accessibility; perceptions regarding culturally appropriate indigenous treatments and dissatisfaction with the treatment outcomes at modern health care facilities; and the relatively high cost of modern health care. The study also revealed that social relations and networks play important role in the choice people make regarding health-care options.

The finding suggests that integrating the best features of traditional medicine into the primary health care services, may enhance the reach and cultural acceptability of healthcare. The fact that extension of modern protective and curative services do not yet reach the predominantly rural population to level with which they are satisfied, traditional medicine is considered necessary to complement health care demands at least in the foreseeable future. Considering their role in the community and relative understanding of the role traditional medicine plays, health extension workers were considered to function as bridges between the traditional healing and modern health care system. The study investigators hope public and policy dialogue on the need for integration of health care resources at least at primary health care level continues.

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