

ORIGINAL ARTICLE

Etiology and Indigenous Healing Practices of Genu Kisha'a among the Shinasha of Benishangul Gumuze Region, Northwestern Ethiopia

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Abstract

Indigenous medicine is still widely used for preventive and curative purposes for various ailments. Peoples of Shinasha from Bullen districts depend on traditional medicine for their primary health care services since time immemorial. This study investigates the cultural beliefs, local terminologies, and indigenous treatment practices associated with 'Genu Kisha'a', an illness associated with the biomedical condition of amoebiasis and other abdominal diseases. Despite the widespread use of traditional medicine, there is a limited understanding of how specific indigenous illnesses like 'Genu Kisha'a' are culturally defined and treated. A qualitative research approach with an ethnographic design is employed. In-depth interview, key informant interview, focus group discussion and non-participant observation were used to elicit pertinent data about genu kisha'a. A total of 33 individuals (14 FGD participants and 19 interviewees) took part in this study. The data were thematically organized and triangulated. The finding revealed that Genu kisha'a is understood not merely as a biomedical disorder, but as part of a wider cultural system that interweaves knowledge, morality, and kinship. While its recognition often begins with the observation of symptoms, its significance extends beyond the body, encompassing recurrent disruptions to social relationships and spiritual well-being. Environmental exposures, labor practices, and moral and ritual transgressions, such as breaking food taboos and ancestral norms, are all examples of causative interpretations. Help-seeking in the community primarily follows indigenous pathways, guided by the perceived effectiveness of herbal remedies and trusted family advice. Biomedical and local approaches are often used side by side, with people moving between them based on illness perceptions, accessibility, and effectiveness. In rural Ethiopia, recognizing this pluralism can help design cooperative and socially relevant health initiatives. Culturally sensitive public health strategies that engage with traditional medical wisdom are therefore crucial.

Keywords: Genu kisha'a, Shinasha, indigenous healing, illness interpretation, abdominal diseases, ethnography

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DOI: <https://dx.doi.org/10.4314/erjssh.v12i2.9>

Introduction

Health and healing are not universally interpreted in biomedical terms; rather, they are mediated through culturally constructed worldviews and indigenous knowledge systems. In many parts of Ethiopia, indigenous medicine continues to play a central role in everyday health care, particularly in rural and marginalized communities where access to modern health services remains limited. Indigenous traditional medicine is the oldest and still widely used medical practice in Ethiopia. Although far past estimations (Bishaw, 1991) indicate that about 80% of Ethiopians use traditional medicine, more recent, methodologically sound data paints a more complex picture. Sixty five percent of Ethiopians use traditional medicine, and 46% specifically use herbal remedies, according to a meta-analysis of 36 studies (N = 16,288) (Tuasha et al., 2023). Furthermore, estimates among patients with chronic illnesses show a prevalence of roughly 57% (Tassew et al., 2024), and in Merawi town, 70.9% of adults reported using traditional healing techniques personally, with 61.5% exhibiting good knowledge of them (Wassie et al., 2015). The persistence and resilience of indigenous healing practices underscore the value that communities place on local knowledge, especially in diagnosing, explaining, and treating illness.

Among the Shinasha people of Bullen *Woreda* in the Benishangul-Gumuz region of Ethiopia, indigenous medicinal knowledge remains the primary system through which people prevent and treat a wide range of illnesses (Abrham, 2018). One such condition is *Genu Kisha'a*, which is recognized as a local illness category encompassing a constellation of gastrointestinal symptoms, including abdominal cramps, diarrhea (bloody or watery), fatigue, nausea, and bloating. These symptoms overlap with several biomedical conditions, such as amoebiasis (*Entamoeba histolytica*), giardiasis (*Giardia lamblia*), shigellosis (*Shigella* spp.), schistosomiasis (*Schistosoma mansoni*), cryptosporidiosis (*Cryptosporidium* spp.), typhoid fever (*Salmonella typhi*), and intestinal helminth infections (*Ascaris*, *Trichuris*, hookworms) (WHO, 1987). While biomedical literature identifies the transmission of gastrointestinal diseases, among others through contaminated food and water, the Shinasha explain *genu kisha'a* using culturally embedded ideas about health, environmental exposure, and social behavior.

Since these diseases share similar clinical manifestations, and laboratory confirmation is often unavailable in rural settings, *genu kisha'a* functions as a culturally meaningful, symptom-based category rather than a pathogen-specific diagnosis. Local explanatory models link it to environmental exposures, dietary practices, and moral or ritual transgressions, while treatment is primarily guided by indigenous medicinal knowledge. Recognizing *genu kisha'a* in this way allows for bridging biomedical and traditional approaches to gastrointestinal illness,

particularly diarrheal disease, in resource-limited contexts.

Despite advances in medicine, gastrointestinal remains a significant public health concern on a global scale. Particularly in areas with limited resources, they are the main parasitic causes of intestinal illness and diarrhea. Gastrointestinal and waterborne infections continue to be major global public health issues, especially in low- and middle-income areas (Ngowi, 2020). Eastern Africa has a high prevalence of waterborne parasitic diseases, according to a systematic scoping review of research done between 1941 and 2019. With prevalence ranging from 17% to 93.7%, schistosomiasis was the most frequently reported disease, with especially high rates seen in Tanzania, Burundi, and Uganda. With prevalence estimates ranging from 4.6% to 58.3%, amoebiasis was also noteworthy, particularly in Ethiopia and Kenya. The prevalence of giardiasis ranged from 0.6% to 55%, with higher rates reported in Eritrea and Uganda. The prevalence of soil-transmitted helminths ranged from 4.7% to 85%, with Somalia and Ethiopia registering some of the highest burdens (Ngowi, 2020). When taken as a whole, these results show that waterborne and gastrointestinal parasite infections continue to be a significant and enduring health concern in the area.

Despite some progress in reducing mortality, gastrointestinal disorders have continued to be a significant global health concern in recent decades. Half of the burden was borne by children under five, especially in low-SDI areas where inadequate nutrition and recurrent infections increase vulnerability. Diarrheal diseases alone were estimated to have caused 1.17 million deaths globally in 2021, down from 2.93 million in 1990, but they still accounted for about 59 million DALYs (GBD 2021 Diarrhoeal Diseases Collaborators, 2025; Troeger, C et al., 2018).

Ethiopia has a consistently high prevalence of a number of waterborne parasitic infections Ngowi (2020). The prevalence of schistosomiasis varied from 1.9% to 73.9%, and it was most common in peri-urban and rural areas. There was notable regional variation in the prevalence of amoebiasis and giardiasis, with reports ranging from 4.6% to 15.3% and 0.6% to 55%, respectively. Estimates of the prevalence of soil-transmitted helminths range from 41.7% to 52.4%, indicating their continued prevalence. According to the review, Ethiopia is one of the Eastern African nations with consistently high rates of these infections, which are mostly caused by contaminated water supplies, inadequate sanitation, and restricted access to medical care (Ngowi, 2020). The impact is particularly evident in rural and under-resourced regions of Ethiopia, where limited access to clean water, sanitation, and health services contributes to high rates of gastrointestinal illnesses (Abossie & Seid, 2014; Alelign et al., 2024).

Structural obstacles like limited access to formal healthcare, economic hardship and geographic isolation exacerbate the disease's persistence in areas like Northwestern Ethiopia. However, despite these obstacles, communities continue to respond to illness by using deeply ingrained indigenous medicine (IM) systems. Treatment of waterborne parasitic infections among the Shinasha is intricately linked to holistic healing techniques, traditional knowledge, and reliable local remedies (Abrham, 2018).

Ethnographic studies that examine how communities themselves view, use, and assess indigenous approaches in connection to common illnesses are remarkably lacking, despite the methods' enduring popularity and continued applicability. Specifically, from a cultural standpoint, little is known about waterborne parasitic diseases, like *genu kisha'a* (amoebiasis) among the Shinasha. The majority of current research focuses on biomedical prevalence and control methods, paying little attention to the cultural meanings, logics, and therapeutic approaches related to these conditions.

Even though many Ethiopian communities still rely heavily on indigenous healing methods for health care, public health systems and biomedical narratives tend to ignore or undervalue them, often depicting them as outdated, ineffective, or even dangerous. In addition to undermining local knowledge systems, this dismissal runs the risk of destroying confidence in modern health interventions, which would alienate the very populations that these systems are meant to assist.

By recording and examining the local meanings, customs, and perceived efficacy of traditional treatments for *genu kisha'a* among the Shinasha people, this study aims to fill this gap. By doing this, it adds to more general conversations about health equity, medical pluralism, and culturally sensitive healthcare.

Benishangul-Gumuz is one of the highly gastrointestinal diseases affected region in Ethiopia. In the year 2019, diarrhea diseases were the second leading cause of death, next to lower respiratory disease in the region (MOH-Ethiopia, 2021). Despite the significant presence such illness in the region, there is lack of ethnographic research that examines how local communities conceptualize and respond to such conditions. Existing public health efforts often overlook the explanatory models and healing logics of indigenous communities, resulting in limited acceptance of biomedical interventions. It has been suggested that understanding community beliefs and practices is crucial for designing culturally appropriate health education and intervention strategies.

Therefore, this study aims to explore the cultural beliefs, local terminologies, and indigenous treatment practices associated with *genu kisha'a* among the Shinasha

people of Benishangul Gumuz Region. It also seeks to contribute to broader debates on the coexistence and tension between biomedical and indigenous health systems in Ethiopia.

Materials and Methods

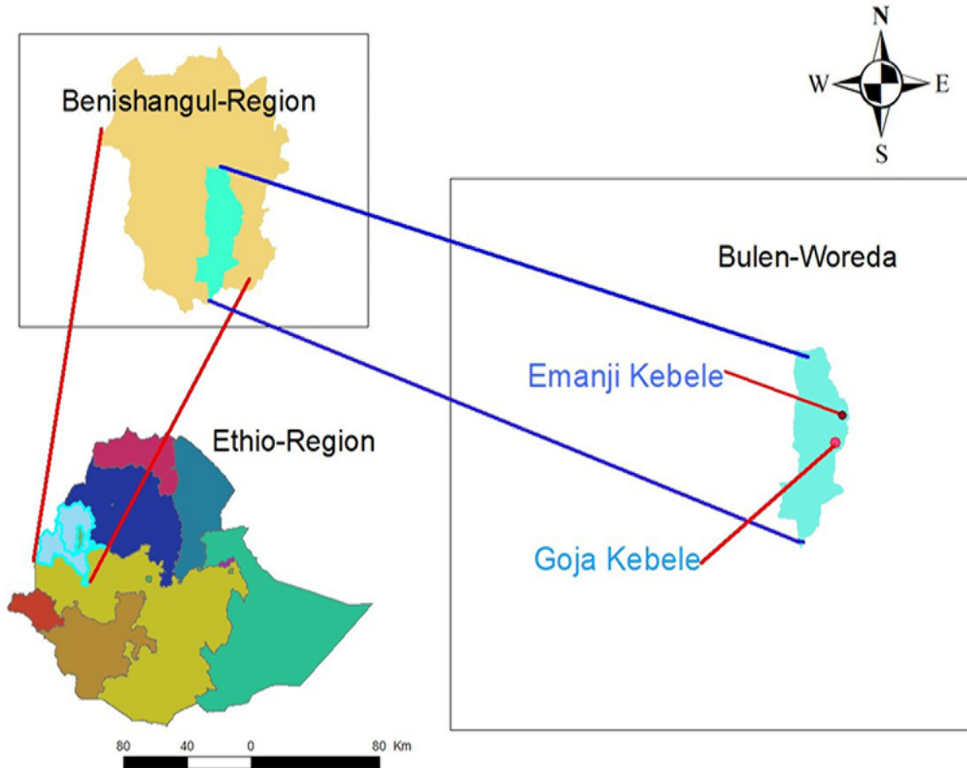
Description of the Study Area

The Shinasha are a minority ethnic group in Ethiopia and the Region, constituting 7.7% of the population of Benishangul-Gumuz Region (CSA, 2008). While regionally smaller than the Berta, Amhara, Gumuz, and Oromo, they form the largest group in Bullen *Woreda*, accounting for 48% of the local population (CSA, 2008). The majority of Shinashas inhabit in rural areas in the Metekel zone, mainly in Wonbera, Bullen, Dibatie and Dangur sub-districts. Their language Shinashegna (Borna) belongs to the North Omotic, Gonga language sub-family. Areas occupied by the Shinasha people range from highlands to lowlands.

The prominent agro-ecological feature of Bullen *Woreda* consists of mainly warm and moist (sub-humid lowland to mid and highland cool sub-humid). The dominant agro ecological zone of the *woreda* is mostly Kola (lowland) which constitutes 85% of the territory. Woinadega (mid-highland) and Dega (highland) zones cover 10% and 5% respectively. Economically, the Shinash people rely on subsistence agriculture.

In Bullen *woreda*, there are four (4) health station, nineteen (19) health care centers and one (1) hospital, but there are many villages that have no nearby health care center. For instance, Dugi, Zigih, Dosh, Mindi, Gichi bemeti and E'etushi are some of them. However, in Emanji and Goja kebeles, the study area, there is only one healthcare center with two health extension workers.

Figure 1: Location map of the study area



The existing enormous dependence on traditional medicine is caused in part by the limited availability of biomedical services, such as underequipped health facilities, a lack of necessary prescription drugs, and financial or geographic obstacles that make access to formal care challenging. Consequently, the district's everyday health management and primary healthcare still heavily rely on indigenous medicine.

Research Approach

This study employed a qualitative research approach with an ethnographic orientation, guided by the anthropological imperative to understand cultural knowledge systems from the emic perspective—that is, from within the lived experiences and meaning-making processes of the community under study. Explanatory models, as conceptualized in medical anthropology (Kleinman, 1980), were used as an analytic framework to interpret how participants described the

causes, symptoms, and treatments of *genu kisha'a*. This approach allowed the study to capture both the depth of participants' lived accounts and the cultural logic through which illness is understood and acted upon. According to Russell (2006), qualitative research gives the researcher access to rich, complex, and context-specific data, particularly when it comes to subjects that are intricately woven into local life ways and belief systems. Thus, for this study, which aims to investigate the Shinasha people's indigenous medical knowledge, the qualitative tradition is suitable. This method made it possible to engage deeply with participants' cultural constructions of illness, healing, and the function of traditional medicine, in line with Creswell (2009) and Patton (2014).

Research Design

An ethnographic research design was selected in order to take into consideration the range of viewpoints and approaches related to indigenous methods of medication. This design facilitated triangulation by utilizing focus group discussions (FGDs), in-depth and key informant interviews, and non-participant observation. This kind of multi-method approach is in line with anthropological ethnography, which develops understanding via fieldwork and ongoing engagement.

Participants and sampling technique

The study was conducted in Bullen district, in northwest Ethiopia, specifically in the Emanji and Goja kebeles, where *genu kisha'a* is reported to be a particularly serious problem, according to 2021–2022 reports from the *woreda* health office. Participants in the study included male and females community members of various ages, biomedical health professionals, indigenous healers, and people who had suffered from amoebic illness. These individuals were regarded as cultural specialists whose expertise and life experiences were crucial to the study's goals. Overall 33 individuals (19 men and 14 women, aged 19 to 72 years) were selected using purposive sampling technique. Nineteen participants (11 men and 8 women) were chosen for in-depth and key informant interviews. Seven of them were indigenous healers, 6 of them were community members who had experienced *genu kisha'a*, and the rest 6 of the participants were key informants (2 traditional/indigenous healers, 2 biomedical professionals, and 2 knowledgeable elders). Besides, 14 individuals from both sexes were purposefully selected for two focus group discussions.

Recruitment methods varied across group of participants. Indigenous healers were first identified through community leaders and elders, and further participants were located using a snowball approach, where one healer referred others recognized for their expertise. Patients with direct experience of *genu*

kisha'a were identified and referred by healers, ensuring inclusion of individuals with lived illness experiences. Biomedical practitioners were selected from the only health post in Emanji kebele, while knowledgeable elders were approached with the support of community leaders. Finally, focus group participants were purposively chosen from both Emanji and Goja to reflect diversity in gender, age, and occupation, with invitations extended during community gatherings.

Data Collection Methods

In-depth interview: This method was employed to elicit not just factual data, but also symbolic meanings, social relationships, and cultural interpretations related to health and healing (Dawson, 2002). We have collected detail information about *genu kisha'a* from seven traditional healers and six former patients of the disease. Indigenous healers provided insights into cultural conceptions and healing practices, while sufferers contributed lived experiences and social interpretations of the illness.

Key-informant interview: Key informants were traditional healers, selected elders and the health workers. We chose two persons from each category and harnessed a lot of information about the cultural beliefs towards the cause, symptoms and prevention strategies of *genu kisha'a* as well as indigenous treatment practices associated with the illness.

Focus Group Discussion (FGD): Two focus group discussions (FGDs) were held. Six people who had encountered *genu kisha'a* in the previous five years participated in the first focus group discussion (FGD), but they were not included in the in-depth interviews. Their individual experiences with *genu kisha'a* and the therapies they employed were covered in detail in this conversation. The second one was held with carefully selected eight community members to crosscheck the data gathered through in-depth and key informant interviews and gain new insights about the nature, causes, prevention strategies and treatments of *genu kisha'a* used by the local community.

Non-participant Observation: this kind of observation was conducted without taking an active part in the situation under study (Jibril, 2018). It gave us the opportunity to record observable behaviors about the topic under study in our field notes. The interaction between traditional healers and their patients and the local community as well as their respective medicinal plant garden were observed.

To ensure comfort and confidentiality, all interviews and focus group discussions were conducted in the participants' homes, community centers, or other preferred locations. With the participants' permission, audio recordings of the sessions were

made in Shinasha vernacular. Discussions on subjects like illness recognition, regional terminology, causality beliefs, treatment practices, and experiences with healthcare systems were facilitated by interview guides. The principal investigator moderated the focus group discussions (FGDs), promoting candid conversation and guaranteeing that all participants could express their viewpoints. In order to record observations, contextual information, and nonverbal clues, field notes were taken both during and right after each session.

Data Analysis Method

The data gathered were analyzed through thematic analysis method. All the audio files have been transcribed (and later translated into English) by one of the researchers, who is a member of the Shinash community and native speaker of Shinashegna (Borna) vernacular. After familiarizing ourselves to the transcribed data through reiterated reading and close examination, all the data were coded. In doing so, we identified common themes and categorized them accordingly. We then synthesized these findings into a comprehensive report.

Ethical Consideration

This study was conducted in accordance with established ethical standards for research involving human participants. All participants were informed about the purpose of the study and their right to withdraw at any time without consequence. Consent was obtained verbally, as many participants preferred oral agreement over written forms, in line with local cultural practice.

To ensure protection of informants' identities, pseudonyms were used in all transcripts and reports, and identifying details such as specific locations or personal histories were omitted where necessary. Special attention was given to indigenous healers, whose medical knowledge is both socially sensitive and culturally significant. Their contributions were treated with respect, and findings are presented in ways that avoid misrepresentation or appropriation. Throughout the research process, principles of respect, honesty, and minimization of harm were followed to safeguard participants' social and personal security.

Findings

Cultural Logics of Amoebiasis and Embodied Experiences

The ethnographic results presented in this section shed light on the local conception, diagnosis, and treatment of *genu kisha'a* within a larger cultural and social context. Instead of viewing illness as purely biological, the community members use culturally embedded frameworks that integrate environmental,

moral, spiritual, and social aspects to understand abdominal disorders, including those linked to amoebiasis.

Experiences of symptoms like fatigue, diarrhea, and stomach pain were not always identified as a single biomedical illness but rather were placed within adaptable local taxonomies of suffering across households and conversations. Treatment decisions, causality interpretations, and thresholds for seeking care were found to be highly contextual, originating from bodily knowledge, local epistemologies, and routine negotiations between various therapeutic options.

The data revealed four major themes. These consist of: local conceptions of abdominal illness; meaning and interpretation of symptoms; causal beliefs and moral dimensions of illness; and indigenous healing practices and help-seeking behavior. Taken as a whole, these topics shed light on how *genu kisha'a* is not only managed but also understood, personified, and given social significance. They illustrate the dynamic interplay between symptoms, social roles, spiritual beliefs, and the broader structural forces that shape access to care.

1. Local Conceptions of Health and Illness among the Shinasha

Among the Shinasha people, health and illness are understood holistically, encompassing physical, mental, social, spiritual, and environmental dimensions. Health is not merely the absence of disease; it is a state of overall well-being, balance, and harmony with oneself, the community, and the environment.

1.1 Perceptions of Health

Community members describe health as being physically well, having a good appetite, sleeping properly, and being active and productive. Beyond physical aspects, health is closely linked to mental stability and internal peace. An informant explained this as:

“Being healthy is not only related to the physical well-being of a person; it also involves mental stability and internal peace. People who are free from stress... can make their day full of joy and success” (woman, age 25).

Health is also associated with harmonious social relations. A 28-year-old informant noted:

“To be healthy, it is necessary to respect the socio-cultural traits of a given community, support each other, participate in associations, and solve conflicts peacefully.” Health may further be framed in terms of family and economic stability. According to a 45-year-old female key informant, “Health is the state of having a happy family, stable life, stable economy, and stable working

environment.”

Spiritual and ecological responsibility is likewise emphasized. An elderly key informant remarked: “A healthy person does not damage natural resources but works to preserve and develop them”.

1.2 Perceptions of Illness

Illness is understood as the disruption of this holistic balance. It is not only physical discomfort or inability to perform daily tasks but also emotional instability, negative thinking, and social disharmony. A 35-year-old male FGD participant summarized this view saying “Illness is a bad feeling and unhealthy experience of an individual”. Illness may extend beyond the individual to encompass social, economic, or political instability, indicating that the community’s well-being is integral to personal health. Mental states such as persistent negative thinking are considered symptomatic of illness. A 45 year-old female key informant explained: “Someone who develops bad thinking habits and negative attitude is not normal; they are living under ill conditions”.

1.3 Perceived Causes of Illness

Among the Shinasha, illness is understood as resulting from a combination of supernatural, physical, hereditary, contagious, and psychological factors.

Supernatural causes, including evil spirits, ancestral spirits, and the evil eye, are believed to affect both physical and mental health. A 58-year-old female key informant explained: “It is common that evil spirits affect people who do not respect God or the community; they can gradually cause mental illnesses.” Similarly, a 38-year-old male participant noted: “Most people protect their children from those who are considered to have an evil eye, especially during weddings or festivals, because it can cause illness.”

Physical and natural causes, such as environmental exposures, contaminated food and water, and certain locally available plants, are also recognized. A 38-year-old male participant stated:

“Our environment provides many fruits, but some like ula’a can cause abdominal pains or stomach illness if eaten, and children are punished for eating them.”

Hereditary causes, often linked to familial oaths or curses, are believed to transmit disease across generations if unresolved. A 67-year-old traditional healer explained: “If someone’s illness comes from an oath made by their ancestors, it must be solved through guidance from community elders.”

Psychological factors, such as stress, are acknowledged as visible contributors to illness. A 54-year-old FGD discussant illustrated: “Do not be stressed since you cannot live thousands of years. Stress weakens the body and can lead to headaches, anxiety, or depression” (FGD-2).

Collectively, these beliefs reflect a multidimensional understanding of illness, in which physical, mental, social, spiritual, and ecological factors are interwoven, guiding how individuals interpret symptoms, assign causation, and select appropriate preventive or therapeutic measures.

2. Meaning and Interpretation of Symptoms Of Genu Kisha’s

The Shinasha term *genu kisha’a*, which translates to “stomach illness”, refers to a culturally significant ailment that manifests as symptoms like diarrhea, decreased appetite, and abdominal pain. Although this category roughly matches the amoebiasis biomedical diagnosis, local interpretations take into account a complex interaction between dietary habits, spiritual influences, and environmental exposures. Health professionals, traditional healers, and community leaders all agree that *genu kisha’a* is a well-known and one of the most common health issues in the community. This reflects the ways in which indigenous disease classifications shape both the recognition of symptoms and the responses to abdominal distress.

Symptoms are socially constructed and given meaning through local cultural lenses, rather than being merely biological events. Treatment-seeking behavior, social reactions, and illness narratives are all influenced by how a community interprets symptoms. For instance, based on interviews and discussions, the experience of illness among the Shinasha is shaped by symptoms that are interpreted as signs of environmental contamination, spiritual imbalance, or moral failing.

According to local interpretations of *genu kisha’a*, the primary basis for identifying illness is observable physical symptoms that are interpreted within a cultural context. Instead of depending on a medical diagnosis, members of the community recognize the illness based on a variety of gastrointestinal symptoms, especially those that are obvious, frequent, or well-known in the community. A respected 60-year-old indigenous healer put it this way:

A person is said to have *genu kisha’a* if he/she has bloody stools, mucus in their stools, and blood-marked diarrhea. Family members advise those exhibiting these symptoms to

seek treatment through traditional medicine right away.

This shows that the recognition of *genu kisha'a* relies heavily on visible and bodily symptoms mentioned, showing a symptom-oriented local diagnostic system.

Moreover, symptoms are incorporated into the larger context of everyday life rather than being seen in a vacuum. An expanded explanation that integrates symptomatology, causality, and social impact was provided by another healer. He noted:

... if a person got sick of the *genu kisha'a*, he/she is suspected of eating raw meat, tainted food, or drinking contaminated water. Abdominal cramps, gas, and diarrhea are symptoms of the illness that makes a person hard to stay at work, attends coffee ceremonies, or get a good night's sleep.

These descriptions highlight how *genu kisha'a* disrupts social relationship and occupational life, preventing individuals from participating in work, community events, and everyday routines, thereby affecting both personal well-being and social relationships. In addition to being physically uncomfortable, symptoms like diarrhea, cramps, and flatulence disrupt important social customs like the coffee ceremony, which is a culturally significant setting for community involvement and interpersonal bonding. The effects also extend into the home and economic spheres, influencing people's capacity to work, sleep, and interact with others. In this sense, *genu kisha'a* is not just a physical ailment but also a socially and economically crippling experience, as it is interpreted through culturally embedded knowledge systems that relate physical symptoms to more general limitations in life.

3. Causal Beliefs and Moral Dimensions of the Illness

Among the Shinasha, understandings of illness are deeply entwined with beliefs about causation that extend beyond biological explanations. Many people view illness as a sign of an imbalance, whether it is dietary, spiritual, moral, or environmental. Consuming "wrong" or "impure" foods, being exposed to tainted water, or breaking moral and social norms are taken as some possible causes. The distinction between the natural and the moral worlds is often blurred by the belief that a combination of these factors causes chronic stomach ailments like *genu kisha'a*. The illness is attributed to a number of causative factors, according to community members. It is connected to contaminated food, water, or cultural transgressions. It is deeply ingrained in a morality regulated by social behavior, cultural taboos, and ritual practice.

3.1. Dietary and Environmental Factors

The Shinasha community of the study area interpretations of stomach disorders frequently highlights how the body interacts with its immediate surroundings. The natural world is viewed as both a source of resources and a possible source of harm, from drinking contaminated water to eating food that has been improperly stored or left over. As a result, illnesses such as *genu kisha'a* are ascribed to both external factors and the larger circumstances of daily life. These interpretations reflect a practical, experiential understanding of health, grounded in local ecological knowledge and everyday interactions with the environment.

A few of casual explanations about the disease are aligned with the explanation of causality found in biomedicine. The Shinasha also connected the *genu kisha'a* cause to their daily routines and eating habits. Based on the information gathered from the community members, common sources of contamination were found to be wild or domesticated fruits, such as *go'oha*, *fuya'a*, and *diw'a*, which are frequently consumed directly from the field. An excerpt from an FGD illustrates this as:

Genu kisha'a is an abdominal illness caused by consuming contaminated food, such as raw vegetables, fruits, and meat. It can also result from drinking unclean water. Since we often spend most of our time in the forests and farmlands, we have limited access to clean water and are, therefore, more likely to drink unclean water. We also frequently eat contaminated fruits like *go'oha*, *fuya'a*, and *diw'a*—which grow in our gardens and farmlands—and these can easily lead to the illness known as *genu kisha'a* (FGD-2).

Inhabitants of the study area consistently ascribed *genu kisha'a* to customs influenced by their daily lives and the environment. Focus group participants explained that the illness was caused by consuming unwashed or spoiled foods, such as raw fruits, vegetables, and meats, and drinking tainted water. They emphasized the difficulties associated with rural living, where extended stays in farms and forests restrict access to safe food preparation and clean water, increasing susceptibility to conditions that can lead to stomach ailments like *genu kisha'a*.

The aforementioned quotation exemplifies a contextual understanding of illness that incorporates practical knowledge, local health beliefs, and environmental

factors. The Shinasha understanding of *genu kisha'a* partially corresponds with biomedical explanations (specifically, contaminated water and food, and bad hygiene). It also includes culturally particular interpretations that are not included in biomedical discourse, such as spiritual imbalance, moral transgressions, or exposure to environmental forces. Both convergence and divergence are highlighted by this partial overlap: although some causative factors are agreed upon, other locally significant explanations are still separate. Understanding this dichotomy creates opportunities for culturally sensitive health education, whereby preventative programs can respect and incorporate the community's interpretive frameworks while addressing systemic issues like food safety, access to clean water, and rural exposure.

3.2. Violation of Food Taboos and Ritual Norms

According to Shinasha cultural logic, sickness can also result from breaking moral and ceremonial rules, rather than just being caused by environmental exposure or microbial contamination. Many people view the local term *genu kisha'a* as both a physiological illness and a kind of physical punishment brought on by eating foods that are socially or ritually forbidden.

Eating the meat of dead domestic animals (which were not ritually slaughtered) or of animals like monkeys or apes is often thought to be a serious moral transgression. Such behaviors are thought to be extremely polluted in addition to being unsanitary. According to a 72 years old key informant,

In our community, there are different activities that are culturally forbidden. Among them, eating the meat of wild animals like monkey and ape is completely forbidden. It is also forbidden to eat the meat of any domestic animal that dies without being slaughtered by a person. They say: '*Bi'al kirtsi gi'ezi du'ine ma'atsoo ashi'i naaraliyee, gira'azo biyeree kane'efee*'—[which means, 'a person who eats flesh of a dead animal is not considered human—even a hyena is better than him']. If someone eats such meat, he will develop *genu kisha'a*, with symptoms like bloody diarrhea.

This quotation serves as an example of how food taboos (particularly those pertaining to meat) are ingrained in larger moral frameworks that establish what it means to be socially acceptable, human, and pure. Violating these boundaries—by consuming “unblessed,” “unclean,” or ritually prohibited food—is believed to disrupt both bodily and social order, resulting in illness. In this case, *genu kisha'a* serves as both a diagnosis and a culturally significant indicator of moral

transgression.

Ritual meals are not exempt from the moral implications of food consumption. A 67-year-old male informant connected the start of *genu kisha'a* to the inappropriate consumption of beedi mishaa, a unique communal dish made with curd, butter, and chicken stew. In his own words:

Eating *beedi mishaa* alone, in the presence of others, leads to *genu kisha'a*. This food is not meant to be consumed individually—it is a communal dish to be shared with family or community. If someone eats it alone, especially in front of others, it will turn into diarrhea. At this juncture, sickness is viewed as a social corrective. Eating special or sacred food in a self-centered or improper way goes against the values of respect, humility, and sharing. The conversion of nutritious food into a cause of disease represents how individualistic behavior disturbs social harmony.

When taken as a whole, these stories show a culturally embedded explanation of disease, wherein physical suffering results from transgressions of ritual propriety and food taboos. Kleinman (1980) referred to this as an example of an illness meaning system in which symptoms such as diarrhea are interpreted in terms of both biology and morality. In relation to this viewpoint, one's level of health is a reflection of his/her conformity to social and ritual norms rather than just his/her physical condition. Instead of overlooking these moral and cosmological logics through purely biomedical messaging, public health interventions should engage with them and undertake research to assess their relevance and significance in such situations.

3.3 Familial and Hereditary Interpretation

Among the Shinasha, some illnesses—including persistent stomach conditions like *genu kisha'a*—are understood not only as individual afflictions but as conditions that may “run in the family.” This perspective draws on observations of repeated illness patterns across generations and kin groups, which are interpreted through both biological reasoning and culturally specific notions of inherited weakness, bloodline traits, or ancestral influence. In such cases, illness is often seen as embedded in family history, either through physical constitution or unresolved spiritual inheritance. These beliefs shape care practices, as families may consult elders or traditional healers to understand whether the illness reflects a shared familial vulnerability or a need for collective ritual attention.

Interestingly, among the Shinasha, *genu kisha'a* is at times understood not only as an environmentally acquired condition but also as one that “runs in families.” When illness recurs in successive generations, this hereditary interpretation frequently comes to light. An informant who had experienced *genu kisha'a* firsthand described a pattern of affliction in his family and connected the illness to transmission through the family. Additionally, he attributed his own and his family members’ recovery to the help of a well-known traditional healer. He noted:

About three years ago, I suffered severely from *genu kisha'a*, but I was completely cured by the indigenous medicines prepared by *Nemi ati dantsotsi* [a well-known traditional healer]. I believe I may have inherited this illness from my family, as both Eyaye [Borna term for mother] and my younger sister have also suffered from *genu kisha'a* multiple times—until they, too, were treated with the same indigenous remedies.

This story combines culturally grounded explanations of biological inheritance with personal experience to show how illness is viewed through a familial lens. It also emphasizes the continued dependence on indigenous healing practices, which are valued for their effectiveness as well as their ingrained cultural and historical roots.

4. Indigenous Healing Practices and Help-seeking Behavior

The Shinasha community’s approach to illness is woven into a complex web of social guidance and traditional healing knowledge. When faced with conditions like *genu kisha'a*, people choose to go to culturally grounded treatment options rather than relying solely on biomedical solutions. Deeply held views regarding the origins and significance of illness, the decision-making roles of family members and elders, and the perceived effectiveness of home cures are all reflected in these customs. This theme explores how people seek healing through familiar avenues, often beginning with trusted traditional healers, receiving support from family members, and drawing on intergenerational belief in indigenous remedies. These patterns suggest that medical pluralism is experienced as an integrated part of social and cultural life, rather than merely an alternative when other options fail.

4.1 First-Line Treatment by Traditional Healers

Among the Shinasha community, traditional healers often serve as the first and most trusted point of care for illnesses such as *genu kisha'a*. These healers draw on a deep reservoir of botanical knowledge, ritual practices, and cultural

authority to diagnose and treat ailments using locally available medicinal plants. The preparation and administration of remedies are governed by customary norms, gender roles, and spiritual beliefs, reflecting a holistic approach that integrates body, mind, and social context. Patients are not merely treated—they are guided through a culturally meaningful healing process that includes dietary restrictions, behavioral guidelines, and ritual blessings. This sub-theme illustrates how indigenous healing is not only curative but also preventive, rooted in intergenerational knowledge systems and adapted to the environmental and social realities of rural life. For many, turning to traditional healers is not an alternative but an essential and immediate response to illness.

The Shinasha community uses a combination of biomedical knowledge and culturally ingrained healing techniques to treat *genu kisha'a*. Traditional healers continue to be the main and prompt source of treatment once symptoms appear, even though basic hygiene practices like washing hands and avoiding contaminated food and water are widely recognized as crucial preventive measures.

Indigenous knowledge that has been passed down through the generations is the foundation of traditional healing for *genu kisha'a*. Each healer specializes in particular remedies and preparation techniques, and a vast variety of medicinal plants are used. E'maniyaa (*Dioscorea abyssinica*) is a highly esteemed plant, valued for its leaves for children and its powerful root for adults. Only on fasting days (i.e. Wednesdays and Fridays and with empty stomach) is this plant harvested, and blessings are given to increase its effectiveness. Following certain customs, collection and preparation are typically done by men or postmenopausal women who are considered spiritually qualified.

Other frequently utilized plants are: the leaves of the *Shawa'a* (*Vernonia amygdalina*) plant, which is grown in home gardens, are used in cooking and to relieve stomachaches. *Muna'a*: Known among the *Nihi na'o* clan, its roots resemble onions and are used to treat mucus and bloody stools. Elder healers are the only ones who can use it. A common home remedy is a mixture of lemon and garlic that is mashed into juice and eaten raw, frequently without additives. *Kua'ula* and *Shee'ri Tsa'pa* are used to treat diarrhea and amoebiasis, respectively. *Shee'ri Tsa'pa* is prized for its versatility.

Remedies are prepared and administered by crushing, boiling, chewing, or combining with water. Usually, household utensils like spoons, tea glasses, or *borde* (local beer) cups are used to measure the amount of the liquid prepared as remedies from the herbs. Age-appropriate dosages are given to children in spoonful and to adults in larger containers or vessel. While some healers discourage mild flavoring with tea or honey out of concern for diminished effectiveness, others

permit it.

Treatment extends beyond medication, encompassing the patient's beliefs and adherence to specific dietary and behavioral guidelines. Because they are believed to interfere with the medication, healers frequently forbid foods like beans, chilies, raw vegetables, fatty meats, porridge, and maize. It is also recommended to refrain from sexual activity. The patient resumes normal diet only after a ceremonial blessing, in which the healer formally authorizes the patient to resume his/her life, is when the healing deemed complete.

This process highlights the holistic and culturally embedded nature of health care among the Shinasha. In this context, first-line treatment by traditional healers is a comprehensive process that combines plant-based remedies, ritual observance, and communal support.

4.2 Family and Community Advice Networks

Additionally, healing is a collective and social activity. Families, particularly mothers and spouses, are crucial in helping patients by preparing meals and following treatment guidelines. One informant recalled how difficult it was to avoid most foods in the house while undergoing treatment, and how his wife assisted him in following the dietary guidelines.

In the Shinasha community, decisions about sickness and recovery are rarely made in isolation; they are shaped by family input, community norms, and shared cultural and spiritual understandings. Instead, they are a part of networks of caregiving duties, intergenerational trust, and family guidance. When it comes to identifying symptoms, starting treatment, and utilizing natural healing resources, mothers, in particular are essential. Family members actively influence the care plan rather than being passive observers.

This dynamic is vividly illustrated by a participant's account. The mother was the one who initially suggested seeking biomedical care after exhibiting symptoms similar to *genu kisha'a*. However, when barriers such as lack of transportation, financial constraints, or limited access to health facilities made it impossible to follow the usual care-seeking route, the mother's role shifted from navigating the health system to providing treatment herself. One of our in-depth interviewee reinforces this as:

Having suffered from *genu kisha'a*, my mother advised me to visit the health care center. I went there in the morning, but found it closed, with only the guard present. I greeted him

and asked why the center was closed, and he explained that the health workers had been in the field for five consecutive days to vaccinate children. I returned home and told my mother about this. Following this, she collected *shaw'a* leaves, crushed them finely, mixed the powder with water, and asked me to drink it from a coffee cup. She instructed me to take this remedy for five consecutive days. Although I noticed some improvement, I was not fully cured. After a week, my mother arranged for me to visit a well-known indigenous healer. I was afraid to go alone and asked her to accompany me. The healer gathered medicinal plants from his garden and provided us with instructions on how to prepare and use them. After taking the medicine for two consecutive weeks, I was completely cured of my illness.

This story illustrates that the important roles of family members, particularly, mothers in mediating various therapeutic systems. Their knowledge is based on social responsibility and lived experience, and it is both relational and practical. From suggesting a clinic visit to making herbal remedies and enlisting the help of a healer, the mother's active role reflects a culturally ingrained caregiving ethos that values continuity, kinship, and trust.

Depending on accessibility, perceived efficacy, and family consensus, these narratives demonstrate how treatment decisions are frequently co-constructed within the home, where biomedical advice and indigenous knowledge are selectively combined. In this sense, care becomes a team effort influenced by enduring cultural values and interpersonal ties rather than merely a matter of healing the body.

4.3 Perceived Efficacy of Indigenous Treatment

Indigenous medical knowledge is not just a substitute but a reliable and frequently preferred treatment option for diseases like *genu kisha'a*, among the Shinasha of Bullen *woreda*. Traditional remedies perceived effectiveness is ingrained in daily routines, ecological familiarity, and the passing down of knowledge from generation to generation. In situations where biomedical services are either unavailable or deemed ineffective, community members frequently expressed their trust in herbal preparations and the advice of local healers.

The accuracy with which traditional healers prepare and prescribe treatments was also highlighted by focus group participants, who pointed out the significance of following particular instructions as well as the meticulous dosage calibration. A community member participated in our FGD recalled his dedication to adhering

to his healer's regimen as:

My indigenous healer told me, if you want to heal from *genu kisha'a*—or amoeba—you must drink the remedy in a cupful used for drinking *borde* [local beer], every morning and night before food. You must not mix it with anything—no milk, honey, coffee, or tea. The first day I vomited because it was very bitter. My mother suggested mixing it with *borde* to make it easier, but I refused. I followed the instruction strictly for two weeks and, thanks to God, I was healed. Now I am a living testimony for others, even for you (FGD-2).

Such testimonies reveal not only perceived pharmacological effects but also a broader framework of efficacy grounded in discipline, ritual observance, and embodied experience. Trust in indigenous medicine is further reinforced by its cultural resonance—some remedies require the healer to invoke or incorporate the patient's name during preparation, are made only on specific ritual days, or involve symbolic gestures such as blessings, which strengthen both social bonds and expectations of healing. Crucially, the widespread preference for indigenous medicine is not solely a response to health system inadequacies; it reflects a deeper conviction in the effectiveness, affordability, and cultural appropriateness of local healing traditions. As one FGD participant explained, “biomedicine does not always work, but what our elders give us is effective.” In this way, indigenous healing operates as a system of care that integrates material, spiritual, and social dimensions of well-being, aligning closely with local understandings of illness and recovery.

4.4 Prevention Strategies and Everyday Health Practices

By their daily routines, moral behavior, and space-use and organization practices—such as keeping homes clean, separating waste, and making sure that water sources are safe. The study community places a high priority on preventing diseases like *genu kisha'a*. These behaviors represent fundamental public health concepts and represent an indigenous logic of cleanliness, bodily integrity, and social responsibility, even though they are not always expressed in biomedical term.

The risks of eating unwashed or spoiled food, particularly raw foods like meat, vegetables, and fruits, were often stressed by informants as the causes of the disease. It was mentioned that washing hands, sometimes with soap but more often with ash or local leaves, was a customary precaution, especially before meals and after returning from forests or fields. A 54-year-old FGD participant explained his belief on how to prevent *genu kisha'a* as follows:

It is necessary to create awareness to our family and

community members regarding the cause and prevention mechanisms of *genu kisha'a*. Especially, children have not developed the habit of hand washings, which can easily cause *genu kisha'a* and lead them to different adverse impacts of this illness. Hand washing before serving food is important in preventing the disease. Therefore, it is necessary to advise all families to wash their hands properly before going to eat any kinds of food (FGD-1).

In addition to hygiene related care, many also recommended consumption of certain food items (including garlic and chilies) to avoid the illness. Besides, eating together was also mentioned as a preventive strategy, not just a cultural preference but a defense against what one participant called “the illness of isolation.” For example, eating *beedi mishaa* (a fermented staple) alone was considered as dangerous since it is believed to cause *genu kisha'a*, or diarrhea, in addition to breaking social norms. The reasoning behind such beliefs may have its roots in collective memory, wherein some foods are believed to disturb bodily harmony if they are handled improperly or consumed covertly.

Discussion

This study explored Shinasha conceptions, causal beliefs, and healing practices related to *genu kisha'a*. The findings demonstrate how explanatory model (Kleinman, 1980) is not only culturally embedded but also interwoven with environmental, moral, and spiritual dimensions. These insights have important implications for health education and culturally responsive care.

The participants' accounts of *genu kisha'a* demonstrate the culturally specific naming of illness and the local symptom-focused diagnosis. Local categories frequently arise from lived, bodily experiences and the interpretive frameworks shaped by everyday life rather than from biomedical nosology, as is the case with other ethnographic studies (Good, 1994; Nichter, 2008). The connection between *genu kisha'a* and bloody or mucous stools is consistent with “pragmatic symptomatology,” as defined by Hahn (1995), in which visual and visceral signs serve as the basis for lay diagnosis.

Furthermore, the way the illness interferes with daily activities like farming, sleeping, and social obligations shows how it is assessed not just only for its discomfort or pain but also for its interference with social functioning. This supports the claim made by Scheper-Hughes & Lock, (1987) that illness is experienced in both somatic and social ways. In this case, like other illnesses, *genu kisha'a* becomes more than just a medical condition; it also poses a risk to

an individual's ability to carry out their responsibilities to their family and the community.

The aforementioned finding exemplifies a contextual understanding of illness that incorporates practical knowledge, local health beliefs, and environmental factors. Although the Shinasha understanding of *genu kisha'a* partially corresponds with biomedical explanations—specifically, tainted water, tainted food, and hygiene (Mesfin et al., 2020; Soboksa et al., 2019)—it also includes culturally particular interpretations that are not included in biomedical discourse, such as spiritual imbalance, moral transgressions, or exposure to environmental forces. Both convergence and divergence are highlighted by this partial overlap: although some causative factors are agreed upon, other locally significant explanations are still separate. Understanding this dichotomy creates opportunities for culturally sensitive health education, whereby preventative programs can respect and incorporate the community's interpretive frameworks while addressing systemic issues like food safety, access to clean water, and rural exposure.

The Shinasha combined ecological, behavioral, and moral logics in their causal interpretations. In line with results from public health studies conducted in rural Ethiopia, contaminated water, poor hygiene, and dietary practices are commonly mentioned (Mesfin et al., 2020; Soboksa et al., 2019). Beyond material reasons, people also highlight ethical and spiritual transgressions, such as eating unblessed food or wild animals—actions that are thought to go against both moral and cosmological orders as the causes of the disease.

Kleinman's distinction between disease and illness is echoed by this convergence of biological and moral reasoning: local interpretations focus on moral behavior and social harmony, whereas biomedical discourse targets pathogens (Kleinman, 1980). The notion that selfishness, such as eating sacred meat in secret, could lead to *genu kisha'a* is consistent with Janzen's (1981) observations of Central Africa, where illness frequently serves as a social corrective.

Although it may appear to be genetic inheritance, the concept of hereditary and familial transmission is actually a symbolic extension of kinship. It is believed that illness is ingrained in a family and not just an individual's bad luck. This result is consistent with research conducted on other Ethiopian communities (Kahissay et al., 2017), which shows that familial relationships influence both caregiving and etiologial knowledge.

The logic of health-seeking behavior is pluralistic. Before seeking biomedical care, participants often seek the advice of elder women or traditional herbalists. The logic of accessibility, trust, and perceived efficacy is reflected in this prioritization.

According to Nichter (1980), the first line of treatment is frequently the one that is most ingrained in local trust networks and experience rather than the one that is most “effective” in biological terms.

One of the main factors influencing treatment decisions is seeking of advice from family members, especially mothers and elders. According to other research conducted throughout sub-Saharan Africa shows that health service provision is socially embedded (Helman, 2007). People frequently seek advice from religious leaders or trusted family members before acting, demonstrating a type of relational autonomy, rather than acting independently.

Furthermore, the perceived efficacy of indigenous treatments is evaluated based on their conformity to moral and cosmological frameworks in addition to their ability to identify symptoms. According to Feierman & Janzen (1992), healing in many African contexts reestablishes the disturbed equilibrium between individuals, spirits, and the environment in addition to the physical body.

The Shinasha case illustrates that medical pluralism is a cohesive system where biomedical and indigenous practices are judiciously combined based on cultural appropriateness, accessibility, and trust. Important starting points for culturally sensitive health education are provided by the overlap between indigenous and biomedical conceptions of causation, especially in relation to food safety and hygiene. However, it is also necessary to recognize differences, such as ritualized healing and moralized causation, lest interventions be written off as lacking. Working together with traditional healers, acknowledging the caregiving responsibilities of families, and incorporating indigenous preventive logics could increase community trust and enhance the adoption of biomedical interventions.

Conclusion

This study emphasizes the deeply rooted cultural logic that influences the Shinasha people’s causal understanding, diagnosis, and treatment of *genu kisha’a*. The illness is interpreted through locally grounded terms, observable symptoms, and its disruptive impact on daily life, making it anything but a strictly biomedical category. In order to make sense of disease, the Shinasha view of causality utilizes both environmental and moral frameworks, reflecting the intersections of work, landscape, and ritual norms.

Indigenous healing practices are not seen as alternative; rather, they are recognized as fundamental health strategies that are contextually grounded, adaptable to individual and communal needs, and backed by networks of family and community counsel. The perceived effectiveness of herbal treatments and the

high intergenerational trust in traditional remedies highlight the critical role that local epistemologies play in influencing behavior when seeking help.

The findings highlight the importance of integrating local explanatory models into health communication and intervention strategies. By recognizing *genu kisha'a* as a significant illness category and understanding how it is recognized, caused, and treated in Shinasha knowledge systems, public health messaging can become more pertinent. To be effective and culturally relevant in this setting, public health initiatives must move beyond clinical outreach and meaningfully engage with indigenous knowledge systems. New paths for health system integration and equity can be created by acknowledging regional explanatory models of illness, working with reputable traditional healers, and promoting culturally embedded health-seeking behaviors. In the end, this ethnographic realization suggests a pluralistic strategy that builds respectful, participatory, and sustainable connections between local healing worlds and biomedical objectives in the prevention and treatment of *genu kisha'a*.

Conflict of interest

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors. The authors declare that there are no conflicts of interest related to this study.

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