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OTHER AGENCY

FROM - ALLIS ABABA

SUBJECT - End-of-Tour Report, Simon L. Messing

REFERENCE - TOAIL A-1165, June 13, 1967

6634-500-055

Inadvertently, Mission's comments concerning refair were omitted in the transmission. These comments are as follows:

Dr. Messing's report portrays the breadth and depth of his understanding of the socio-cultural factors operating in Ethiopian towns. It also gives ample evidence of the way in which Dr. Messing's capabilities in this respect have been utilized to the benefit of the Demonstration and Evaluation project.

Dr. Messing's recommendations are, to a considerable extent, embodied in the recommendations of the final report for this project but recommendations numbers 6 to 9 inclusive are not specifically referred to elsewhere and will be incorporated in the published monograph later on.

The evaluative measures included in recommendation 9 merit special attention.

KORRY

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DRAFTED BY: <i>J. S. Prince</i>	OFFICE: Public Health	PHONE NO.: 48115	DATE: 6-29-67	APPROVED BY: Charles J. Nelson, Deputy Director
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OTHER AGENCY

FROM - ADDIS ABABA

SUBJECT - End-of-Tour Report - Simon D. Messing

REFERENCE -

END-OF-TOUR REPORT

Name: Simon D. Messing, Ph.D. Job Title: Sociologist
Country of Assignment: Ethiopia
Tour of Duty Began: March 2, 1966
Tour of Duty Ended: June 1967 Prior Country Assignment: Ethiopia, 4 years
Project Activity: Demonstration & Evaluation Project, Public Health
663-11-530-055

Content: Technical, Administrative and Human Resource Factors

Publication During This Tour:

1. "Health Practices in Ethiopian Pre-Urban Communities" Journal of Health and Human Behavior, winter 1966, vol.7, pp.272-276
2. "Sociocultural Strengths and Barriers to Optimal Health in Ethiopia" In press, Technical Assistance Journal
USAID-Washington

Field Activities

Resurvey, by random sampling (questionnaire) and socio-cultural analysis of these Ethiopian small towns: Motu, Huruma, Rosaina, Durame, Baychew, Korem, for the purpose of measuring changes over a period of 3 - 4 years that might be attributable to effect of the new Health Centers.

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DRAFTED BY S. Messing:ml	OFFICE Public Health	PHONE NO. 48115	DATE 5/20/67	APPROVED BY: C. J. Nelson, Deputy Director
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Training

Participation with staff from Ministry of Community Development during the In-Service Training Course for Community Development District Officers in Awassa, April 9-13, 1967.

Personal contributions included the following topics:

"Gaining Community Acceptance and Participation"

"Leadership and Communications Skills"

"Cultural and Social Factors Affecting Change in Health Beliefs and Practices"

Participation at Scientific Conferences

1. 6th International Sociological Conference at Evian (on administrative leave). Participation in Workshop on Application of Medical Sociology in Developing Countries. September 1966
2. 3rd International Conference of Ethiopian Studies, Addis Ababa, April 1966. Presented paper "Health Practices in Ethiopian Pre-Urban Communities".
3. 1st Ethiopian Social Science Seminar, Addis Ababa, Haile Selassie I University, April 21-23, 1967. Presented paper "Medical Attitudes and Practices in Ethiopia in Relation to Development," and participated in discussions on Law as a Factor of Social Change, Social Factors in Development, Market Practices in Ethiopia, etc.

This paper will be published by the Social Science Institute of Haile Selassie I University, provided clearance can be obtained from the Ethiopian Ministry of Public Health and USAID.

Mimeographed Documents authored during this tour:

- "Restudy of Hesaina" March 1966
- "Restudy of Durame" April 1966
- "Restudy of Metz Community" June 1966
- "Restudy of Hurumu" July 1966
- "Restudy of Maychev" November 1966
- "Restudy of Korem" December 1966

Other Application

My chapter "The Abyssinian Marketing Town" (in Bohannan & Dalton: Markets in Africa, Northwestern University Press, 1962) was used in training students of the College of Business Administration, Haile Selassie I University, in the course given by Professor Maurice de Young. (See Ethiopian Herald of March 9, 1966).

Conclusions

Responses to the questionnaires indicate continued fatalistic attitudes.

Parents of children who have heard of water boiling in the health education classes in schools, conducted by sanitarians, usually agree that the idea is good. But it is not practiced because fuel is expensive or laborious to obtain, and because it is not customary. Soap would be used more if it were free. A convenient source of water is one of the local improvements most desired, but safety of the water is still not a popular consideration.

The health officer usually finds that his clinical activities take up most of his energy and time. Poor roads in the hinterland soon discourage his "far-field" trips to villages and to the scattered dressers. The community nurse often reduces her home visits to a few, and prefers to spend much time in these. The sanitarians often resign themselves to drawing charts on local occupations, attempting a census of the little town, and giving lectures at the school where they do not insist that their lessons be practiced. Teachers as well as students often pollute the school grounds, where neither water nor latrines are considered essential parts of the practical problem of school construction.

The health councils, which health centers are advised to form and promote, are soon inactive. Often they are composed of less influential levels in the power structure, which in small towns can be indicated as consisting of four major categories:

A. Appointed officials such as district officers, municipal chiefs, etc. These may have the chief executive power, but their tenure may be brief and end suddenly. As outsiders, they usually have little, if any, permanent influence. Sometimes, they are modern-educated and would like to make improvements, which takes more time than they have at their disposal.

B. The traditional chiefs of the local ethnic group. These may hold office as lesser judges (atbiya danya, chiqa shum), or be simply "great men" of the local majorities. They are traditionalist, but may aspire to the return of ancestral lands. Religious leaders (priests, sheykhs) are also in this category.

C. The traders, who often constitute the single largest occupation group, especially if one includes the divorced women heads of household who brew and sell alcoholic beverages at home. The male traders are often of the Muslim minority. This occupational class includes the millowners, transport owners, ~~and houses,~~ tailors working on foot-operated sewing machines, carpenters, retailers. This category commands much of the ready cash in the locality, and is open to suggestions in line with economic motifs.

D. The small but growing local educational elite. These include school teachers, health officer, agricultural extension worker, Coffee Board delegate, etc. These are outsiders, but most accessible to modern ideas. Often they work in isolation from each other, and barely know each other's names.

Recommendations

When one takes in consideration the factors of traditional standards of living, existing power structure, and the new role of the health centers, the following recommendations can be offered for future development:

1. It is a mistake to rely on verbalization when trying to change practices and attitudes. Therefore, the establishment of safe and convenient water sources in the small towns is a prime necessity. Then, public bathhouses and school water and latrine facilities should be established.

2. Little can be done to change attitudes and practices of the current adult, illiterate generation. Therefore, most efforts should be directed at the growing school population. This is a self-selected group, since education is not compulsory. The young are open to new ideas. There should be weekly inspections at which any children found with lice in their hair or with eye diseases are sent home, and the community nurse delegated to visit that home.

3. Health Council organization should attempt to bring all four categories of the community together. Failing that, emphasis should be on level three - those with economic motivation and ready cash. Funds will be needed for the facilities mentioned in 1. Where a community is too poor to provide these, the council could at least promote the collection and storage of rainwater and the sunning and airing of bedding; perhaps also the wholesale import or manufacture of soap. In many parts of the country, collections of the soapwort that grows wild and free of charge (andod, shibti) can be organized.

4. Where latrine programs have failed, or latrines are poorly maintained, it may be better to encourage the traditional early morning walk far out of the village, to defecate in spots remote from kitchens.

5. A few test cases should be made at court to see whether existing legislation is sufficient, e.g., to protect the public in places where food and drink are handled for sale. If these cases lose, new legislation can be encouraged. Meanwhile, the sanitarian should be appointed municipal official, perhaps with a uniform. The concept "nuisance against public health" should be introduced into health legislation and explained to the public.

(traditional healer)

6. The woggesha/is apparently here to stay for some time, especially in the less accessible areas. Therefore, the attempt should be made to upgrade him through first-aid training, and thus at least reduce his more objectionable practices. He can also be encouraged to report epidemics at early stages.

Traditional "midwives" have been upgraded in several developing countries, sometimes with success. The confidence of the people in these practitioners can be a valuable asset.

7. The new, though small, educational elite, in the small town, should form a local intelligentsia, at least on a social basis. Members can improve their understanding of the local culture, and exchange experiences that arise from their efforts of introducing development.

8. Although the Orthodox Church has long emphasized spiritual purity over physical cleanliness, perhaps the younger leaders among the bishops can be enrolled in a campaign recommending ablutions with clean water (e.g., by extending the principle of the holy spring to rainwater). Such an imprimatur has been used successfully to overcome resistance to malaria eradication sprayers in Tigre Province.

9. Since the interval of 3 - 4 years between the Baseline study and Resurvey was too short to observe much change in health attitudes and practices, there may be some value in another, briefer resurvey about 10 years after Baseline. In this case a few of the more specific indices should be selected. Since the greatest value of such research will be for the world scientific community, sponsorship should perhaps come from a private, non-governmental institution.