

AIRGRAM

DEPARTMENT OF STATE

HS

PD-AAU-860

UNCLASSIFIED
CLASSIFICATION

ET

614.0963

E84a

c.2
9

TO - AID/W

TOAID A-769

For each address check one ACTION

INFO
INT
DE

DATE REC'D.
NATIONAL
DEVELOPMENT

266 MAR 4 AM 9 56

sm = 23149

CABLE & AIRGRAM BRANCH

DATE SENT
February 9, 1966

DISTRIBUTION
ACTION

a7r
INFO.
amp
SRD
a7RP
PTG
CRS
Res-4
JCR
WC
15^W

FROM . ADDIS ABABA

SUBJECT . End-of-Tour Report

REFERENCE .

Name: Simon D. Messing, Ph.D

Job Title: Sociologist

Country of Assignment: Ethiopia

Contract Employer: USAID

Tour of Duty Began: June 17, 1964

Tour of Duty Ended: Dec. 16, 1965 Prior Country Assignment: Ethiopia 2 years

Project Activity: Demonstration and Evaluation Project, Public Health
663-11-500-055

Content: Technical, Administrative and Human Resource Factors

See attached unexpurgated, summary article prepared for publication
(subject to clearances): "Sociocultural Strengths and Barriers to Optimal
Health in Ethiopia."

OTHER AGENCY

Labor
State
PC-4
HEW

Publications During this Tour:

"Health Culture Research in a Developing Country." The American
Behavioral Scientist, Vol. VII, No. 8, April 1964.

"A Method for Historical Reconstruction of Demographic Growth in
African Small Towns." Current Anthropology, Vol. 5, No. 3, June 1964.

PAGE 1 OF 18 PAGES

DRAFTED BY

SDM
Simon D. Messing:jeb

OFFICE

Public Health

PHONE NO.

47115

DATE

11/30/65

APPROVED BY:

Willard H. Meinecke, Director

AID AND OTHER CLEARANCES

J.S. Prince:PH
J. Kent:FR

UNCLASSIFIED

CLASSIFICATION

In Press:

"Application of Health Questionnaire to Pre-Urban Community in a Developing Country." Human Organization, winter issue 1965.

Presented at Scientific Meeting

(Read by co-author Dr. Prince): "Problems and Results of Measuring Work Loss Due to Illness in Ethiopia." — Rennes, France, September 1965.

Attempted measurement of Cost-Benefit Ratios in Establishing Health Services in Ethiopia.

Prepared for Meeting of Ethiopian Studies Association, Addis Ababa, April 1966,

"Health Practices in Ethiopian Pre-Urban Communities."

Mimeographed Documents authored during this tour.

"Problems and resistances in Implementing Health Programs in Small Town Ethiopia." Prepared for the Peace Corps Health Education Workshop of Secondary School Biology and General Science Teachers, August 1965.

"Determination of a Person's Age through Historical Reconstruction of Ethiopian Events." Prepared for D&E Census Activities, August 1965.

"Tentative Questionnaire for the Study of Family Planning Attitudes in Ethiopia."

"Chronological Development of the Wollamo-Sodo Water Project." August 1964.

"Post Report Bibliography." Addis Ababa, November 4, 1964.

"On the Training of Young Priests for Epidemic Surveillance." Feb. 16, 1965.

"On Terms to Use for Community Nurse Diplomas." June 10, 1965.

Field Activities

Sociological Supervision of Health Center Communities:

- a) Changes in the communities of Maichew, Mattu and Hosanna since Baseline Research.

AIRGRAM

DEPARTMENT OF STATE

UNCLASSIFIED

CLASSIFICATION

For each address check one ACTION | INFO

TO - **AID/WASHINGTON** **TOAID A- 769** **X**

DATE REC'D
AGENCY FOR
INTERNATIONAL
DEVELOPMENT

14 MAR 11 24

FROM - **ADDIS ABABA**

DATE SENT
February 9, 1966

SUBJECT - **End-of-Tour Report - Simon D. Messing, Ph.D.**

REFERENCE -

Transmitted herewith is the End-of-Tour Report of Simon D. Messing, Ph.D., Sociologist.

While the report does not follow the usual pattern for End-of-Tour Reports, it covers essentially all required matters and is highly informative.

The Mission has noted Dr. Messing's recommendations and concurs in them. Means for utilizing the "health tax" funds for constructive purposes are being examined. His suggested techniques for adapting local customs and using local opinion leaders and traditional health practitioners to further improved health and sanitation practises appear sound. Efforts to incorporate these ideas more fully into existing methods of operations will be made.

The report demonstrates Dr. Messing's high technical qualifications and in concise and interesting language treats the large area of his involvement and achievement during the period covered by his report. The Mission believes the report should be made a matter of official record in the employee's personnel file.

FOR THE AMBASSADOR

PAGE 1a OF 18 PAGES

DRAFTED BY
JSPrince/RCohen

OFFICE
PH/Program

PHONE NO. DATE
25 2/8/66

APPROVED BY:
W. H. Meinecke, Director

AID AND OTHER CLEARANCES

JHKent:PR JK

UNCLASSIFIED

CLASSIFICATION

7

b) Preparation and Distribution of Manuals, Topics, Methods.

c) Analysis of Sociological Quality of Health Center Programs. (See mimeographed reports 1964/65).

Feedback to H.S. I Public Health College at Gondar, and graduates in the field:

a) Recommendation cards, based on rural sociological supervision.

b) Guide on How to Work with a Health Council in Small Communities.

New Field Research:

"Sociological Quantitative Baseline Data from Wollamo-Sodo," Mimeographed March 1965.

"The Community of Wollamo-Sodo," Descriptive anthropological analysis, mimeographed August 1964.

"Ethnological, Ethnographic and Environmental Reports on the Nuor. and Anuak Cultures of Gambala Awraja," mimeographed June-July 1964.

Statistical Analyses of Baseline, and preparation for study of changes:

"Polynomial Index Determinations to ascertain Distribution of Responses and Standard Deviations in Baseline Responses: Maichay & Kora, Mesenna & Durami, Mattu & Hurumu, Wollamo-Sodo"; prepared and mailed to Johns Hopkins University for computer analysis.

Schedule V Preparation for Study of Change, mimeographed.

New Manual for Enumeration of Schedule V.

New Punchcard Code Transfer Sheets.

New Instructions for Coding the Restudy.

Lectures Given:

1. At Itegue Menen Nursing School, Asmara, November 16-22, 1964: **Sociology;** Application of social and cultural methodology to public health;

- Analysis of traditional forms of medicine in various parts of Ethiopia.
2. For USIS at Prince Makonnen Officers Club, Asmara, November 1964;
"Research on Social Customs Relating to the Development of Public Health in Ethiopia."
 3. At the Haile Selassie I Public Health College at Gondar, January 25-31, 1965:
"Sociology and its Application in Public Health Research" for first year health officers.
"Communication Pathways in Rural Ethiopia" and "Power and Authority Relationships in Woreda and Meketi Woreda Governments", for second and third year health officers.
"The Selection of Peripheral Health Workers", conference with staff members.
"Land Tenure in Relation to Health", panel discussion for staff and students.
 4. At Peace Corps Health Education Workshop for teachers, Addis Ababa, August 1965: "The Zar Cult in Ethiopia."
"Problems and Resistances Encountered in Implementing Health Programs in Small-Town Ethiopia."
 5. In Course on Health Education for Healthier Living, H.S.I. University, Addis Ababa, December 6 and 10, 1965.
"Impact of Non-Scientific Beliefs and Attitudes on Health in Ethiopia; review of research and motivation, learning and change."
 6. At Kagnev, orientation lecture on Ethiopian culture, to be given U.S. military personnel, Asmara, December 1965 (if schedule permits).

KURRY

SOCIOCULTURAL STRENGTHS AND BARRIERS TO OPTIMAL HEALTH IN ETHIOPIA

**A Contribution to Publications by the Demonstration & Evaluation Project,
Public Health Division, USAID/Ethiopia**

by
Simon D. Messing, Ph.D.

Introduction

In Ethiopia, a system of decentralized, generalized health services has been in process of implementation since 1948, when it was introduced by an Imperial Proclamation. This involved training health workers as teams to function in rural health centers throughout the country.

These teams have of course encountered many difficulties in carrying out the program laid down by the Ethiopian Government Ministry of Public Health. This paper deals with some sociocultural aspects of these problems with respect to the introduction of modern principles of medical and public health practices into a traditional rural society. (Footnote 1)

At the outset, however, it should be emphasized that the problems encountered by the paramedical personnel (health officers, "community nurses" and sanitarians, trained at the Haile Sallassie I Public Health College at Gondar, Ethiopia) are not those of any organized resistance or even of a notion that traditional practices are superior to modern ones. The problems are those of novelty, communication, and confused blending of old with new practices and attitudes.

Strengths

Even the traditional, indigenous-type healer, commonly referred to as wogesha in the Amharic language (but known under different names as well in the other Ethiopian languages), is usually an empiricist. This means that he is not stubborn about his methods, but, like the pre-scientist, he practices as best he can and is willing to adopt better methods which he may find effective through trial and error. The only laboratory he has are his patients. He not only sets bones, but has a formidable array of purgatives, febrifuges, fumigants, astringents, vesicants and stimulants.

The desire for health is expressed in the daily greeting and "thank you" expression in the Amharic language: "May He (God) give you health for me" and "May God give you health for me". This also indicates the "quantum theory" of health held in the tradition: every person is regarded as equipped with a quantum of health, and in greeting and in gratitude he assigns some of it to the other.

Every language in Ethiopia in the regions studied has a term for "contagious fever", distinct from the term for malaria. (Footnote 2)

Either father or mother can send a child to a clinic, and there is no objection to the eating of fish. (Both of these problems are encountered elsewhere in Africa.) The mild sorghum or barley beer is also nutritious.

As in many other African regions, pregnancy of a lactating mother is discouraged by various means until weaning, which occurs late, to give the infant a chance of survival.

The soft soil in many parts of the country would render well-digging easy even with simple tools.

Travelling traders over the improving road and trail system carry exposure to modern methods, breaking isolation. The desire for injection by hypodermic needle, hopefully filled with an antibiotic "miracle drug" has become universal.

Respect for constituted, administrative authority is widespread on the highland plateau where the majority of the population lives, and should be a foundation on which health centers could build. The intelligent questions asked by elders upon arrival of the Demonstration & Evaluation Team in their little towns indicate their responsible comprehension of larger issues:

"Why was our town selected for study?"

"Will you help our water problem?"

"Are you concerned with the development of civilization - do you do this kind of study also in your own country?"

"If doctors had lived here before, most of this area would be overpopulated now."

Numerous traditional patterns of cooperation exist particularly in Southern Ethiopia, and some have been spreading to Northern Ethiopia. The "edder" burial society, a social invention of the Gurage people, meets every Sunday to collect small dues, and to discuss expenditures for funerals and aid to the bereaved family. "Iqub", also an invention of the Gurage, has been spreading fast in recent decades. This is an investment lottery, ranging from very small sums to large figures. Pre-determined contributions are collected at meetings of these voluntary groups once a week or once a month, lots are drawn, and the jackpot enables the winner to invest in a cow or an ox or other enterprise. "Dabo", a tradition of agricultural Galla people, provides cooperation in harvesting, threshing and hut-building. This is characterized also by feasting, rhythmic work songs, and spinning clubs of the women. Gudela-Kambatta farmers break sod together through their "jigi" organization, using digging sticks while maintaining a fast rhythm with work chants. Galla husbandrymen provide a kind of clan insurance against loss of cattle through their "gossa" organization. Semi-itinerant weavers, particularly among the Gurage, organize their "emmet-wor" after the harvest, walk to a market town, and set up their handlooms in a rented hut which also serves as their living quarters. Coptic Amhara and Tigre communion brothers find occasion to discuss informal cooperation during their religious "mahabbar" meetings in each other's homes. All of these patterns can be utilized by health center staff in the interest of community cooperation for public health.

Barriers

Problems of communication were encountered by health center staff from the beginning. They were often sent to places where a language unknown to them was

spoken and ethnic customs differed from their own. When the Gondar program commenced it was difficult if not impossible to find qualified students for all the various ethnic groups represented in the locations of health centers.

The local population usually fitted the health officer into the traditional expectations of "hakim", healer, rather than as preventer of disease. The community nurse was regarded as a new type of traditional midwife rather than as conductor of preventive practices in mother-and-child-health care. The sanitarian was such a new type of practitioner that there was no traditional role for him at all. If he tried to press for latrines, boiling of water, fly screening and handwashing in food-dispensing establishments, he was often regarded as a nuisance. In their own confusion, some sanitarians began their work by criticizing the relatively better establishments while as yet ignoring the far more numerous dirt-floor huts which dispensed home-brew beer and traditional bread in places accessible to undiapered infants and domestic cattle.

The health officers were often also misunderstood by the local officials and other "big men" (e.g. landowners) who regarded them as their private physicians, to be available for (free) home calls at any time of day or night. If the health officer refused on account of his scheduled duties, he endangered his rapport. If he refused to dispense drugs to the ladies who were old syphilis cases on the ground that such treatment had to be limited to cases that were still contagious, the client was likely to patronize one of the many self-styled, unqualified "dressers" who make a good living by giving injections.

Some health officers were also handicapped by difficulties of transportation, though it was necessary to reach "far-field" villages within their assigned region for purposes of health education and supervision of licenses government "dressers."

As indicated before, the sanitarian had to work in a cultural vacuum more severe than that of his colleagues. When teaching health to school children, the sanitarian spent much time drawing fine pictures of wells and latrines on the blackboard of schools that had no such facilities and were unlikely to receive them in the foreseeable future. This communicated to the children that health education was a verbal matter rather than related to practice, so that many requested the sanitarian to lecture in English rather than Amharic, in order to improve their grades in English. Some sanitarians acceded to this request and practiced a catechism type of question and response that fitted into the traditional methods of learning by rote.

The local population often misunderstood the functions of the health tax (Footnote 3) and some refused to pay the registration fee (Footnote 4) of the health center on the grounds that the tax already covered it. Patients often insisted on receiving an injection by needle, while tablets were sometimes regarded with apprehension lest they prove ineffective or even contain "poison".

Numerous traditional practices and beliefs still constitute problems. It is considered a friendly gesture in much of Ethiopia to pass a long tobacco pipe from

mouth to mouth, and at markets customers usually pay per puff. People generally eat from the same bowl with their fingers. People generally eat the same kind of food at every meal, little fruit is consumed, and vegetables are held in low regard. Polluted river water is considered purified by mixing it with barley compound to make mild beer.

There is a general belief that women learn by instinct how to protect their children's health when they become mothers; hence barren women "never know". The believe that disease can be caused by smelling something dirty can lead to objection to latrines. The cause of malaria is often attributed to eating the stalk of sorghum in a lowland environment. Many serious illnesses are blamed on various forms of the evil eye. Ironsmiths and pottery-makers are particularly suspect of drinking the victim's blood with a look from their eyes so that he wastes away. Hence the refusal to expose babies and infants to sunshine (from which they could derive free vitamins and reduce the high infant mortality). Serious swellings and some skin diseases are blamed on the spirit of "lekeft". Exorcism of the "buda" spirit is to transfer the disease into the body of a chicken which is then dropped near a path where passers-by will unwittingly carry the disease away. Mental ailments cause some victims to join the "zar cult". (Footnote 5) Amulets are worn by children and pregnant women in little towns and villages. Pious Coptic Christians of the Province of Tigre often tattoo a cross on the forehead and hands of female children and others, while Wollamo children have a round scar burnt on the skin between eyes and temples.

Home remedies include the use of animal fat for wounds, eyebrow cutting against eye infections, the eating of the rabid dog's raw liver by his victim, and, in nomadic lowlands, the application and ingestion of camel's urine for almost all ailments.

Religious traditions maintain wide use of holy water for intestinal and other ailments. Nuns believe that bathing their bodies would be sinful vanity.

Modern products are sometimes misapplied. Thus, kerosene is at times used against earaches. Where electricity is first introduced, some believe that electric shock carries the blood to the Electric Power Company.

The attitude to rely on government to initiate, organize and pay for improvements, based on the tradition that all good things come from above and can be obtained by petition for relief, maintains an inertia in many places. Local officials are usually on temporary tours of duty, so that continuity of development programs is rendered difficult by this attitude.

Law enforcement powers for public health by the health center staff, were not examined as part of the Gondar Public Health College curriculum. Numerous Imperial Proclamations on public health legislation exist, but have not yet been translated into functional details for enforcement.

One of the first was Proclamation No. 27, 1942, which provided, in section 2, that "no person shall practice for gain medicine, surgery or dentistry unless he

has been licensed by the Director of Medical Services to practice"; and section 7: "Any person not licensed who practices the profession of medicine, surgery or dentistry is guilty of an offense and shall on conviction be liable to a fine not exceeding Maria Theresa dollars 1000 or imprisonment not exceeding one year or both." (Footnote 6) Meanwhile self-styled "dressers", some itinerant, prosper by giving unsupervised injections without regard to aseptic requirements. The numerous woggesha are also unsupervised. (See below)

Proclamations in 1950 prohibited the offering of "unsafe water" to the public for drinking; urination or defecation in public or in places other than properly constructed fly-proof latrines; the sale of milk without stamp of public municipal slaughter house; etc. But a Public Health Officer or Sanitarian who brings suit on these violations before a small-town judge who himself practices acts contrary to public health legislation, will probably lose his case, in the opinion of a Peace Corps lawyer. (Footnote 7) Another Proclamation in 1951 provided penalties of 25 cents Eth. or 12 hours in jail to be imposed on any individual found urinating or defecating in any public street or along any public watercourse. It will be difficult to enforce this law even in the capital of Addis Ababa until sufficient public latrine facilities are constructed. (Footnote 8) Despite the fact that prostitution is inextricably linked with the dispensing of home-brewed alcohol such as arrak, mean (tedj) and beer (talla), a Proclamation in 1950 provided that "no prostitute shall practice prostitution on premises or places where intoxicating liquors are sold or consumed." This law would be difficult to enforce due to public opinion, in the view of the Peace Corps lawyer (Footnote 9). The latter also cautions that the Criminal Procedure Code of 1961, Article 51, prohibits arrest without a warrant unless the offense is punishable by imprisonment for not less than one year.

Therefore, until legislative details are enacted, no one can expect a health officer in a provincial small town to challenge sociocultural practices by law enforcement, which has been the practice in all developed countries.

Some other recommendations that have been made to health center staffs are also unrealistic in view of culture barriers. One is the use of a venereal contact slip given to a patient who is found to have early syphilis or gonorrhoea with the request that that person hand the slip to each sexual contact, to be returned by the new contact to the next polyclinic session. No prostitute or other person can be expected to advertise her illness that way. (Footnote 10)

For further realism of the situation faced by the health officer, the following case histories of traditional healer activities can serve. (Footnote 11)

Some Case Histories of Woggesha Healers

The continuing role of the traditional healers even after the establishment of the health centers can be observed in such small towns as those studied, where the health center ignores the woggesha on the grounds that any attention paid would enhance the ~~health~~ healer's reputation.

The following two healers were interviewed in their huts on the outskirts of one of the study communities in October 1964.

The first, a male Amhara aged about 50, whose home had been marked by the Health Center census (Footnote 12), enjoyed upper-level social status as "neftenya-lij Amhara". This meant that he was descended from the riflemen of Emperor Menelik who had entered the region in the late 19th century and had been rewarded with inheritable land. He claimed that he derived more income from his agriculture and coffee trees than from his medical practice, although he had no tenants and employed only his sons. One son had gone to Addis Ababa and had reached the 9th grade. The woggesha himself was illiterate.

Like most woggesha he had begun by setting broken bones, which he had learned from his father. When he began having many children and paying fees to other woggesha for treating their ailments, he started to observe their practices, experiment with them, and soon neighbors addressed him as "hakim". His reputation expanded when he cured the 6-months old daughter of a local Gerazmach (baron). The baby had swallowed an empty pistol cartridge. Taken to the nearest Mission hospital for x-ray, the foreign doctor recommended that the baby be taken to Addis Ababa for surgery. The father refused and consulted the woggesha who roasted a cabbage leaf until soft, rolled it to a point, pushed it down the baby's throat and pulled. There was some bleeding, the baby fainted, was awakened and given some water and a herbal laxative. Several days later the cartridge emerged in the stool.

The woggesha's practice includes the usual cutting of the uvula, using two strands of twisted horsehair on infants, and wire for older patients. In addition, when a child grows poorly and at the same time suffers from diarrhea, the woggesha may examine the gums, and pull out the root of a budding tooth with one of the two screwdrivers he carries at all times as standard equipment. He treats hemorrhoids with an herbal shrinking agent and butter as lubricant, but sometimes burns the spot with one of nine types of twigs. Axix Burning of the skin surface on other parts of the body is resorted to to heal an internal ailment near that spot. To treat eye infections, the eyebrow is cut so that the blood will wash out the disease as it flows over the eyeball.

Circumcision of males and females is part of the woggesha's practice. The age of male clients for this operation ranges from seven days in case of religious Copts to men of 30 years among local Gudela (original inhabitants) (Footnote 13) who wish to convert to Coptic Christianity. It appears the clergy in this region require the operation prior to baptism of pagans as proof of sincerity. Girls on whom cliterectomy was not performed in infancy have it performed at age 12-13, prior to first marriage. In order to reduce bleeding and swelling, the woggesha applies a leaf drenched in its juice, and uses the vein of the leaf to tie the bandage.

The woggesha is also called to childbirth complications such as breech births and removal of placenta, and it is in such obstetrical cases that the Health Officer more frequently encounters him. Ointments with wheat powder as base are concocted by him as liniments against skin infections, wounds and scabies, on humans, mules,

donkeys and horses. His fees range from Eth. \$0.50 to 1.00, but some patients are charged as much as Eth. \$5.00.

This woggesha's wife's brother was a literate astrologer (metshaf gelach) who used the "opening of the book" to diagnose and prognose ailments. The woggesha memorized some of these formulas and uses them while mixing powders for use against paralysis, particularly in infants, blamed on the spirit of a bird. But he sends epileptics and mental patients possessed by "zar" (Footnote 14) or "buda" (evil eye) spirits to Galla or Gudela specialists (Qalitcha) in the nearby lowlands.

The second woggesha was a woman who lived at the other end of town. She claimed to be Galla, but looked like Shanqalla, i.e., the physical type formerly identified with slaves, and still indicating low social status.

However, there was no trace of servility in her bearing. On the contrary, although barefoot, poorly dressed and already in old age, she had a calm, self-assured manner that could easily inspire confidence in her care. Her husband, an aged ~~Amara~~ Amhara peasant, stood by her. She responded freely as if being interviewed were not unexpected or unusual tribute to her role in the community. She had been brought to Hosaina as a child. God had taught her how to help pregnant women and she had gradually added the other phases of her practice.

She stated that she was often consulted on delivery complications, and also practiced abdominal massage for many ailments, including ruptures. She denied cutting the uvula, but approved the practice and referred such clients to Gudela healers (Fuga) in the nearby lowlands.

Circumcision and cliterectomy made up a considerable part of her practice. The age range of such clients ranged from seven days to age 15. She had special prescriptions for complicated cases. If a boy's parents were chronic syphilitics (warde) she advised waiting until the boy had reached the age of seven or eight to avoid complications, and further advised an antibiotic injection after the operation. Prior to any circumcision and cliterectomy she purged the intestines with kosso (Footnote 15) for sanitary reasons and to reduce bleeding. Kosso was also part of the poultice, together with butter and a certain leaf, to cover the wound. She was convinced that her Coptic Christianity insisted on cliterectomy because "Mary does not want a female to sleep with a man unless operated properly," and because a non-operated girl would be oversexed (genzerenya), break all the dishes and be disloyal to her husband. "Don't you circumcise your girls?" she retorted to her interviewer. Convalescence for 15-year-old girls ranged from three to eight days, during which they were fed butter and other "good" food.

Her fees ranged upward from a minimum of Eth. \$0.20 charged poor people to Eth. \$5.00 charged the rich.

Conclusions and Recommendations

1. It is clear from the foregoing that a comprehensive socio-cultural program toward optimal public health is required, and that the "cookie-cutter approach" will fall short (TB, VD programs, etc.). Educational, family and legal institutions

need to be functionally related toward the aim of public health.

There are numerous opportunities. One is the aforementioned respect for administrative authority, which, however, has not yet been extended to the staff of the health center innovation. If officials would publicly treat the health officer as a high-level administrator, and perhaps put the sanitarian into a new type of officer uniform, the aura of authority would extend to them and facilitate their work.

Meanwhile the prevailing attitude toward sanitation is that of "camping out", casual public disposal of human and other wastes, even in town. Often a single hut serves as bedroom-kitchen-stable-beerbrewing establishment. The curriculum at the Gondar Public Health College should take cognizance of these socio-cultural phenomena.

Since about 4,000 community nurses are needed to do their part of the decentralized public health work in Ethiopia, according to the estimate of the biostatistician of the Demonstration & Evaluation Team, and Gondar has not even trained 1/10 that number, the facilities of the College need to be vastly expanded. One professional visitor recommended that an additional Public Health College be built at Jimma. If funds becoming available from the health tax are not used for some such creative enterprise, Parliament may decide to divert them to other needs. All these resources of society have to be mobilized to achieve a breakthrough in public health.

2. The practices of the traditional healers are still widespread two years after health center operation, even within the census areas of the towns being studied. Since the woggesha are empiricists and have such a large clientele, a good opportunity is being missed in ignoring them. They would make good candidates for salaried "peripheral health workers" - a type of minimal training that has been discussed at Gondar in order to extend public health communication to the rural areas beyond the little towns. At the same time this would reduce the woggesha's more deplorable practices and encourage them to refer more of their difficult cases to the available government health installations before the patients' conditions become irretrievable. The woggesha have access to regions too inaccessible for far-field health center work. The more distribution of sulfa powder to the woggesha would reduce morbidity and mortality from infections. The woggesha can give health center staff much insight into local attitudes and practices relating to health and sickness, into regional response to the effect of health center work. For the population he carries the psychological aura of the "family doctor", familiar with personal problems of his clients from birth to death.

3. In order to develop communication with the local communities, health centers have been advised to organize health councils. Since officials are often on temporary tours of duty, it is important to reach the more permanent local "opinion leaders". Such decision-makers can be traced by inquiring as to the identity of the local chairman of "edder" burial societies and of "iqub" investment lotteries (Footnote 16). The local judges, school principal, bank manager (a recent innovation in some small towns), transportation operators, chief teahouse owners (where serious traders meet) are easy to locate.

The initial health councils can be recruited from these more permanent community leaders, also the ward chiefs (sefer shum, chiqa shum), mill and bar owners, etc. If funds are needed for such purposes as a school well or school latrine, the health council could more readily collect them than the school children from their parents, since children occupy low social status within their families. In areas where the church owns tracts of unused land, the health council can attempt to request rent-free use of land for health center facilities. In areas where wage labor is difficult to obtain (e.g., where group labor predominates), the health council can request the services of prisoners convicted of tunneling under huts (robbery at night), to dig public latrines. In this region (Kambatta-Gudela) there is a good chance for popular introduction of cement floors, since many householders already spend money on stone or wood foundations and moats to prevent tunneling.

Ideally, a health council should meet periodically throughout the year. There should be a permanent meeting place, e.g., at the school or health center. The place should be adequate in space and provide health education experience for the members, to which the first part of each meeting should be devoted: posters explained by the sanitarian, audio-visual aids, discussions, etc. Members should be consulted on best places for immunization substations, and should attend, together with Health Center staff, "social reinforcement events" such as sports, weddings, funerals.

4. Since the role of the sanitarian is so new in the culture and therefore least understood, he should begin his campaign by answering some "felt needs", especially those not requiring local expenditure of funds. These include free malaria suppressives, free distribution of soap, DDT powder, the organization of rainwater collection from the corrugated metal roofs, airing of bedding, etc. His sanitation advice from loudspeaker mounted on a landrover on market day can attract multitudes, especially since many rural folk come to market also for reasons other than economic (Footnote 17). At other times this loudspeaker can be driven through town to remind members of the health council of meetings, to announce sanitary ordinances of the local government. This is in the tradition of the use of the large Ethiopian drum (negarit).

It is important for the sanitarian to speak the local language, and if he cannot learn it, he should be transferred to a region of his own ethnic group. This is necessary to overcome the culture barrier facing modern concepts of sanitation, which is much higher than the barrier to modern medical practices or modern midwifery.

Some sanitarians consider population mobility such a liability that they cancel food-handler classes. But migration of people is an increasing factor with improvement of means of travel, and should be regarded as an opportunity to spread the lessons.

Cooperation with other local change agents interested in sanitation, such as veterinary aides, agricultural extension workers, Peace Corps teachers, on projects as well as exchange observations, should be cultivated to mutual benefit.

5. Action against cattle disease is sometimes a greater "felt need" than human

endemic problems. Health lectures delivered at the schools should be accompanied by provision of basic sanitary facilities such as latrines, soap and water for hand-washing, or should be postponed until such facilities are at least under construction. Health classes should not be regarded as "remedial English."

When a public bathhouse is built it should be made available at low rates (e.g., 5¢ Eth. per adult or 2 children). Time and water can be limited for economy, if necessary.

Daily "personal cleanliness inspection records" should be kept for each child in school, and filled out either before or after the daily flag raising ceremony assembly. The older students can be taught to inspect hair, eyes, neck, nails and clothing of the younger, under spot-check supervision of the sanitarian. This will set up the school as a model, communicated to children not attending school and to adults, in a more realistic fashion than mere verbalizing.

6. The recent development of ~~Provincial~~ Provincial Health Departments, interposed between the health centers and the capital, should improve communication to fill the needs for supplies, transportation, legal status, epidemiological reporting and other requirements.

7. The field observations and analyses of the Demonstration and Evaluation Team, which are being "fed back" to the Public Health College at Gondar, should improve the curriculum and orientation given future health center staffs prior to their graduation.

8. A system of rewards should be developed to balance the "nuisance" phenomena of modern measures in the public mind.

Members of the health council can be rewarded with lapel pins, with free trips to the Health Department at the provincial capital in government vehicles, with introduction to high-status visitors, formal installation ceremonies, even a plaque at a member's house listing him as a "health councilman". This might encourage him to keep house and yard clean, as a model to others.

Mothers whose children's faces have been found clean for a particular period of time (especially the eyes, on account of conjunctivitis), could be rewarded by public announcement on a suitable occasion, plus a useful gift or a medal. In line with tradition, this medal could read "Imperial Order of Mary's Water" in case of a Coptic Christian, or "Imperial Order of the Hand of Fatima" in case of a Muslim. These might replace some of the amulets.

FOOTNOTES

1. In 1954, when the Haile Selassie I Public Health College and Training Center was founded at Gondar, there were few Ethiopian physicians. The country's population was estimated at upward of 20 million, the large majority living in mountainous rural areas. The "Gondar idea" included establishment of health centers in small

provincial towns that would be staffed by paramedical personnel oriented primarily toward preventive medicine, mother and child health, and sanitation.

After a few years it became clear that the implementation of such a novel program in the ecologically and ethnically diverse provinces presented problems of research and communication. Little was known of the specific complex of diseases encountered by health center teams who had received only limited geographical orientation about their places of assignment. The original Gondar scheme did not provide adequately for regular and frequent communication with the isolated health centers, so that staff often felt abandoned amidst their problems of local cooperation, financing, means of transportation, medical supplies, etc.

To study the effect of health centers on solving health problems, and to relate difficulties encountered to the training program, the Demonstration & Evaluation Team was formed. It consisted of public health physicians, a public health nurse, a sanitary engineer, a sociologist-anthropologist, Ethiopian laboratory technician, health officer, dresser, sanitarian, and other staff. Pairs of communities were selected, consisting of "health center community" and similar "control community" (the latter would not receive a health center) to represent major ecological and ethnic dimensions. In effect, only 3 pairs could be studied due to political and logistic problems. Upon arrival in each little town, rapport was established with the local leaders, a map was drawn to show location of every household, and the sociologist studied local culture including the practices of traditional healers. When the map had been completed, a representative household sample was drawn from it at random, so that 150 households with about 450 individuals were invited for examination in each community. This was about the largest number the medical team could process in the field. One-third of this sample was drawn at random for the more detailed sociological questionnaire. Data were obtained on physical conditions, serological aspects, intestinal parasites, etc. Practices relating to water and sanitation and attitudes and practices relating to health and illness were investigated. These communities will be resurveyed beginning in 1966, about four years after the baseline survey, in order to measure changes that would test health center effectiveness. Meanwhile supervision visits are being made to provide optimum communication and professional advice.

2.	Amharic:	tālalafi bāsheta, Wardshin
	Tigrinya:	chelā wotē
	Wollamo:	Issi assape issi assako hāngē
	Somali:	urduba immane
	Gallinya:	dukuba golfa
	Kambatta-Gudela:	holama

3. The Empire-wide health tax is levied to support the Public Health budget, which cover hospitals, administration, building of health centers, etc.

4. The registration fee is Eth.\$0.50 (US20¢) per month; but tuberculosis and venereal disease treatments are free, and there is no charge for the mother-child health session one afternoon a week.

5. Messing, S.D.: "Group Therapy and Social Status in the Zar Cult of Ethiopia", see bibliography.
6. Wollo Province Public Health Report. Dessie, 1965.
7. Cohen, John M.: Health Legislation in Ethiopia. Mimeographed report by Peace Corps Legal Division, Addis Ababa, 1965. Reference is made to

<u>Citation</u>	<u>Legal Notice Number</u>	<u>Title</u>
10/1 (1950)	146	Water Rules
10/1 (1950)	147	Food Laws
8. Ibid 10/12 (1951)	157	Urination & Defecation
9. Ibid 10/3 (1950)	151	Veneral Disease Rules
10. Manual of Procedures for Health Center Operations, 1965, Chapter IV: Communicable Disease Control, p.3. Mimeographed.		

11. These case histories were taken from the author's "Sociological Supervision Report of Hosaina Health Center", October 1964. Mimeographed.

12. When a health center is established in a community, one of its first tasks is to conduct a census of the community, to number all houses for purposes of easy location in the event of need for home visits.

13. The original inhabitants of this region were "pagan" when conquered by the Coptic Christian Abyssinians in the 1890's. Many of the rural people in this region retain their ancestral religions.

14. See Footnote 5.

15. Kosso is quassia, composed of twigs, leaves and bark of this tree, and consumed in form of tea. It produces a rather violent purge of the intestines.

16. These aforementioned organizations, as well as many of the other cooperative groups, elect trusted persons to chairmen and secretaries. These watch over compliance with by-laws and safeguard collection and distribution of funds.

17. Messing, S.D.: "The Abyssinian Market Town". See bibliography.

BIBLIOGRAPHY

- Asfaw Dante** : Equb. Ethnological Society Bulletin, University College of Addis Ababa, July 1958, pp. 63-76.
- Bogardus, Emory S.** : Social Distance and its Practical Implications. Journal of Sociology and Social Research, Vol. 22, 1938, pp.462-476.
- Cavanaugh, Joseph A.** : The Social and Behavioral Scientist in Latin American Assistance Programs. The Milbank Memorial Fund Quarterly, Vol. 42, No. 3, Part 1, July 1964, pp. 7-19.
- Chang, Wen-Pin** : General Review of Health and Medical Problems in Ethiopia. Ethiopian Medical Journal, Vol. 1, No. 1, July 1962, pp. 9-27.
- Demonstration & Evaluation Project** : A Study of Health Center Effect on the Health of Selected Ethiopian Communities. USAID/Ethiopia, 5 volumes, 1965:
Introduction and Methodology
Maichaw and Korem
Metu and Hurumu
Hosaina and Durame
Degahbur and Aware
- Dodd, Stuart C.** : A Controlled Experiment in Rural Hygiene in Syria. A Study in the Measurement of Rural Culture Patterns and of Social Forces. American University of Beirut, Social Science Series, No. 7, 1934.
- Messing, Simon D.** : The Highland-Plateau Amhara of Ethiopia. Ph.D. Dissertation, University of Pennsylvania, 1957.
- : Group Therapy and Social Status in the Zar Cult of Ethiopia. In Opler, M.K.: Culture and Mental Health. Macmillan Co., New York 1959, (Chapter 13).
- : The Abyssinian Market Town, in Bohannan & Dalton: Markets in Africa. (chapter 14), pp. 386-408, Northwestern University Press, 1962.
- : The Community of Chwahit. Technical Report No. 4, Haile Sellassie Public Health College, Gondar, August 1962.
- : Health Culture Research in a Developing Country (with Prince and H.E. Yohannes Tsoghe). The American Behavioral Scientist, Vol. vii, No. 8, April 1964.
- : A Method for Historical Reconstruction of Demographic Growth in African Small Towns. Current Anthropology, Vol. 5, No. 3, June 1964.
- : Application of Health Questionnaire to Pre-Urban Communities in a Developing Country. In press, Human Organization, 1965/66.

- Million Tesfay** : Mutual Aid Organizations Among the Kcetu-Galla of Harar. Ethnological Society Bulletin, University College of Addis Ababa, Vol. 2, No. 1, July-Dec. 1961, pp. 71-76.
- Prince, Julius S.** : Community Social Structure and Attitudes Toward Public Health. Unpublished doctoral thesis, Harvard School of Public Health, December 7, 1956.
- : Public Philosophy in Public Health. Journal of the American Public Health Association, July 1958.
- : Public Health Practice in New York State and Ethiopia - A Comparative Analysis. Health News, N.Y. State Health Department, Vol. 40, No. 3, March 1963, pp. 6-16.
- : Training of Rural Health Workers in Ethiopia. Ethiopian Medical Association Journal, Vol. 1, No. 2, October 1962, pp. 79-83.
- Rosa, Frans** : Project of the Haile Selassie I Public Health College and Training Center. Ethiopian Medical Journal, Vol. 1, No. 2, October 1962, pp. 72-78.
- Textor, Robert B., et al** : Manual for the Rural Community Health Worker in Thailand. Ministry of Public Health, Thai-American Audiovisual Service, 1958. 66 pp.
- Temesgen Gobena** : Gega, Däbo and other Communal Labors Mainly Among the Oromo of Western Sawa and Willige. Ethnological Society Bulletin No. 7, University College of Addis Ababa, Dec. 1957, pp. 65-76.
- Weir, John M.** : An Evaluation of Health and Sanitation in Egyptian Villages. The Journal of the Egyptian Public Health Association, Vol. 27, No. 3, 1952.