THE AFTERMATH OF AID: MEDICAL INSECURITY IN THE NORTHERN SOMALI REGION OF ETHIOPIA

by

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DEDICATION

To my father, Bruce Carruth,
for instilling in me curiosity about the lives of others and a sense of adventure.

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GUIDE TO SOMALI LANGUAGE PRONUNCIATION

Consonant sounds for northern Somalis' pronunciation of Somali (Orwin 1995):

q	Known as a "voiced uvular plosive" – made by pronouncing a hard "k" sound in the back of the throat.
kh	Pronounced as the Arabic خ, and used in words derived from Arabic. Pronounced like "loch" in Scottish.
x	It is not exact, but for ease, pronounce like an English "h" as in "help" but more from the back of the throat as if you were clearing your throat. This is called a "voiceless pharyngeal fricative." For example in the Arabic word for the "hajj" or حج in Somali spelled "*xaj*."
c	Pronunciation is similar to the "ou-" as in "ouch" or "ah" in English but voiced at the back of the throat with the mouth and throat wide open. So "*Ciise"* in pronounced more like "ahee'-sah" but with only two syllables.
r	All "r"s are rolled.
'	This apostrophe signals a glottal stop.
b	Pronounced like "b" or "p" interchangeably
j	Either pronounced like a "j" in English or "ch" in English

Vowels in Somali

a	Pronounced like "bottle" in American English
e	Pronounced like "red"
i	Pronounced like "bit"
o	Pronounced like "top"
u	Pronounced like "put"
ii	Pronounced like "reed"
uu	Pronounced like "fool"
ay, ey	Interchangeable, and pronounced like "hay"
aw	Pronounced like "cow"
ow	Pronounced like "show"

ABSTRACT

This dissertation explores the lasting effects of recurrent temporary medical humanitarian operations through ethnographic research in communities, clinical facilities, nongovernmental aid organizations, and governmental bureaucracies in the northern Somali Region of Ethiopia. First, I found that medical humanitarian aid has altered persons' subjective experiences and expectations of biomedicine, spirit possession, health, and healing. Popular health cultures and conceptions of "biomedicine" as well as "traditional medicine" were changing, in part due to repeated exposures to relief operations. Second, I documented novel social formations to cope with recurrent aid: new labor relations to enable temporary work with international NGOs; new medical migrations to access comparable care and foreign medical commodities at distant private hospitals; and transnational extra-legal economies of medicine to fill gaps in care.

Third, a set of racialized narratives have emerged in the interstices of aid that warn of malpractice and abuse by non-Somali Ethiopian clinicians. Such discourses echo Somalis' historical experiences of ethnic-based conflict with Ethiopian groups as well as their contemporary marginalization from Ethiopian sources of power. Accordingly, although aid is designed to improve immediate access to basic healthcare and medications, I find it also exacerbated *medical insecurity*. Northern Somalis' discursive expressions of medical insecurity have increased, paradoxically alongside steady improvements in their health and nutrition indicators.

Finally, health and humanitarian interventions have altered local notions and practices of citizenship. In the last ten years, as Ethiopia has decentralized its health care delivery system, aid has been progressively channeled through Somali Regional State institutions. Accordingly, many Somalis now discuss the diverse ways in which they are increasingly interpolated into regional politics–often in opposition to the Ethiopian government. Medical aid has shaped expectations of government as well as biomedicine. I argue that these new forms of citizenship have emerged primarily because of the intimate and profound nature of medical encounters themselves. The narrow humanitarian mission to minister to what social theorists call the "bare life" of victims, in actuality, is neither dispassionate nor removed from sociality and politics. Medical aid potentially provides spaces in which relations of care-giving, trust, and therefore responsive governance structures can develop.

INTRODUCTION

> The mobile team[1] provided *kiniini* (pills), mostly, to the people here. People loved the mobile team. And they [people here] believed in those pills, during the six months they were serving here. The people all of them they focused on the mobile team, they liked them personally, they took the [medical] services from them and they believed that their medicine was high quality medicine. The people even said that these pills were not sent by Ethiopia, they were surely sent by Allah!
>
> If I was the chairman of this *kebele* or the *woreda*[2] I would recommend this mobile team to serve the community as much and as long as possible. We got a good service from them that we do not get from the government [of Ethiopia]. And it was also that we got free pills, and also that they reached the remote areas that the government has never reached. More people, even now, they are asking each other, "Where is the mobile team?" "Where did they go?" [Hassan, a resident of the northern Somali Region of Ethiopia]

This dissertation explores what remains as medical humanitarian operations[3] repeatedly recede from and return to communities in the northern Somali Region of Ethiopia. Medical aid during humanitarian emergencies typically prioritizes the efficient provision of life saving materials to first responders – rations, essential medicines, clean water, and first aid kits. Indeed, popular social theories cast humanitarian relief as merely brief encounters with the "bare life"[4] of victims. Instead I find that clinical

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[1] Mobile teams, formally called "Mobile Health & Nutrition Teams," were UNICEF-funded humanitarian relief programs to send teams of Somali nurses out to remote and conflict-affected pastoralist areas of Ethiopia. They provided free medications, basic medical care, and therapeutic foods to malnourished or sick infants, children and their lactating and pregnant mothers (UNICEF 2009).

[2] A *kebele* is a neighborhood or community administrative unit in Ethiopia; *woredas* are administrative districts, one level larger than kebeles. The administrative organization of Ethiopia and the northern Somali Region is describe din greater detail in Chapter 1.

[3] I define medical humanitarian interventions as the biomedical and public health responses during and after catastrophes – clinics opened, medications distributed, therapeutic foods dispensed, and wounds tended – by governmental as well as nongovernmental institutions and clinical facilities.

[4] Here I quote Giorgio Agamben (1998), but draw on how others (Comaroff 2007, Fassin 2007, Razack 2008, Ticktin 2006) have used the idea of "bare life" in their own work.

encounters during and after relief operations have enduring effects and are imbued with both sociality and intense emotion. In the aftermath of aid, people's expectations and evaluations of biomedical therapies and healthcare provision transform, and they may feel abandoned and left without the level of medical care they have come to count on. Therein, temporary medical interventions can make health disparities even more perceptible and profound. Medical humanitarian interventions are also inescapably political in that they have the potential to either establish responsive healthcare governance structures or widen social cleavages and inequities. I argue that this in part explains why, despite four decades of prodigious spending on health and humanitarian interventions in the northern Somali Region of Ethiopia, Somalis there continue to live without adequate and trusted medical facilities and medicine. Aid itself, at times, contributes to northern Somalis' heightened vulnerabilities to racialized experiences of violence, discrimination, and illness.

Anthropologists have long contributed valuable insights into how people cope with and survive disasters and wars (de Waal 1989[2005], Hammond 2004, Hoffman and Oliver-Smith 2002, Hutchinson 1996, Jok 2001, Malkki 1994). Anthropologists have also long been interested studying economic development and humanitarian[5] regimes (Bornstein and Redfield 2011, de Waal 2002, de Waal 2010, Fassin 2011, Ferguson 1994,

[5] For the purposes of this dissertation I define humanitarianism as efforts that are structured by International Humanitarian Law and designed to protect and care for persons during and in the aftermath of wars, disease epidemics, natural disasters, or sudden collapses in governance structures or assets (Bouchet-Saulnier et al. 2007, Walker and Maxwell 2009). In its strictest sense, as articulated by the founders of the International Committee of the Red Cross, humanitarian action includes efforts to make war itself more humane, but *not* to campaign for or foster human rights or economic development. More broadly, "humanitarianism" is a fashionable moniker and mission in the contemporary world of global aid. Its moral and sentimental associations make it a useful and compelling descriptor to which no one can object (Fassin 2011).

Duffield 2001, Minn 2007, Redfield 2005, Richards 2010). Within the anthropology of aid, there is an emerging interest in "medical humanitarianism" – or the invocation of avowed "humanitarian" morality and biomedical actions to save lives and witness suffering (Fassin 2011, Fox 1995, Ticktin 2011). Thus far, ethnographic studies of medical humanitarianism have mostly been limited to institutional ethnographies of relief organizations, refugee populations and asylum seekers in Europe, and theoretical analyses (e.g. Castañeda 2007, Fassin 2007, Fassin and d'Halluin 2005, Redfield 2006, Ticktin 2006), rather than historically situated ethnographic studies in communities where humanitarian crises and responses recur.

This study, by contrast, was grounded in the everyday lives and concerns of residents of the northern Somali Region of Ethiopia, as well as in the various logics and practices of the particular humanitarian aid actors and institutions there. I found that medical humanitarian interventions altered not just people's health indicators as measured and monitored by relief organizations, but also their subjective experiences of illness, health, healthcare, and healing. More specifically, exposure to new clinics, diagnostic technologies, vaccines and pharmaceuticals during relief operations altered the ways in which many people subsequently spoke about and conceived of clinical biomedicine, their bodies, their uses of "traditional" or non-biomedical healing modalities, the behavior of malevolent spirits in their bodies, and their pluralistic therapy management strategies. Many persons also acknowledged that antibiotic regimens, vaccines and therapeutic foods provided during relief operations had saved numerous lives. Together all these experiences provided a foundation from which relations of care

and trust were forming between northern Somali patient populations and healthcare providers during relief operations. And this did not only occur under the aegis of the stated relief mission; instead, it often happened when healthcare providers, like those comprising the Mobile Health & Nutrition Team mentioned in Hassan's statement, bent the rigid architecture of humanitarian procedures and the boundaries of target groups in response to local categories of need and local expectations. Yet when these new clinical relationships were subsequently severed, at the end of the emergency funding cycle, persons often felt forsaken and resentful about subsequent health disparities and perceived injustices within the remaining Ethiopian healthcare facilities.

Methodologically and theoretically I looked to medical anthropologists studying global pharmaceutical systems and biomedical encounters in non-Western settings to help me decipher the significance of these clinical relations and subjectivities (e.g. Biehl et al. 2007, Hamdy In press, Petryna 2009, Whyte 2009, etc.). Accordingly, this dissertation provides an ethnographic case study of what I call *medical insecurity*,[6] or a lack of accessible, high quality and trusted medicine and medical care. I argue that although many humanitarian missions save lives and improve medical care during emergencies, they may also indirectly heighten medical insecurity upon their departure. In places where local primary medical care has long been untrustworthy or inadequate, relief agencies at times have raised people's expectations of biomedicine without successfully contributing to the development of high quality and sustainable facilities. Medical

[6] The term "medical insecurity" I use here draws primarily on the concept of "food insecurity" as defined by the UN Food and Agriculture Organization (2011). The FAO maintains that food insecurity is at its core, "about risks and uncertainty."

insecurity in the northern Somali Region was characterized both by recurrent humanitarian crises and, in the aftermath of aid, scarce and ill-equipped healthcare facilities, anxieties about the safety and quality of contraband and Ethiopian generic medicines, provisional and sporadic donations of medicines from NGOs, and crucially, racialized antagonisms and relations of distrust between Somali patient populations and their non-Somali *habasha*[7] Ethiopian healthcare providers. Northern Somalis' idiomatic and narrative expressions of insecurity, vulnerability, and health disparity have intensified, paradoxically alongside steady (but meager) improvements in their health and nutrition indicators.

Medical insecurity is a term that has not hitherto been used by aid or policy organizations, but I find it has the potential to encompass the protracted risks and uncertainties that shape healthcare and illness experiences in the aftermath of aid. The term *food insecurity*, by contrast, has for nearly thirty years been used to index a broad range of problems: lack of food, higher than normal prevalence of malnutrition, extortionate prices of food products, collapse in agricultural or livestock holdings, lack of food safety standards, lack of adequate variety and nutritional value of existing food supplies, or potential future loss of the ability to access or afford safe and adequate food (Baro and Deubel 2006, Frankenberger and Drinkwater 1999). The United Nations Food

[7] "Habasha" (otherwise spelled "habesha" or ሐበሻ in Amharic) is an ancient term that previously referred to persons who were part of the Axumite then Abyssinian Empires, but is today colloquially defined as persons of Amhara or Tigrynia ethnicities (sometimes also Gurage) residing in Ethiopia or Eritrea, or persons who speak either Amharic or Tigrynia languages as a first language. The term habasha for many rural Somalis in eastern Ethiopia indexed not just ethnicity and language group but political support of the current Ethiopian government, although many habashas would object to this usage and association. The term "highlander" is also used to refer to persons of Amhara or Tigrynia ethnicities. "Highlander" is often used pejoratively in counterpoint to "lowlander" which refers to Somali, Oromi, Afari, and other ethnic groups in southern and eastern Ethiopia. "Highlanders" are seen by "lowlanders," in general, as more powerful and favored by the Ethiopian government, among other things.

and Agriculture Organization (2003:33) argues, "Since food insecurity is about risks and uncertainty, the formal analysis should include both chronic sub-nutrition and transitory, acute insecurity that reflects economic and food system volatility." The FAO also finds that the calculation of future risks and volatility is necessary to understand the current food security situation because farmers, merchants, and market analysts all depend on accurately predicting what is yet to come—prices, rainfalls, and yields. These elements apply to the concept of *medical* insecurity as well, especially in situations when adequate care is perceived to only accompany intermittent and provisional humanitarian operations.

Research Questions and Ethnographic Situation

An interest in medical insecurity as it transforms in the aftermath of aid led me to pose following research questions: What happens when medical humanitarian aid ceases, relief workers depart and supplies of free medications dissipate? And then what happens when aid returns a few months or years later, and then ceases again? More specifically, what effect does the temporary, repeated provision of free medications and medical care to underserved populations have on local social relations of illness and healing, health behaviors, local health systems, extra-legal[8] transnational healthcare economies, and the governmental and nongovernmental humanitarian regimes built to respond to crises? To

[8] I use the term *extra-legal* the way Ferguson (2006) and Nordstrom (2004, 2007) do, to denote activities that fall outside legality as it is defined by governments and law enforcement. This includes illegal and illicit economies of goods purposefully hidden from taxation and declaration, as well as informal exchanges of commodities such as interpersonal gifts and trades.

address this issue, I conducted multi-sited ethnographic field research in select communities in the northern Somali Region of Ethiopia as well as in the particular clinics and humanitarian institutions responding to health and humanitarian crises there.

This dissertation focuses on healthcare and medical insecurity in Aysha *woreda* (district) in the remote northeastern corner of the Somali Region of Ethiopia, close to borders with Somaliland and Djibouti. A vast majority of the residents there are Somali, and most also belong to the Issa clan (*Reerka Ciise*). Most residents of Aysha woreda were at some point either designated a refugee or internally displaced due to a combination of drought, livestock loss, and political conflict. Several residents had fled from multiple wars, natural disasters and personal calamities during their lifetime, and had at different times lived in Ethiopia, Somalia, Somaliland, and Djibouti. Nomadic pastoralism is the most common way of life in the northern Somali Region, even for displaced persons, but for various reasons I discuss throughout the dissertation, increasing numbers of families have settled year-round in communities and towns. Settled households often cultivated a few subsistence crops, kept smaller livestock like goats and sheep for food, engaged in petty trade, or attempted to gain temporary contract work with nongovernmental and governmental humanitarian relief and development agencies. For at least the last ten years, most households in Aysha woreda have also received regular food aid rations from the UN World Food Program – whole grains of wheat, corn-soy blended flour, split peas and vegetable oil. Additionally, over the last ten years several international nongovernmental organizations and the Government of Ethiopia have intermittently provided various relief commodities and services.

Between 1989 and 2005, in the wake of numerous interstate and interclan conflicts, Aysha woreda hosted between 15,000 and 30,000 refugees and internally displaced persons from Somalia, Somaliland and the surrounding area of Ethiopia. Additionally, remnants of past relief operations and medical facilities dot the Aysha landscape: one clinic was opened in the 1930s and closed in the 1980s by the Italian government in the county seat of Aysha; one clinic was opened in the mid-1980s in the Degago camp by Médecins Sans Frontières-Holland, was later operated by UNHCR, and then was closed in 2005; in 2002 a small clinic was erected and supplied (but not staffed) for one year in the village of Elahelay by an international NGO called PNMP; and another clinic further west opened in the 1990s by Médecins Sans Frontières then closed five years later. In the last decade, medical humanitarian aid has increasingly been funneled through regional institutions and staffs, as one part of the federal government's effort to decentralize health care delivery and the distribution of aid commodities (FDRE 2005). Consequently, most of these abandoned clinical spaces have reopened to house various public health initiatives.

From July 2007 until August 2009, the years of this research, both long and short rainy seasons in the northern Somali Region of Ethiopia were significantly delayed, and in 2008 rainfall totals were significantly lower than normal. In September 2008 the UN Office for the Coordination of Humanitarian Affairs declared the existence of severe food and water shortages (IRIN 2009, IRIN 2008). Compounding the drought conditions, in 2008 and 2009 multiple epidemics of acute diarrheal disease and measles occurred in Aysha woreda, and rates of severe acute malnutrition among children peaked. To

respond, in addition to continuing WFP rations, UNICEF funded the aforementioned "Mobile Health & Nutrition Team" of Somali nurses who traveled by vehicle to remote pastoralist villages in Aysha woreda for six months to provide primary medical care, preventative care, therapeutic food, and free medications to malnourished and sick infants, children and their lactating and pregnant mothers (UNICEF 2008b, UNICEF 2009b). An NGO called the Hararge Catholic Secretariat[9] sporadically provided caches of antibiotic medications, water purification kits, and oral rehydration packets to small clinics in communities in Aysha woreda affected by elevated levels of diarrheal disease and severe malnutrition. Additionally, Oxfam-Great Britain provided a daily water truck for several communities who at the time lacked any source of surface or piped water.

Ethnographic scholarship on Somalis has been stymied by the last twenty-five years of political insecurity in the Horn of Africa. There were several anthropological and sociological studies of Somalis living in Somalia and Somaliland based on research conducted mostly prior to the outbreak of civil war in 1989 (most famously including Besteman 1999, Cassinelli 1982, Helander 1990 and 1991, Lewis 1961[1999], 1965[2002], 1966, and 2004, Luling 1978), but these studies did not explore life further north in Ethiopia. More recent social science studies have been done by Somali nationals or were conducted by researchers speaking with Somali refugees outside Somalia or Ethiopia (e.g. Abbink 2003, Abdalla Omar 1995, Abdi 2005, Horst 2009, Johansen and Elise 2002, Lindley 2009, Samatar 2005 and 2008). Still, none of these address community life and livelihoods in the Somali Region of Ethiopia, Somali popular health

[9] The eastern Ethiopian arm of the NGO Catholic Relief Services partnered with the Ethiopian Catholic Church.

cultures or, more narrowly, Somalis' uses and knowledge of biomedicine or their interpretations of Islamic medical beliefs and ethics. Additionally, several critical policy and political economic studies of Somali societies have been situated in communities in the Horn of Africa (Abbay 2004, Bentley 1989, Bradbury 1997, de Waal 1997, de Waal and Omaar 1993, Drysdale 2000, Hagmaan 2005, Hagmaan and Hoehne 2009, Hammond 2011, Jamal 1988, Kibreab 1993, Little et al. 2001, Little 2003, Markakis 1994 and 1998, Menkhaus 2010, Sadler and Catley 2009), but these have not addressed the lasting social and health system effects of specific public health and humanitarian interventions. Most scholars studying Ethiopian cultures (Abbink 1991, Amare 2004, Donham 1999, Helland 1993, James 1990, Levine 1992, Pankhurst 1992, Silverman 1999), humanitarian crises in Ethiopia (Clay and Holcome 1986, Desalegn 1991and 2003, Duffield and Prendergast 1994, Hendrie 1997, Howe 2004, Kelly 1992, Kidanu 2003, Kloos and Lindtjorn 1994, Lautze et al. 2009, Lautze et al.2003, Masefield 2001, Maxwell and Lautze 2006) and Ethiopian health cultures and pluralistic health systems (Berhane et al. 2001, Demissie et al. 2003, Gish 1992, Jeppsson et al. 2003, Kebede et al. 2006, Kloos et al. 1986, Mariam 2003, Vecchiato 1997, Young 1975, 1976, 1977, and 1980) have *not* included considerations of Somali populations residing within Ethiopia. This study aims to fill gaps in the ethnographic literature on northern pastoralist Somalis and on Somali popular health cultures. During the time of this research the northern Somali Region was exceptional among places with majority Somali populations in the Horn of Africa: it was stable and safe. Therein, this dissertation provides a window into the lives and healthcare

concerns of Somalis *not* overwhelmed by the political insecurity, violence, stress migrations, and famine prevalent in much of the rest of the Horn of Africa today.

Paradoxes of Humanitarianism

Humanitarian aid is big business in Ethiopia, and despite its many imperfections and inadequacies, it has saved countless lives. In 2009, US$693 million was spent on humanitarian relief to Ethiopia. Since the early 1970s Ethiopia has been a major recipient of United States bilateral and multilateral development and humanitarian aid, and in 2009 Ethiopia was the second largest country recipient of U.S. humanitarian aid, after Afghanistan (Global Humanitarian Assistance 2011). But crisis and aid are often narrowly imagined. Images of "famine" have dominated media reports about Ethiopia (e.g. Kassahun 2009), and food aid continues to dominate the humanitarian landscape. Despite the breadth of sustainable and politically engaged humanitarian interventions advocated by aid agencies and scholars today – everything from livestock purchasing programs for pastoralists to opening schools for refugees – on average, 76% of all humanitarian aid to Ethiopia in 2008 and 2009 was spent on food (Global Humanitarian Assistance 2011). These numbers reveal a series of paradoxes.

First, there has long been a myopic focus on food aid within the field of humanitarian response. Abundant media stories and donor appeals about Ethiopia narrowly describe "disaster" and "need" in quantitative measures of malnutrition and food aid requirements even as anthropological and critical humanitarian research in

Ethiopia demonstrate that vulnerability to calamity, poverty, morbidity, and mortality are attributable to far more than a lack of food (de Waal et al. 2006, Kloos and Lindjorn 1994, Maxwell and Lautze 2006, Lautze et al. 2009, Pankhurst and Bevan 2004, Pelletier et al. 1995, and Young 2004). In fact, the most common non-violent causes of death in almost every war, famine and natural disaster worldwide, including those in Ethiopia, are infectious diseases: acute diarrheal diseases, acute respiratory infections, and malaria, in many cases complicated by underlying chronic or acute malnutrition (Burkle 2009, Lautze et al. 2003, Toole and Waldman 1997, Seaman 1993). A majority of infectious diseases diagnosed during humanitarian emergencies are treatable with short courses of antibiotic or anti-malarial medications.[10] Consequently, every year millions of people worldwide receive antibiotic and anti-malarial medications as a part of medical humanitarian interventions (Sphere Project 2011), including approximately 4.6 million Ethiopians who were expected to receive "emergency health and nutrition" support in 2008 (Government of Ethiopia 2008).

A second and related paradox is that although prescription pharmaceutical medications have long accompanied humanitarian responses, little policy or social science research has been conducted to investigate the longer-term and social effects of such interventions. Even though there is extensive research on the effects of aid on subsequent food security, commodity markets, agricultural outputs and population health, most studies fail to look beyond epidemiological and econometric measures to changes in

[10] This is not be the case in situations where HIV/AIDS prevalence is high, such as in southern African countries; the prevalence of HIV in Ethiopia and in the Somali Region are thought to be well below 10% despite lack of population-based epidemiological research or surveillance (UNAIDS 2003, UNICEF 2009).

health systems and health behaviors. Public health and emergency medical responses are undoubtedly vital to the survival of sick and injured persons when local sources of medicine and health care break down. Still, the overwhelming emphasis on food in humanitarian responses and media narratives – in Ethiopian in particular – have obscured the ways in which other common forms of humanitarian assistance, namely medical aid, shape subsequent interventions as well as health systems and local social relations of illness and healing.

Third, humanitarian crises and international responses are not anomalous or temporary in the Somali Region of Ethiopia, but are enduring features of local livelihoods and health systems. Still, although humanitarian responses are predictably recurrent, they are conceptualized and budgeted as temporary emergency measures and distinguished from development aid. In the Somali Region, most foreign aid is budgeted as humanitarian relief; consequently, emergency funding was being used in lieu of development aid to improve the public health system and train community health workers[11] (Ministry of Health 2008, UNICEF 2009). Beyond this, the structure of relief has remained largely ahistorical and unresponsive to the ways in which aid itself tends to reproduce the very social inequalities and political dysfunctions underpinning recurrent crises (Lautze et al. 2009, de Waal 1997, de Waal 2010). Historical amnesia allows aid agencies to, in a sense, begin anew with the declaration of every new emergency, and therein releases organizations from culpability when violence and poverty continue

[11] In Ethiopia called "health extension workers" and in pastoralist areas of Ethiopia called "pastoralist health extension workers." The roles and practices of these community health workers are outlined in Chapter 1 and described throughout this dissertation.

(Duffield 2001). This dissertation situates specific medical humanitarian responses in the Somali Region of Ethiopia within their broader historical, social and political-economic *milieux*. In the dissertation that follows I expose how provisional medical aid is integral to larger political, economic and social structures – structures that, paradoxically, reproduce the very animosities and inequalities between Somalis and other Ethiopians that make the region more susceptible to crisis and marginality.

Summary of Methods and Methodology

Medical humanitarian interventions never happened in isolation; instead, relief agencies entered and re-entered communities in the midst of multiple existing flows – flows of people, medicines, and ideas about health and healing. This dissertation draws on data gathered during twelve months of multi-sited ethnographic research between July 2007 and August 2009, and draws on my three summers of work for the UN World Food Program and UNICEF in Ethiopia between 2003 and 2005.

I developed a combination of methods in order to study various flows of medicine and aspects of medical insecurity at multiple levels and positions within health systems in the northern Somali Region of Ethiopia. Interviews with governmental and nongovernmental policymakers and analysis of various policy documents provided multiple perspectives on the development, implementation, and evaluation of specific health and humanitarian programs in the Somali Region. To complement interviews with policymakers, I then interviewed persons involved in the distribution of medicines around

the Somali Region, including licensed pharmacists, physicians, nurses and community health workers, businessmen responsible for the supply chains of regulated medications, merchants along the major trade routes in eastern Ethiopia, and unlicensed shopkeepers and pharmaceutical sellers. Finally, I conducted interviews with a diverse sample of laypersons and lay health experts.[12] Initial interviews delved into local flows of medicines, locally prevalent diseases, various non-biomedical treatments, Qur'anic healing,[13] and beliefs about bodily constitution and health. Subsequent additional interviews with laypersons focused on their uses of pharmaceuticals and healthcare facilities, using elicitation devices with samples of locally available medicines.

In total I conducted 193 ethnographic interviews with 146 different individuals. Additionally, I conducted a series of 18 structured observations within nongovernmental aid organizations, governmental bureaus, local markets, and clinical facilities; I shadowed nurses on mobile teams in Aysha woreda; and on several occasions I attended policy meetings and briefings at aid organizations. For additional information on historical events I searched archived periodicals and unpublished papers at Addis Ababa University. I made careful notes of local happenings during participant observation and had numerous personal conversations with individuals in the course of everyday life

[12] By using the term "laypersons" I refer to persons without formal biomedical training or education, nor a state-issued license to practice biomedicine or sell pharmaceutical medications. By the term "lay health expert" I refer to persons who lack formal biomedical training or a license to practice medicine, but are regarded by their peers as experts on illnesses, healing, and health in general. Details on the roles of these individuals will be discussed in Chapters 2 and 3.

[13] Qur'anic healing is a popular healing practice in some Islamic societies in Africa, whereby illnesses caused by attacks or possession by invisible spiritual beings are diagnosed and treated by local mullahs or sheikhs. These Qur'anic healers are able to discern the etiology of a given presentation, then dominate and dispel the spirit through invocation of the Holy Qur'an, words of the Prophet Mohammad, and famous hadiths. Qur'anic healing practices in the Somali Region are discussed in Chapter 3.

throughout the year. Details on my methods, data sources, interview strategies, data analysis and human subjects protection measures are discussed in Chapter 2.

I approached flows of medicines and knowledge about medicine using what van der Geest and Whyte (1996) call "a biographical approach to pharmaceuticals." Such an approach outlines the "life cycle" medicines follow – or their "social lives" (Appadurai 1986) – including their marketing, prescription, distribution, purchasing, consumption, and measures of efficacy (van der Geest and Whyte 1996; Whyte et al. 2005). Similarly, a "commodity chain analysis," originally formulated as one aspect of world-systems analysis, allows for an examination of commodity and labor flows in the global economy (Hopkins and Wallerstein 1994). Commodity chains link the raw material of commodities—like medicines—to labor markets, consumer demand, and exchanges of information, thereby connecting various individuals, societies, economies, and geographic regions of the world (Gereffi and Korzeniewicz 1994, Hughes 2007, Kaplinsky 2001). Moving beyond movements of commodities and ideas, a "socially embedded commodity chain analysis," described by Rammohan and Sunaresen (2003), harkens back to biographical models by emphasizing the importance of social relations around each node of the commodity chain. Their framework demands an integrated, political economic examination of transnational and local systems of exchange, and requires scrutiny of the historical structural inequalities central to the unequal distribution of treatments and diseases. Additionally, beyond the contemporary "social lives of medicines" (Whyte et al. 2005) in the Somali Region, this study also follows the biographies of medicines historically, as they move through time as well as space. In so

doing, I also highlight the social memories and lingering reverberations of medicines and medical encounters.

This methodological framework allowed for the recognition and investigation of diverse kinds of medicines and medical practices beyond the purviews of Western biomedicine, regulated therapeutics, and licensed health care facilities. The northern Somali Region was a hub of contraband trade, and many of the medications available there were non-prescribed contraband pills produced in India, China, Pakistan and elsewhere, shipped to ports in Puntland and Somalia, trucked into the Ethiopian interior, and sold in small shops and unlicensed pharmacies. In addition, I found that boundaries between discrete illness designations and etiologies were contingent and often lacked consensus, and so I drew on Nichter and Nichter (1996:120) in their use of "taskonomies" of illnesses to highlight ambiguous processes involved in illness labeling, health beliefs, and medical practices. Also, I went beyond an assumption that emic perspectives and indigenous ideologies of healing were necessarily "traditional;" this data reveals routine ways in which Western biomedical technologies and concepts have been variably appropriated, changed, and used metaphorically by biomedical healthcare providers, laypersons, lay health experts, shopkeepers, herbalists, and spiritual healers. Each stage in the social lives of medicines – broadly conceived – presented rich opportunities for ethnographic inquiry.

Summaries of the Chapters

Chapter 1 describes the ethnographic and historical context in which this research unfolded. A few important characteristics are shared by most Somalis in the northern Horn of Africa: a Sunni Shafi'ite Islamic tradition, the Somali language (despite regional differences and dialects), a cultural ideal of nomadic pastoralism, mythical and symbolic descent of the major clans from the Prophet Mohammad, and a history of colonial domination and partition. In the 18th through 20th centuries, Somali people were partitioned among five colonial empires: France claimed what is now Djibouti, the British Empire claimed what is now (approximately) Somaliland and the Northern Frontier District of Kenya, Italy colonized most of what is today Somalia,[14] and Ethiopia controlled (or colonized[15]) much of what is now the Somali Region of Ethiopia. Each of these colonial projects imposed borders through Somali homelands, cutting communities off from their pasture, surface water sources, markets, extended families, routes of pilgrimage, and places of worship. A majority of the adult residents of the northern Somali Region are displaced and dispossessed pastoralists; while many persons still own small herds of goats and sheep, most have lost significant camel and cattle livestock due to drought, disease, raids, and conflicts in the last three decades. Despite this, the northern Somalis with whom I spoke remained proud of their heritage and history of nomadic pastoralism, and saddened at the declining viability of this life way in the Horn of Africa today.

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[14] To be clear, when I refer to citizens of Somalia, I call them "Somalian" to distinguish from "Somalis" – or ethnic Somalis – in general. The Somali Regional State within Ethiopia, or the Somali Region, as will be discussed subsequently in great detail, is an ethnically autonomous region of the Federal Democratic Republic of Ethiopia. Ethnic Somalis are also citizens of Ethiopia I refer to as "Somali-Ethiopians."

[15] Many northern Somalis in the Horn include Ethiopia as another colonizing power beside France, Italy and the British Empire, because of its occupation of the Ogaden and fight for control over *haud* pastureland and trade routes linking Djibouti to Dire Dawa.

Also, I outline several flows of medicines and medical practices critical to the research questions. First, newly popular "Mobile Health & Nutrition Teams," as mentioned, were the vanguards of efforts to bridge humanitarian relief for pastoralists in conflict zones with sustainable improvements to local health systems. Second, the mission of the mobile teams by 2008 had expanded to include the informal training of young, newly minted Somali "pastoralist health extension workers" (or community health workers) who were trained and employed by the Government of Ethiopia to provide primary and preventative healthcare to rural and underserved areas. Third, the provision of additional relief commodities provided by a few NGOs during recent humanitarian operations – including antibiotics, water purification kits, oral rehydration salts, therapeutic foods, and potable water – had extended effects on markets and health systems beyond the period of the emergency itself. Finally, since relief operations typically came and went for years, I discuss ways in which extra-legal economies have emerged in eastern Ethiopia in part to complement gaps in the supply of medicines, and to respond to shifting local demands for certain pharmaceutical and injection medications.

Chapter 2 specifies what ethnographic research methods were used and why. As previously stated, this research involved twelve months of multi-sited research in communities, clinics and relief programs attempting to provide care to displaced and impoverished northern Somalis.

Chapter 3 provides an introduction to popular health cultures in the northern Somali Region and illustrates specific ways in which local medical practices and local

social relations of healing have changed in the wake of repeated health and humanitarian interventions. Somalis' notions of health and illness were largely dependent upon two forces: ultimate divine causality and balance between bodily fluids or humors. Humoral pathologies – primary among these illnesses resulting from excessive digestive bile and stoppage of blood flow and digestive flows – were managed by triggering diarrhea or vomiting, inducing bleeding, consuming camel milk, feasting or otherwise changing the diet (*buulee*), and increasingly, consuming certain pharmaceutical medications. Spiritual illnesses were mostly attributed to malevolent jinn (*jin*) or invisible spirits attacking or possessing the bodies of humans, in particular young women. These illnesses were diagnosed and treated by local mullahs who were able to discern the etiology of a given presentation using popular hadiths, then dominate and dispel jinn through invocation of the Holy Qur'an and words of the Prophet Mohammad.

In sum, popular health cultures were at once pluralistic and ambiguous. Treatments for a range of commonplace illnesses – everything from indigestion to infertility to tuberculosis – drew upon multiple strategies at once or in close succession. For example, many persons preferred to drink raw camel milk to manage levels of digestive bile but also consumed short courses of antibiotics. Several women with whom I spoke struggled with infertility, and in an effort to conceive they sought both counsel with local mullahs to exorcise a jinn, as well as biomedical counsel and abdominal ultrasounds at private hospitals. A glossary of common biomedical, illness, healing, and body terms is provided in Appendix A.

Popular health cultures and expectations of biomedicine were also changing. After positive experiences with clinicians in the Degago refugee camp or with the Mobile Health & Nutrition Team operation Elahelay, many persons desired better diagnostic equipment and better pharmaceutical supplies. The two Somali mobile team nurses I profile, in particular, did constant translational work between what were oftentimes incommensurate and vexing illness presentations and labels. For their efforts and assiduousness, many local Somalis praised them and sought them out for counsel and care—but after six months, the mobile team departed. Subsequently, habasha clinicians in the remaining governmental facilities were detrimentally compared to the mobile team nurses; they were perceived by local Somalis to lack empathy, they lacked knowledge of Somalis' popular health cultures, and most concretely, they could not speak or understand the Somali language. Frequent misunderstandings during clinical interactions in Aysha woreda worsened existing racialized tensions between many Somalis and habashas residing there.

Chapter 4 unpacks these misunderstandings and tensions further by examining flows of commonplace stories – radio news, rumors, jokes, and popular idioms – as points of departure. Prevalent stories frequently voiced a generalized sense of medical insecurity. In the absence of foreign medical aid, these narratives also articulated increasingly attenuated boundaries of trust between Somali patient populations and their mostly Ethiopian health providers. The narratives I outline include radio news stories about disease outbreaks on the Somali-language BBC news; narratives of crisis and poverty told in NGO reports and donor appeals; stories about misdiagnoses and

malpractice at Aysha Medical Center; stories about the theft of human remains and scientific experimentation on cadavers in a nearby public hospital; stories about preferences for medicine "from abroad" over contraband and generic formulations; and stories about incidents of discrimination between Somali patients and non-Somali habasha healthcare providers. These stories were consequential because they both generated and reinforced racial stereotypes and animosities: Somalis, on the whole, were portrayed as obtuse, ungovernable and noncompliant, and habasha healthcare providers were portrayed as careless, incompetent and racist. Thus, I argue, harm is done when medical aid programs depart, both because medical aid typically leaves untouched entrenched health disparities and social frictions, and because the departure of medical aid programs can leave populations with higher expectations of biomedical treatments, yet no way of subsequently accessing comparable or trusted care.

In Chapter 5 I delve further into social mechanisms by which Somalis cope with recurrent absence of medical aid. Kinship and migration are both fundamental to the lives, livelihoods and social identities of northern Somalis. Here I demonstrate how new configurations of clan and sub-clan groupings, new roles for wealthier extended family members, and new migration patterns have emerged in the wake of recurrent humanitarian emergencies and aid interventions. These findings contribute to a more general critique of how past influential ethnographic studies of Somalis as well as stories about Somalis circulating in the media and between habasha healthcare providers have portrayed the immutability and deterministically violent nature of Somali clanship. I argue that the destructiveness and xenophobic tribalism attributed to the segmentary

lineage systems and clan-based political formations are inappropriate. To the contrary, kinship and clan-based groupings enabled necessary and supportive "therapy management groups." Smaller units within clans – usually either within the *mag*, or blood compensation group, or within groups of siblings or close cousins – were responsible for helping their family members access and pay for hospital care and private clinical visits. In addition, these kinship formations facilitated the emergence of new migration patterns in the northern Somali Region: migrations to gain temporary employment with relief agencies; migrations to access relief commodities; migrations and settlements in communities where free medical commodities are delivered and relief workers visit; and migrations to access distant and expensive private hospital care once aid agencies depart.

Chapter 6 draws on each of the previous chapters to describe an important moment of change for northern Somalis: health and humanitarian interventions were altering the frames within which people devised and revised their expectations of citizenship and healthcare governance. Northern Somalis live in the margins of multiple "state" entities – the ethnic federal system of the Federal Democratic Republic of Ethiopia, the autonomous Somali Regional State within Ethiopia, and the transnational ethnic community of Somalis throughout the Horn of Africa and diaspora. In the absence of many reliable governmental services, transnational kinship networks, *xeer* (Somali customary law), extra-legal economies, and the international nongovernmental aid industry remain vital to life and healthcare there.

As one part of Ethiopia's larger project to decentralize its health care delivery system, in the last ten years medical humanitarian aid from NGOs and UN agencies was channeled through regional and local governmental staffs and institutions. The Somali Regional Health Bureau, for one, was growing in prominence and public awareness. As Somalis in the periphery of the Ethiopian state began demanding more services from these regional governmental facilities, notions of citizenship and belonging vis-à-vis the Somali Regional State were also shifting. Instead of conceiving of themselves narrowly as being from the Issa clan or as ethnic Somalis, northern Somalis increasingly discussed the diverse ways in which they were interpolated into regional politics. Accordingly, what it meant to be a Somali, a Somali Regional State citizen, an Ethiopian citizen, and even a foreign aid "beneficiary" were all being forged within the walls of various clinical facilities and medical humanitarian operations. Medical aid shaped expectations of government as well as biomedicine.

These novel manifestations of "biological" or "therapeutic citizenship"[16] (Nguyen 2005, Petryna 2002, Rabinow 2005) have emerged in the northern Somali Region not because of the relative size and power of the Somali Regional State per se, but rather because of the intimate and profound nature of medical encounters themselves. Personal experiences of illness and hunger were never divulged lightly; caring and trust were always key to evaluations of clinical encounters, and key to subsequent health and healing. Somali mobile team nurses and community health workers understood this fact,

[16] In other words, citizens' ideas about the state's responsibility for their health and healthcare, states' own notions of its responsibility for its population's health and healthcare, and how states determine who should lawfully have access to public health resources and facilities.

and worked hard to forge positive and lasting relationships with their neighbors. The narrow humanitarian mission to minister to the "bare life" of victims during relief operations, in actuality, was neither dispassionate nor removed from sociality and politics. Medical aid provided spaces in which relations of care-giving, trust, and therefore also responsive governance structures could potentially develop. This was, however, a double-edged sword. As cautionary tales and idioms of distrust in Chapter 4 demonstrate, perceived breaches in trust, injustices and malpractice inside government clinics exacerbated racialized antagonisms between Somalis and habasha Ethiopians, and undercut the potential for political as well as bodily health and healing.

In the concluding chapter I return to the major findings of this research in order to provide an ethnographic depiction of "medical humanitarianism" and "medical insecurity" in the aftermath of aid. I argue that repeated and ephemeral medical humanitarian interventions in the northern Somali Region of Ethiopia have in fact caused greater medical insecurity, as defined by a paucity of trustworthy and exemplary forms of medical care. Although medical interventions do undoubtedly save lives, thus far they have done little to make northern Somalis less vulnerable to future humanitarian and health crises. Lack of trust and local anxieties about the quality of local forms of medicine have derailed well-intended efforts to provide healthcare. I show that trust is fundamental to effective medical humanitarian response, not a luxury or an eventual outcome – therefore addressing medical insecurity and redressing historical injustices means first providing rural Somalis with trusted and lasting medical services.

Throughout the dissertation I point to the primacy of social, discursive and otherwise intangible manifestations of medical insecurity in reproducing the conditions under which northern Somalis are chronically and disproportionately vulnerable to calamity and illness – and these cannot be rectified with technical fixes. However, at the end of the concluding chapter I outline several issues of practical importance for the design of global health policy and clinical care during humanitarian emergencies. Additionally, in Appendix B I make a case for revolutionizing health sciences education for Somalis, starting with enhancing the capacity at Jijiga University in the Somali Region of Ethiopia. The modified curriculum I suggest, designed primarily for students from or serving eastern Ethiopia, would be cognizant of Somali popular health cultures, changing local expectations of medical providers and facilities, the need for added recruitment and retention of Somali students–especially Somali women, the need to teach most courses in the Somali language, and the need for additional courses on English language usage in health care professions.

CHAPTER 1.

ETHNOGRAPHIC SETTING

The research presented in this dissertation examines life and healthcare at the margins of the Ethiopian nation-state, in the northern Somali Region. Although interviews and policy analyses were conducted in select institutions of power in the capital city of Addis Ababa and the Somali regional capital of Jijiga, the focus of this study is in the rural northern Somali Region, in communities along roads connecting the city of Dire Dawa in eastern Ethiopia to Djibouti and Somaliland, and in the healthcare and global aid institutions tasked with responding to health and humanitarian crises there.

Setting the Stage

Addis Ababa (አዲስ አበባ), which means "new flower" in Amharic language, was chosen in 1886 by Ethiopian Empress Taytu Betul, the powerful wife of Emperor Menelik II, to be the Empire's new, more centralized capital city. Addis is located in a verdant yet densely populated and tilted basin, ranging from 7,600 feet at its southern tip to over 9,800 at the edge of the Entoto Mountains. Approximately 3.4 million Ethiopians reside in Addis (FDRE Population Census Commission 2008) in addition to a sizable contingent of foreign diplomats, aid workers, and economic development specialists from around the world. Addis is known as the "Capital of Africa." It hosts both the African Union and Economic Commission for Africa, among hundreds of other international

organizations, and consequently boasts the recent construction of a handful of towering new hotels near the city center. On a clear day from atop these new hotels, one can witness the recent expansion of industry and suburban housing into older agricultural fields, muddy ravines, and eucalyptus groves. Between these new, glassy skyscrapers propped up by flimsy eucalyptus scaffolding, ten and fifteen-story Soviet-era cement structures stand empty and crumbling. This contradiction—evinced in Addis architecture—of a nation thriving on burgeoning foreign aid but pockmarked by a long history of failed development projects, is central to the geography, ecology, economy, and history of all of contemporary Ethiopia.

Travelling east from Addis Ababa towards the city of Dire Dawa and the Somali Region of Ethiopia (*Kililka Soomaalida* or *Gobolka Soomaalida*), the terrain gradually flattens and dries out. Past the traffic-clogged cities of Debre Zeyit and Nazret, the population density peters out as well, until the deserted arid landscape is only dotted with small settlements and livestock. After passing the Awash River gorge, the main road begins to climb out of the Rift Valley, slowly at first, reaching the bustling trading town of Asebe Teferi, and then dramatically, twisting and turning through the eastern Oromo highlands. The road peaks again at around 7,500 feet in altitude. There, through fog and thickets of junipers, small crooked plots of farmland cover the hillsides. These plots are stitched onto one another with euphorbia fencing, and interrupted only occasionally by small towns overflowing with livestock, Chinese fabric samples, green plastic sandals, and neat stacks of vegetables. In the view south of the main road, green escarpments rise from steep valleys, carpeted with corn, millet, and coffee fields and round *gojo bet*s, or

typical Oromo houses. Then, four hundred kilometers from its origin in Addis Ababa, the road descends again, divides, and spirals into a green oasis along a dry riverbed – the city of Dire Dawa. (For a map of the region, see Figure 1.)

Figure 1. Map of Ethiopia.

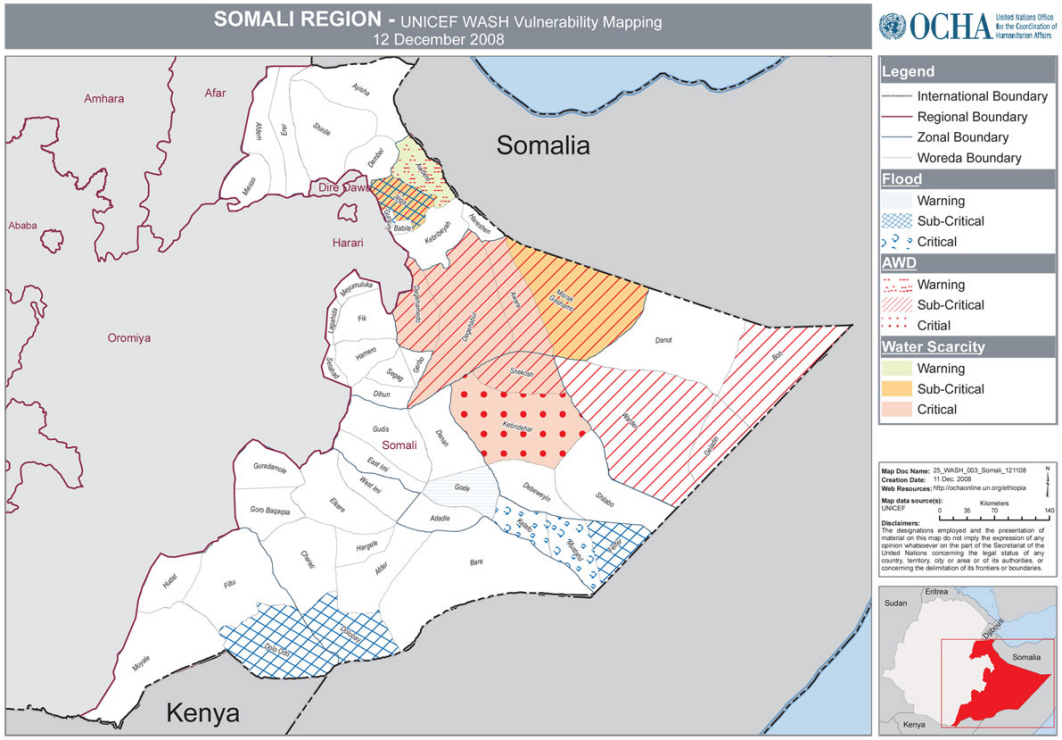
http://www.usask.ca/agriculture/soilsci/ethiopia-map.jpg

Dire Dawa is the second largest city in Ethiopia, and the entire metropolitan region of Dire Dawa hosts almost 400,000 residents. Since its founding in 1902, during construction of the Addis Ababa-to-Djibouti railroad, Dire Dawa has been a melting pot of Horn of Africa cultures and a center of global trade, especially contraband trade. From Dire Dawa, the journey further northeast through the Somali Region to Djibouti and Somaliland becomes more difficult. There is only one major road through the northern portion of the Somali Region. It is unpaved, and simply referred to by locals as, "The Road to Djibouti" (hereafter abbreviated as The Road). The Road is paralleled by a railroad and several remote, winding secondary contraband trucking routes crisscrossing the desert. Residents and government officials will tell you how The Road will surely be paved in the next five years, but any evidence of this is missing. In the year I spent regularly traversing The Road to Djibouti, periodic construction activities to scrape, gravel, and smooth it over only temporarily enabled higher traffic speeds. After a few hundred rumbling cargo trucks passed over the construction sites, the potholes and relentless washboards always returned.

The Road is the main artery through the northernmost administrative region of the Somali Region called the "Shinile Zone," which itself is made up of several smaller districts, or *woredas* (see Figure 2). Ethnographic data in this study was collected from each of the seven woredas in the Shinile Zone, but focuses on life and healthcare in Aysha woreda, the easternmost district, bordering Djibouti and Somaliland. A few small villages – two truck stops plus additional smatterings of huts – are located at points every few miles along The Road from Dire Dawa to the Djibouti border. Although these

villages are increasingly developing independent economies reliant on road traffic and new infrastructure development projects, many only emerged in the last twenty years, as recurrent droughts have driven destitute nomadic pastoralists towards the wage labor opportunities, basic medical care, and food aid only available in larger and more accessible settlements.

Figure 2. The Somali Region of Ethiopia, with boundaries of the different Zones and Woredas (UNICEF 2008).



The Road to Djibouti loosely parallels an ancient camel caravan trade route connecting Zeila (otherwise spelled *Zayla* or *Zaylac* in Somali language), the second largest commercial port city on the coastal Horn from the 7th until the 19th century, to the ancient Abyssinian capital of Axum and the ancient trade city of Harar. The town of

Aysha (*Caa'isha)* was, at that time, the biggest inland town along the caravan route, and was famous for Islamic scholarship and commercial trade. Yet the caravans and cosmopolitan charms of Aysha have since dissipated, first with the plundering of the commercial industrial economies of the Horn by Portuguese traders and looters in the from the 15th to the 18th century, then later with colonial-era wars and the rise of railroad and trucking transit (Burton 1856; Cassanelli 1982; Laitin and Samatar 1987).

On The Road through Aysha woreda toward Djibouti, the landscape dries out even more and slowly descends toward the Gulf of Aden. Ancient volcanoes have left dramatic iron-rich outcroppings and fields of basaltic igneous rock largely barren of greenery or soil. In the few places where indigenous grasses and trees may have once thrived, mostly along dry riverbeds, invasive mesquites and stunted acacia shrubs now dominate, and many of these have been either chewed by livestock or hacked for firewood into stumps and bonsai-like stragglers.

Animals, as well as humans, are concentrated around The Road. Construction to flatten and straighten the route has left occasional depressions in the flat desert floor along the sides of The Road, where rainfall collects for a few days before it evaporates. Led by herdsmen, camels, cattle, and donkeys are in the best positions to take advantage of these artificial oases. Gerenuks, gazelles, giant tortoises, warthogs, hyenas, and wild ostriches, when the coast is clear, also vie for the few natural resources not consumed by roving livestock. UN World Food Program (WFP) donations regularly arrive at the port in Djibouti City, and must be trucked to warehouses throughout Ethiopia prior to distribution. As these trucks, heavily loaded with corn-soy blended flour, whole-wheat

grains, split peas and cans of oil, bounce along the ruts and rocks, grains are thrown from overstuffed sacks onto the road below. Myriad bird species and several herds of baboons gather on The Road to Djibouti during these regular distributions to scavenge and snack on the fallen food aid.

The Road to Djibouti is popular because it is the shortest route across the desert to the highlands of Ethiopia. It is also, however, the most dangerous route. Several factors make The Road dangerous, including the roughness, the dust, and its sheer remoteness. But most of all, The Road to Djibouti is dangerous because of the *khat* (elsewhere spelled *chat* or *qat*) trade.

The highlands of eastern Ethiopia, particularly in the region around the ancient city of Harar, are known for the cultivation, consumption, and export of high-quality *khat* or *jaat* in Somali language (scientific name *Catha edulis*). Khat is an evergreen flowering plant picked for consumption of its mildly narcotic leaves. Although the cultivation, import, and sale of khat is illegal in much of Europe and North America, populations from Yemen, Djibouti, Somalia, and other countries in the Arabian Peninsula have demanded so much khat from eastern Ethiopia, it now provides at least 8% of the country's export earnings – even more than coffee in the eastern half of the country (). Fresh green khat leaves are more valuable commodities than the dried variety typically exported to distant international markets. In order to preserve the freshness of khat leaves for sale in Ethiopia, Djibouti and Somalia, the time between harvest and consumption must be minimal—in the hot desert climate of the Horn, no more than one day. This requires khat to be picked before dawn in the highlands, wrapped in grasses,

packaged in sacks, loaded onto Isuzu-brand flatbed trucks, and driven on The Road to Djibouti as quickly as possible. These Isuzu trucks speed through the sleepy, dusty villages lining The Road to Djibouti beginning around 8:00am until noon; driving at speeds anywhere between 80 to 120km/hour, generating dust storms visible from several miles away. To motivate drivers to the highest possible speeds, trucking companies now offer the driver who gets to Djibouti first a 500birr (US$45) reward—fifty times the daily wage of a manual laborer in Dire Dawa. These trucks never stop on route, and slow down only occasionally to avoid dramatic speed bumps built up by villagers in roadside communities. Additional trucks are deployed from the highlands laden with smaller khat bundles to sell to communities in the Somali Region along The Road; these trucks leave later in the morning and complete frantic routes through the Shinile Zone by late afternoon.

The charred carcass of an eighteen-wheeler, the dismembered axel of a flipped passenger bus, an abandoned Isuzu truck bed, and wrecked military tanks from the 1970s war between Somali and Ethiopia all littered The Road the year I was there, serving as reminders of various past road disasters. By far, Ethiopia has the highest case fatality rate per number of licensed vehicles in the world (Jacobs and Aeron-Thomas 2009). Khat trucks are to blame for some of the carnage, although the wealth they bring to merchants, farmers, drivers, and trucking companies makes reform unlikely. On most days, there is at least one accident involving khat trucks, buses, 18-wheelers, or passenger vehicles on The Road. Several people tangentially associated with my research were involved in vehicle accidents, including my first hired driver, who was killed while

traveling further south, and my research assistant, Farah Mussa, who was nearly killed on The Road, in the back of a khat truck, just after my departure. Even the cocky professional United Nations drivers avoid The Road when khat trucks are out. Inhabitants of roadside communities make themselves scarce during the morning hours to avoid the blankets of dust and threats of accident. But once the trucks have sped through, late into the evening, residents return to The Road, khat stems and boulders in hand, to build up the speed bumps that temporarily slow the Isuzus. The game goes on between villagers attempting to protect their communities and the khat drivers, racing through the desert.

Khat trucks also play another crucial role in communities along The Road. Once the bundles of khat have been delivered to Djibouti and communities along roads in the Somali Region, trucks turn around and drive back to Harar. Each day, dozens of people catch rides on these returning vehicles for 20 to 80birr (US$1.75-$7.00), from remote locations lacking other means of transportation. Up to twenty individuals can fit in an empty khat truck, seated or standing, heavily wrapped with scarves and turbans to protect their faces from dust. Khat trucks are fast and reliably present, despite the risk of peril. Thus, they are absolutely crucial to the movement of various goods, people, and information in the remote northern Somali Region; journeys that would otherwise take days on foot now take only a few hours. Healthcare-seeking in the northern Somali Region frequently involves a ride on the khat truck.

Livelihoods and Basic Demographic Information

The northern Somali Region has a hot arid climate characterized by strong winds, high temperatures, and little humidity. Livestock are central to most Somalis' social organization, daily lives, diet, and livelihoods, making water resources and weather vital concerns. While rainfall is sporadic and unpredictable (some years, reportedly, no rain falls at all in some communities), the average annual rainfall is estimated between 30-40 centimeters per year throughout the Shinile Zone, with significantly less falling in Aysha woreda than other woredas (Federal Democratic Republic of Ethiopia Roads Authority and Intercontinental Consultants and Technocrats, Pvt. Ltd. 2006). There are four seasons in the Somali calendar, and these vary based on specific location and local climate (Laitin and Samatar 1987; Farah et al. 2003). Seasons in Aysha woreda have the following approximate pattern:

Table 1. Description of the seasons in Aysha woreda

Season	Timing & Definition	Migration Patterns
Jiilaal	November–March: the dry season for pastoralists, with much cooler temperatures	Typically, pastoralists in Aysha woreda migrate with camel herds to higher altitudes and wetter pastureland and markets in the coastal city of Zayla and surrounding areas of Puntland and Somaliland once local grasses and surface water sources dry.
Gu'	April – June: the longest and most important rainy season	In much of the Horn of Africa, this is known as a season of plenty, a season for calving, and season for marriages. If rains are adequate in Aysha woreda, this is a season for pastoral migrations back home, closer to where the nuclear family and smaller livestock herds live.
Hagaa	June – late August: a shorter but much hotter dry season	Typically, pastoralists move their camel herds out of Aysha woreda as grazing land dries. Many small villages feel empty at this time, as herds are kept in areas around Zayla and northern Somaliland.
*Karaan (*or *dayr*)	September – October: the shorter rainy season	If the rains come, migrations occur back toward Aysha woreda, first to plain areas with seasonal pasture, then often to grassier areas within the Shinile Zone, then later further east to northern Somaliland once pasture is depleted.

Somalis in Aysha woreda are predominantly subsistence pastoralist livestock herders and agro-pastoralists who have begun small-scale cultivation of some crops to complement livestock holdings (Save the Children 2002; Sadler and Catley 2009; Farah et al. 2003). Somalis' livestock may be grouped into two categories: camels and other smaller herds, such as goats, sheep, and cattle. Somali camels (*geel*) are one-humped; their dromedaries allow camels to go without drinking for up to three weeks. Sheep (*ido*), goats (*riyo*), and cattle *(lo')*, on the other hand, require daily water plus either grazing or supplementary feeding for survival. These livestock remain with nuclear families or family groups throughout the year to provide milk and occasional meat for the household. Women, girls, men with local employment or community leadership roles,

elder men, and boys still too young to travel with herds of camels remain with these nuclear family groups, often clustered together as a village or in small towns, while other adult males migrate with camel herds for pasture.

In plentiful *gu'*, *karaan*, and some *hagaa* seasons, camels may graze within one half a day's walk of community settlements in the Aysha woreda. At the end of the gu' though, some time during the hagaa or karaan seasons, as grasses and watering holes dry, men will travel with camel herds for pasture and livestock markets to areas northeast, east, and southeast of Aysha, often over one hundred miles, and often crossing international boundaries into Djibouti and Somaliland or, more rarely, travelling into mountainous areas of Ethiopia. Families left at a homestead, often in a small village or town, wait anxiously for the beginning of the gu' rains, when larger livestock herds and other family members return, and when camel milk is plentiful.[17]

During this study, from the end of the hagaa in 2008 until the hagaa of 2009, the gu' rains were particularly disappointing. As early as September 2008, the UN Office for the Coordination of Humanitarian Affairs warned of impending severe food and water crises in the northern Somali Region (IRIN 2009, 2008). People I spoke with reported significant delays in 2008 gu' and karaan rains and then later the 2009 gu' rains, and therefore delays in the return of larger livestock herds. Despite the presence of significantly higher numbers of camel and cattle herders in grassy stretches of land in Aysha and Dembel woredas from July 2009 until late August 2009, several pastoralists

[17] The local availability of fresh camel milk is of utmost importance for Somali families in Aysha woreda, far beyond its nutritional value. The myriad uses of camel milk and its importance in relation to Somalis' concepts of bodily constitution and health will be discussed in Chapter 3.

who had left in the 2008 hagaa had not returned home by the end of my research stint in August 2009 due to ongoing drought conditions in their home communities. Although rainfall surveys and population movement statistics are beyond the scope of this study, the failure of the gu' rains and inadequacy of rainfall totals in 2008 and 2009 had deleterious effects on the livelihoods, health, and general mood of families in Aysha woreda. Secondarily, regional drought conditions lowered market prices for livestock throughout the Horn of Africa, adding to the deleterious effects of the falling exchange rate for the Ethiopian birr currency, which made food, livestock, fuel, and other commodities, especially imported goods, significantly more expensive in 2009. According to the UN WFP and UN OCHA, in May 2009, price inflation was at its highest during the period from 2007 until 2009; at that time, average inflation was at 41.6%. By mid-October 2009, seasonal rains had finally begun in most of Aysha woreda, rates of Acute Watery Diarrhea in the Somali Region had begun to decline, and the prices for major food stapes had decreased significantly (UN OCHA 2008c, 2009).

Land in the northern Somali Region is mostly reserved for the grazing of livestock, but several internally displaced and refugee populations who have settled in Aysha woreda in the last few years have begun small-scale cultivation of crops (tomatoes, garlic, watermelons, mangoes, etc.) utilizing the scant --and some say disappearing-- surface water resources, in addition to tending small livestock herds. Farming, however, is not well-adapted to the local conditions. Pastoral land tenure and grazing patterns, in contrast, have evolved to fit just such marginal and fickle

environmental conditions; for most northern Somali groups, including the Issa[18] Somali clan (*Reerka Ciise)*, land belongs to all individuals collectively, regardless of clan or ethnicity. Grazing land is distributed and tended by individuals with help from clan and sub-clan relatives. During times of drought or population displacement, clan-based residential and grazing boundaries become even more flexible than usual, allowing for the grazing of livestock and taking of water by other groups in need, regardless of clan or ethnicity (Federal Democratic Republic of Ethiopia Roads Authority and Intercontinental Consultants and Technocrats, Pvt. Ltd. 2006). Such a flexible system does, however, at times, conflict with informal laws governing land tenure between the Issa and Afar pastoralists (another ethnic group abutting Issa land in the Somali Region and Djibouti) and other neighboring ethnic groups in Ethiopia (Farah et al. 2003). In one of my interviews, for example, a man described the situation in the following way:

> There is seasonal grazing from flat lands (in the rainy seasons) and mountains (in the dry season) by the Afar. They have the Awash river which runs through the whole region, giving them more grazing opportunities than many Issa have. There are also occasionally reserved areas, protected and demarcated by stones. There are regional laws set out to protect these reserved areas from grazing. They punish grazers for violating with one livestock. Issas are different; they welcome anyone to graze anywhere, and take water from anywhere they like, any time. It's hard to apply the Afar laws to Issa people – they just don't get it and don't want to follow it. … Even the Ugas and regional authorities support land sharing rather than land restriction, and this all has to change if the population will ever change. There is conflict between the Issa and Afar now because of this difference in grazing rights. The government has to intervene. Haile Selassie and the Derg

[18] Issa is the English spelling of the clan name, and is pronounced, "ee'-sah." In older archives, policy documents, and travel writings, the Issa clan is also variably spelled "Eesa" and "Esa." Issa is the name given to the prophet Jesus in the Holy Quran (Jesus Christ in the Christian Bible); the namesake of the Issa clan is not the prophet through, rather a Somali forefather named for the prophet Jesus. The Issa clan is one part of the larger clan family (*qabil*), named Dir. The Dir clan family is one of four original Somali clan groups, or as Lewis (1961) calls them, "noble clans" that trace their lineage back to the Prophet Mohammad. The other three noble clan families are called Darood, Hawiye and Isaaq.

> agreed with the Issa that all land should be freely grazed; now the government has changed though, and is beginning to support the Afar's position.

Surface water is typically extracted from hand dug wells, boreholes, piped water sources, or seasonal pools. A few nongovernmental organizations (NGOs), and in one case the US military, have constructed boreholes and wells, connected water pipes, and provided pumps for communities in Aysha woreda, although these projects are prone to failure, misuse, bad design, and disrepair. During my research, several communities had no viable surface or pumped water sources at all, and instead relied on Oxfam International to provide water every other day, by means of a water tanker driven from Aysha town, the woreda capital. Throughout the Aysha district, water is a precious resource, and the maintaining of sources and fetching of water for family and livestock comprises significant energy and time. Women and children are usually responsible for the collection and distribution of water; they haul awkward 20-liter jerry cans in rickety, rusty wheelbarrows to their homes, gardens, or livestock herds from the nearest source. Agriculturalists and herders outside community settlements, both male and female, are also active in the construction of hand dug wells and collection of surface water for their crops and livestock.

Besides the sale of livestock, livestock products, and a few crops, other important sources of cash income in Aysha woreda include petty trade, work as a professional driver (for khat trucking companies, local NGOs, the Government of Ethiopia, or contraband trucking companies), temporary wage labor during local infrastructure development projects, temporary work during humanitarian aid distributions, temporary work during various population surveys (largely funded by international

nongovernmental organizations), international migrant wage labor to Somaliland and Yemen, and wage labor in Dire Dawa and other urban areas of Ethiopia. As pastoralism is increasingly constrained in the Horn of Africa by drought, international trade policies, and regional political conflicts (Little, Smith, and Cellarius 2001; Lautze et al. 2003), petty trade and migrant wage labor opportunities have become increasingly crucial to the cash income of Somalis in Aysha woreda, even as most families still rely on regular food aid donations, locally tended livestock herds, and locally cultivated crops for day-to-day survival. Cash from employment and trade is typically distributed widely within sub-clan groups, supporting multiple nuclear family units, and often provides relatively more cash to sub-clan relatives in greatest need.

The northern Somali Region of Ethiopia, in particular Aysha woreda along The Road between Dire Dawa and the Djibouti and Somaliland borders, is populated primarily by Somalis either born or married into the Issa clan.[19] The Issa clan is one part of the larger clan tree called "Dir," which also includes the Gadabuursi clan in the northern Somali Region and others further south (World Bank 2005, Federal Democratic Republic of Ethiopia Roads Authority, and Intercontinental Consultants and Technocrats, Pvt. Ltd. 2006). Issas reside mainly in and around Dire Dawa, in the northeastern Shinile Zone of Ethiopia, as well as in Djibouti and northern Somaliland. Issas also dominate local political bureaus in Aysha woreda, although they remain a minority clan within the context of the whole Somali Region of Ethiopia and Greater Somalia.[20] Oftentimes,

[19] Although I use the term "clan" here to describe the lineage group, I will interrogate the variable uses of the word in Chapter 5.

[20] The term "Greater Somalia" (*Soomaaliweyn*) denotes the area of the Horn of Africa dominated by ethnic Somalis, extending from Djibouti, throughout the Somali Region of Ethiopia, the northeastern corner of

when Somalis first meet, they ask about each other's clan affiliation and ancestral line. Clan and sub-clan affiliations are means by which people sometimes unite behind political movements (as, for instance many Ogaden Somalis rally behind the Ogaden National Liberation Front contra the Ethiopian government). But while residing in Issa-dominated Aysha woreda, alternative distinctions between individuals residing there were paramount. Differences between families and individuals were often spoken of as being between those who had lived in cities and abroad, and those who were still "rural" or nomadic pastoralist (*qof baaddiye*). Being rural or pastoralist was not entirely or solely associated with lower wealth – indeed many pastoralists owned thousands of dollars in camels and cattle – but instead also indexed relatively different levels of formal education, ability to speak the English language, experience with expatriates, experience with transnational commercial business and monetary exchange, knowledge of and reliance on biomedicine versus "traditional medicine,"[21] and in general, worldliness. As such, nomadic/cosmopolitan distinctions in the northern Somali Region, more than income-based class or clan and sub-clan divisions, traced the contours of persons' differential abilities and desires to access biomedical forms of healthcare.[22] And even though cash was usually necessary for payments to all sorts of healers and healthcare

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Kenya, Somalia, and in the irredentist (although not officially recognized, independent) states of Somaliland and Puntland.

[21] See Chapter 3 for a discussion of "traditional" versus biomedical forms of medical knowledge and medical practices.

[22] Here I do not mean to reify notions of "tribe" as "tradition incarnate" and the opposite of "town" as Southall (1970) describes, but rather relay the linguistic markers of difference uttered by various northern Somalis during my research. Of course, these linguistically and socially constructed divisions are fluid, and metaphoric, and highly consequential during healthcare encounters.

providers, Somalis all generally spoke of reliance on family and migration as keys to paying for, accessing and understanding various the forms of available medicine.

According to the last census, approximately 4.4 million people live in the Somali Regional State (SRS), and constitute 6% of the 74 million total population of Ethiopia (Federal Democratic Republic of Ethiopia Population Census Commission 2008). Most residents of the Somali Region self-identify as ethnic Somalis, and 98.4% of persons in the SRS are Sunni Muslim. The Shinile Zone has a population of 456,434 persons, and according to census data, 58,096 persons reside in Aysha woreda, 86% of these in a "rural" location. The average household size in the Somali Regional State is 6.6 individuals (6.7 individuals for households residing in rural areas), compared to 4.1 individuals per household in Addis Ababa (Federal Democratic Republic of Ethiopia Population Census Commission 2008).[23]

These census data are not completely reliable, however. Mobile pastoralist populations, like those living in the Somali Region, present great logistical challenges to agencies wishing to measure human populations. Thumbing through documents I had collected from the Somali Regional Health Bureau, a regional World Health Organization representative laughed aloud at the most recent census statistics for the Shinile Zone, and joked that the population figures were so exaggerated they must have also been counting goats. Several other laypersons I spoke with in the Somali Region asserted that reports of higher population numbers generated greater amounts of development and humanitarian assistance, and admitted hearing of several such incentives to overestimate population

[23] Rates of marriage, divorce, and polygyny—although both divorce and polygyny are very common in the Somali Region–are not collected during census counts, and therefore I found no data on these phenomena.

statistics and underestimate livestock holdings and rainfall amounts.[24] "No, it isn't raining here—this is not true rain!" a small group of men laughed and chided me as the rain poured down in one small village, "You can't let anyone know it's raining or they'll never say it's a drought!" Despite such fuzzy numbers and strategic statistical accounting at times, there is no doubt that Aysha woreda, like much of the Somali Region, has a very low density human population and considerable fluctuations in both human and livestock population sizes depending on rainfall, pasture, and wage labor opportunities.

Literacy rates are also difficult to accurately measure. Students wishing to complete high school or higher education typically move to Dire Dawa or Jijiga (the capital of the Somali Regional State, south of Aysha woreda) where they can stay with family members. Like elsewhere in the world, this creates a flight of literate individuals from rural to urban areas where more educational and employment opportunities exist. A country-wide representative survey in 2006 that sampled households in the Somali Region for educational attainment, literacy, and other demographic indicators, found that less than 2% of women and less than 3% of men there are literate, and approximately 88% of residents of the Somali Region have never attended any educational facilities at all, although this does not include attendance of Quranic schools (Central Statistical Agency, Ethiopia and ORC Macro 2006). Rates of literacy and school attendance are certainly even less in the Aysha woreda than elsewhere in the Somali Region, since fewer educational opportunities exist there than in more urban areas of the SRS. Literacy rates

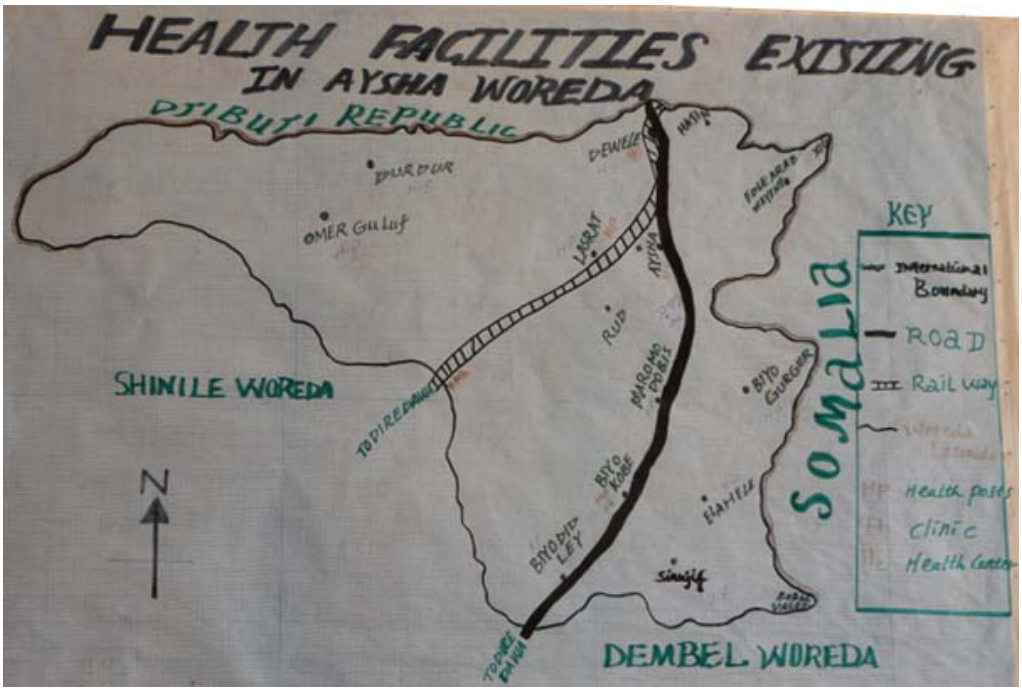
[24] Lewis (1961:102-103) discusses what he calls, "the size factor" in northern Somali societies by saying that, "numerical strength is still the primary factor in the evaluation of political status." Extrapolation of Lewis's findings to the propensity of northern Issa Somalis to exaggerate the number of individuals and livestock to government census takers would be speculative at best. Still, numerical size may have multiple meanings, and this may still be one.

may also be changing. In 2006, Jijiga University was founded, and is now the first and only four-year university in the Somali Region, enrolling thousands of Somali students (many more than were previously willing to travel outside the Somali Region for university education). Additionally, strides have been made to improve local schools in rural parts of Aysha woreda, including the recent inauguration of what are termed, "pastoralist schools" where the children of nomadic pastoralist households have separate class times in the afternoon hours, allowing them to walk into village centers from distant locations where their families are camped.

Community Field Sites

As will be discussed in greater detail in Chapter 2, three communities in Aysha woreda were selected for extended fieldwork: Aysha town, Degago, and Elahelay. These communities, shown on the map in Figure 3, exhibited comparable demographics but contrasting health systems and experiences with medical aid.

Figure 3. Poster of Health Facilities in Aysha Woreda, Drawn by Health Extension Workers in Elahelay Community. [Note the different spellings of Elahelay (Elahele), Degago (in light color near Maromadobis), and Aysha (Ayisha).]



Aysha town

Aysha is the county seat of Aysha woreda, and has a population ranging from 2000 to 3000 persons depending on the season and the activity of local development projects. Driving into Aysha town from Dire Dawa on The Road to Djibouti, the first thing one notices is that the graveyard is larger than the town. Volcanic rocks are arranged into neat circular piles as grave markers, and these piles often sprout invasive mesquite shrubs that catch blowing bits of plastic bags and torn fabric. For the first several nights my husband and I stayed in Aysha we both had vivid nightmares and slept little. That effect moderated over several months of returning for extended stays, but

even at the end of the research stint, we never slept soundly there. Part of the reason, we postulated, was the palpable history of the place: it is the site of repeated ethnic violence against Somalis.

In 1960, during the reign of the Ethiopian Emperor Haile Selassie, soldiers and police forces killed between several hundred and three thousand Somalis,[25] displaced thousands more, looted and burned businesses and livestock herds, and generally terrorized the remaining population. Some of the victims were buried in mass graves; others were buried in the expansive graveyard on the edge of town. Volcanic rocks and bricks from burned and destroyed buildings were reused to rebuild in the wake of the violence. Somali residents call this "*xasuuqa*" (literally translated from the Somali as "the genocide"). After a coup d'etat in 1974 deposed Haile Selassie's regime, a communist military junta called "the Derg," led by Mengistu Haile Mariam, established military outposts in Aysha and other towns in the Somali Region to hold off incursions by Siad Barre's forces. Residents of Aysha recall that throughout the Derg's rule, especially during the outright war between Somalia and Ethiopia in 1977-1978, there were repeated instances of violence, rape, and intimidation of Somalis. A religious leader in Aysha named Mahmood told me, "at that time, there were soldiers everywhere. …and the soldiers always had many questions for Somalis." The government soldiers during the Derg were all of Amhara ethnicity, and had difficulty telling other ethnic groups apart from each other; he added, "they were so suspicious of others [those who were not

[25] No one I spoke with could provide an exact figure of the number of persons killed, and I could find no historical or archival data. Local lay historians recounted how Aysha town used to be much larger than today, maybe hosting 5000 to 7000 residents; after the 1960 massacre, and after many remaining Somalis had fled to Djibouti, only 1000 to 2000 residents remained.

Amhara]." A few men who were soldiers during the Derg still lived in Aysha in 2009, and although the community is largely "at peace," Mahmood said, "we feel bad against them still … when we remember all the persons who have died."

During local reconstruction efforts in the 1980s, a public school was built next to the two mass graves, and a mural on a whitewashed wall next door depicted live bodies being thrown into the graves by Ethiopian soldiers. The school was still open in 2008 and 2009, and the mass graves remain neither marked nor hidden. All of the teachers at the school were non-Somali "*habasha*"[26] Ethiopians, and several lived in small apartments a few feet away from the mass gravesites. Two of these teachers gave my husband and me a tour of the grounds one warm winter evening. They showed us the two mass graves; one of the holes were not completely filled, but instead loosely covered by dried acacia branches to keep children and livestock from falling inside. We asked the teachers if ghosts or spirits of the dead still resided in Aysha, to which our friend, Berhanu, closed his eyes, laughed good-naturedly, reassuring us, "Nah. No! There is nothing here now. Do you see anything?" Indeed, since the end of the socialist dictatorship in Ethiopia in 1991, the northern Somali Region has been relatively peaceful. Nevertheless Aysha town remains largely abandoned and ethnically segregated.

Still sleep deprived, we broached the subject of nightmares and sleeplessness in Aysha with Farah Mussa. He nodded, unsurprised, and said that he and his friends have experienced the same phenomena. When they have to sleep in Aysha for an extended

[26] "Habasha" (otherwise spelled "habesha" or ሐበሻ in Amharic) is an ancient term that previously referred to persons who were part of the Axumite then Abyssinian Empires, but is today colloquially defined as persons of Amhara or Tigrynia ethnicities (sometimes also Gurage) residing in Ethiopia or Eritrea, or persons who speak either Amharic or Tigrynia languages as a first language.

period for work with NGOs or during a trip to visit family members, they travel to other villages for a night or two during the period to catch up on sleep. Visibly shuddering, Farah concluded it was the history of atrocity and continuing tensions in Aysha town that kept us all from properly sleeping.

Like the other community field sites, most of the residents of Aysha town are of Somali ethnicity and from the Issa clan, but a few individuals of Amhara, Tigrynia, or Oromi ethnicities reside in Aysha for work in government bureaus, NGOs, local restaurants and hotels, or an electricity substation construction project. Aysha has one medical center, staffed by several recently trained nurses and community health workers who do not speak any Somali. The medical center was built three years prior to my research, but already showed many signs of disrepair and disregard. Few Somalis in Aysha town visited the medical center as a first resort when they were sick; instead, most would seek care or advice from their peers, the Mobile Health & Nutrition Team nurses (discussed subsequently in this chapter), trusted traditional medical practitioners, Qur'anic healers, herbalists, or shopkeepers selling medications.

Degago

Degago is located 12 miles southwest of Aysha town, one mile off The Road to Djibouti. It had been a small village for several generations, but was the settlement site for between 15,000 and 30,000[27] refugees and internally displaced persons from Somalia,

[27] No one knows for sure the exact number, and it changed dramatically over time.

Somaliland, and the surrounding Somali Region of Ethiopia from the time of the civil war in Somalia in 1989 through 2005. By the year of my research most of these displaced persons had been repatriated or resettled, and between 1000 and 2000 people lived there depending on the season (Federal Democratic Republic of Ethiopia Roads Authority and Intercontinental Consultants and Technocrats, Pvt. Ltd. 2006). During the refugee camp period there was a medical facility funded first by the humanitarian aid organization Médecins Sans Frontières then by UNHCR while administered by the governmental refugee agency (ARRA). This facility provided free medicine and medical care to local residents, refugee and not, but with the exit of most refugees in 2005, the clinic closed, leaving the remaining population without any local clinical care or easy access to regulated pharmaceuticals.

In 2008 a small government health post was founded in the medical facility built during the refugee period. The health post was staffed by young Somali community health workers (in Ethiopia officially called "health extension workers") who had been provided training and certification in public health education and diagnostic screening for pregnancy complications, malnutrition, malaria and respiratory illnesses (Federal Ministry of Health in Ethiopia 2005, 2008). The roles and challenges of "health extension workers" are discussed later in this chapter. In July 2009, three Amharic-speaking, non-Somali nurses were transferred from the medical center in Aysha to Degago to enhance the capacity of the facility. However, one month later, these staff had grown weary of an isolated life in Degago, far away from their friends and family, and without other Amharic-speaking colleagues. As of September 2009, all the non-Somali

staff had left Degago, and no Somali or Somali-speaking nurses had been hired to replace them.

Despite competition from the government health post in Degago, one unlicensed private pharmacy provided the majority of consumed pharmaceuticals in the town. Ali, its co-owner and manager, was informally trained as a medical assistant by expatriate relief workers in the refugee camp clinic, and he acquired many of the materials – scales, thermometers, blood pressure gauges and the like – left behind when relief agencies departed. His pharmacy provided unregulated and contraband prescription pharmaceuticals as well as over-the-counter medications from suppliers in Somaliland and Dire Dawa, and although some doubted the quality of contraband medications, many residents of Degago felt this business was crucial to filling local gaps in pharmaceutical supplies and health care. Under pressure to close his business from the woreda health bureau, during in the summer of 2009 Ali reduced the quantity and variety of materials and services he provided in Degago. In July 2009 he opened another private pharmacy in Hargeisa, Somaliland, and by August spent most of his time running the pharmacy there.

Elahelay

Elahelay was the most remote community field site I chose for extended stays. It is located approximately 20 kilometers from The Road to Djibouti, 50 kilometers from Aysha, and in the other direction, 18 kilometers from the Somaliland border. The population there is also majority Issa Somali and ranges from 400 to 1000 residents

depending on the season. A government-run, UNICEF-funded emergency project provided a "Mobile Health & Nutrition Team" consisting of two nurses and one health extension worker to give basic pharmaceutical medications, primary medical care, supplemental food aid, therapeutic food aid, and referrals to children and pregnant and lactating women once per week (mobile teams will be discussed later in this chapter as well as in Chapter 2 and 3). This intervention lasted from October 2008 through March 2009. Additionally, in December 2008, two newly trained health extension workers moved to Elahelay to staff an intermittently stocked health post and provide public health education to resident women. Local shops there provided a few antibiotic and analgesic medications, but many people traveled to unlicensed pharmacies in Somaliland to purchase medications that were not available locally. More medications were available in these small, unlicensed shops prior to the arrival of the mobile team and community health workers.

To summarize, Aysha had a larger health facility than the other communities, but one lacking trust between the residential Somalis and the non-Somali medical staff. Impoverished, geographically isolated, and disenfranchised by repeatedly failed development and healthcare initiatives, Aysha struggled to meet the health needs of the local population. The health system in Degago served as a case study in the lasting effects of temporary medical humanitarian interventions, namely, the refugee clinic that closed three years prior to this research. Elahelay was selected in order to conduct ethnographic research before, during, and after the mobile team intervened in the local health system. Research in Elahelay revealed changes over time in one community

experiencing a temporary medical intervention, and provides a comparison between the mobile team's healthcare practices and the healthcare practices in the Aysha Medical Center.

Histories of Somalis in the Horn of Africa

Various histories of Somalis living in the Horn of Africa expose the saliency of contemporary antagonisms and misgivings between Somalis and the Ethiopian political elite – as such, these histories are key to arguments made throughout in this dissertation. Few ethnographers or historians have conducted extensive research with northern pastoralist Somalis in the Horn of Africa. Consequently, the data I present below is triangulated – gathered from the scant scholarly literature, from data collected by local Somalis and published in grey literature, from colonial travel writing, and from oral histories I collected of elders and leaders in the northern Somali Region of Ethiopia.

Much academic and public debate has fixated on the origins of Somali groups and migrations of Somalis into and around the Horn of Africa, because origin stories shape contemporary racial affiliations and stereotypes (discussed in Chapters 4 and 5). Scholars writing about Somali groups during the colonial period, or before 1960, typically described Somalis as deriving from Arab populations who, beginning at least ten centuries ago, migrated from the Arabian Peninsula into the Horn of Africa and spread south and westward, assimilating and overwhelming with indigenous African populations. Somalis were then assumed to be closer to Arab populations than to Sub-

Saharan African populations, in terms of their physical as well as cultural features (Laitin and Samatar 1987). Such analyses were overtly racialized; they drew distinctions between Somalis as Arab descendants in contrast to Somali "Bantu"[28] groups. More recent historical analyses, by contrast, describe the development of Somali groups through numerous interactions between multiple ethnic groups within the Horn of Africa and the Middle East. Thus most scholars now agree that linguistically linked eastern Cushitic peoples,[29] including most Somali groups,[30] originated in the highlands of southern Ethiopia and northern Kenya, and migrated from there to fill much of what are today eastern Ethiopia, Djibouti, Somalia, Somaliland, and northeastern Kenya (Laitin and Samatar 1987; Abdi 1995).[31]

Between the 11th and 13th century A.D., several legendary Islamic patriarchs and clerics from the Arabian Peninsula began aggressively proselytizing Somali populations

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28 Somali Bantus are minority ethnic groups residing in southern Somalia and the diaspora. They have long been farmers and have mostly resided in southern Somalia, near the Juba and Shabelle rivers. Bantus are descendants of various groups originating from what are today Tanzania, Malawi and Mozambique. Most arrived as a consequence of the Arab slave trade in the 18th and 19th centuries, and have since been marginalized in colonial and Somali politics (Besteman 1999).

29 The eastern Cushitic groups are elsewhere in the literature called "Cushites," "Hamites," "Berberi" (by Arab groups in the pre-colonial period, mostly), or the "Omo-Tana group" which designates a cultural zone around the Omo and Tana rivers in Kenya and Ethiopia, from Lake Turkana all the way to the Gulf of Aden.

30 There are a few groups of what called "Somali Bantu" who still speak a language deriving from other groups and are considered themselves ethnically distinct from other Somalis (Besteman 1999).

31 Archaeological and historical evidence suggest that at least two thousand years ago, scattered indigenous groups began migrating in greater numbers from the plains of northern Kenya and the highlands of southwestern Ethiopia to land around major river systems in the Horn, finally arriving on the coast by approximately 100 A.D. (Abdalla Omar1995). Some of these groups, predominantly camel herders, splintered off from the others and migrated further northeast, to higher elevations and greener seasonal riverbeds for pastoral grazing. These original camel herding groups are collectively termed "Samaale," a name some Somalis attribute to a mythical or symbolic clan father (Abdalla Omar 1995).[31] By 1000 A.D. several groups of Samaale pastoralists occupied what is now the Somali Region of Ethiopia and the eastern coastline of present-day Somaliland and Djibouti. Other indigenous groups living in the Horn were likely integrated or absorbed by these pioneering herders (Laitin and Samatar 1987). Subsequently, a string of larger settlements along the coast developed during the first millennium, connecting Arab and Persian traders and immigrants to these African Samaale groups.

residing in settlements along the coast of the eastern Africa. These early Islamists were given orders to tax the local populations, teach the Qur'an, and "safeguard the security of the country and assure its loyalty to the Islamic state in Damascus" (Mohamed 1995:3). Islamic leaders fortified and centralized a series of coastal settlements, including the coastal cities of Zeila (in Somali *Zaylac*) and Mogadishu, creating pockets of hybrid cultures, prosperous global commercial trade, and Islamic scholarship. For centuries, the coastal Horn of Africa has been a junction of diverse peoples, goods, and ideas. By contrast, the written and academic histories of the processes of Islamicization and Arabization in the interior Horn of Africa, including histories of pastoralist Somali groups, remain incomplete and contradictory, and have been frequent fodder for nationalist and romantic interpretations of a united Somali identity (Mohamed 1995, Abdi 1995).

Elderly public school teachers, present and former community and clan leaders (*oday*), elected *kebele* (or neighborhood) chairmen, and religious leaders (*wadaddo*) I spoke with in the town of Aysha[32] in the northern Somali Region recounted the history of the trade routes from Zeila to Harar and further west into the heart of the Abyssinian Empire during several conversations and interviews. Similar to what Laitin and Samatar (1987) describe,[33] they maintain that from approximately the 13th until the late 18th century, camel caravans originating in locations as far away as contemporary Uganda

[32] Detailed descriptions and maps of Aysha town and Aysha woreda are provided in Chapter 1.
[33] The importance and wealth of the town of Zeila is not, however, undisputed; Mohamed (1995) downplays the role of Zeila in east African trade, and further, cites uncertainty as to the leadership of Zeila, admitted that records from Arab geographers during the Middle Ages could not reliably map the coastal Horn, and other records indicate Zeila might have, for a time, even been under the control of the Abyssinian empire. The versions of history I present here was recounted by elders in Aysha woreda.

carried ivory, ostrich plumes, civet furs, livestock hides, frankincense, myrrh, coffee, gold, and slaves to port in Zeila for export throughout the Ottoman Empire, Arab Peninsula, Persia, South Asia, and China. In the other direction, fabrics, rice, dates, dishes, and weapons were brought into the African interior through the northern Somali port cities.

Oral histories also narrated the emergence of the Abyssinian Empire (most of which would later become Ethiopia) in opposition to burgeoning Islamic societies in the Horn. One of the most popular histories Somalis tell is this: Muslim followers of the Prophet Mohammad in the 7th century A.D. began organizing and worshiping in Mecca only to find persecution with the dominant non-Muslim Quraysh tribe there. A small group of these early Muslims fled Mecca and sought refuge and protection from the Christian Abyssinian Empire based in Axum. In thanks for the Abyssinians' early openness and generosity, for several years Islamic leaders along the east coast of Africa did not provoke or engage in conflict with the Abyssinian Empire. However, by the 15th century, the Abyssinian Empire under the rule of the Emperor Yeshaq, confronted the Ifat Muslim sultanate in Zeila, declaring Muslims enemies of Christians. After this defeat, Islamic authority and commerce in Horn moved its center further south to Mogadishu and Zanzibar, and west to the ancient Somali city of Dakkar, near present-day Jijiga. Subsequently, the famous Imam Ahmed Gurey (translated as "Ahmed The Left-Handed") invaded the Abyssinian Kingdom, successfully avenging the earlier defeat and beating the Abyssinians back toward the highlands. Following this victory, Zeila and the caravan route through the desert to Harar thrived, until Portuguese pirates, looters, and thieves

began violent and destructive incursions into coastal kingdoms from the 16th through the 18th centuries (Laitin and Samatar 1987; Davidson 1972). By the time the explorer Sir Richard Burton arrived in Zeila the late 19th century, recurrent battles with Portuguese pirates and occupations and conflicts with Ottoman rulers had decimated Zeila and the whole of Indian Ocean trade (Burton 1856, Davidson 1972). Contemporary tensions between habasha Ethiopians and ethnic Somalis are often expressed and joked about as originating in these early encounters between Christian Abyssinian and Muslim Somali coastal leaders. This attack of the wealthy Somali Ifat Empire by leaders of the Abyssinian Empire is remembered by many Somalis as a historical precedent, or moment, from which the contemporary suppression of irredentist Somali groups by the Government of Ethiopia, as well as the general neglect of the Somali Region by Ethiopian institutions in Addis Ababa, are understood and resisted.

In the 18th through 20th centuries, Somali people were partitioned among five colonial empires: France claimed what is now Djibouti, the British Empire claimed what is now Somaliland and the Northern Frontier District of Kenya, Italy took most of what is today Somalia, and according to most Somalis, the Ethiopian Empire controlled what is now the Somali Region of Ethiopia, including the prized pastureland called the *haud.* Each of these colonial projects imposed borders through Somali homelands, cutting communities off from their pasture, surface water sources, markets, extended families, and places of worship and pilgrimage (Lewis 1965; Cassanelli 1982; Laitin and Samatar 1987; Markakis 1998; Lulling 1978). The Ethiopian Empire reached its approximate contemporary political boundaries in the 19th century (Pankhurst 1998).

In the area that is today the Somali Region of Ethiopia, eastward territorial expansions by the Ethiopian Empire in the 19th and 20th centuries led to massive dispossession and resettlement of nomadic Somali pastoralists under the leadership of Emperor Haile Selassie. In the 1940s, the Ethiopian Empire commenced serious assimilationist policies in Somali-dominated eastern Ethiopia. These policies included the introduction and legal enforcement of the Ethiopian federal secular school system, the Amharic language, and an Ethiopian national identity, even in peripheral regions of the country. These nationalist Ethiopian projects were based primarily on habasha linguistic and cultural symbols including Ethiopian Orthodox Christianity, a legacy of an independent succession of Ethiopian leaders, and ox-plough agriculture (de Waal 1991). De Waal (1991:19) says further, "One of the main reasons for the last thirty years of warfare has been the unwillingness of marginalized people in Ethiopia to accept the northern-highland definition of national identity." In 1956, on an official state visit to the eastern edge of his country, the former Ethiopian Emperor Haile Selassie said to the Ogaden Somalis gathered nearby,

> "We remind you finally that all of you are by race, color, blood, and custom, members of the great Ethiopian family. And as to the rumors of a 'Greater Somalia,' we consider that all Somali peoples are economically linked with Ethiopia, and therefore, we do not believe that such a state can be viable standing alone." *(The Ethiopian Observer,* December 1956)

Efforts at assimilation and forcible incorporation of Somali groups were met with fierce resistance and resentment by many Somalis.[34] Mengistreab (1997:120) compares these actions to other African states in the post-colonial period of the twentieth century: "Ethiopia's state-building strategy following its expansion was characterized by highly centralist unitarianism accompanied by unbridled arrogance of the ruling elite." Such widespread resentments – among Somalis as well as other ethnic groups in Ethiopia – were reinforced as various leaders in the Horn of Africa vied for control over Somali territories, national resources and economies, and foreign aid.

Post-colonial Histories of Northern Somalis

After colonial independence from Great Britain and Italy in 1960, Somalia's socialist military leader, Maxamed Siyaad Barre (in English spelled and abbreviated Siad Barre[35]) attempted to unify all the dispersed Somali populations in the Horn of Africa, including Somalis living within the boundaries of the Ethiopian Empire. He called for the consolidation of a new ethnic national state centered in Mogadishu called "Greater Somalia" or *Soomaaliweyn*. Consequently, throughout the 1970s, Siad Barre's government financially and militarily supported local cessation movements against the Ethiopian Empire in what is now the Somali Region of Ethiopia. In 1977, three years after the ousting of the Emperor Haile Selassie and the imposition of the Derg military

[34] As well as other ethnic groups, including most prominently, Oromo groups, who later formed the Oromo Liberation Front among other resistance movements.
[35] Siad Barre rose to power as the military leader of a newly decolonized Somali nation-state in 1960, and was elected President in 1969.

regime,[36] irredentist groups in Ethiopia (mostly from the Ogaden Somali clan) united with the Somalian state and attempted to secure their independence from the Ethiopian Empire through war. At the same time, hoping to align with the charismatic Marxist-Leninist Ethiopian leader Mengistu Haile Mariam after his rise to power within the Derg regime, the Soviet Union switched from supporting Somalia to supplying military aid to Ethiopia in 1978 (Abbay 2004). In addition to the influx of Soviet weaponry, troops from Cuba and Yemen augmented the Derg military force, and helped defeat the Somali alliance. The Ogaden War ended in late 1978 when Somali forces retreated back across the prior border and a truce was declared (Bron et al. 1993). The Somali Region was subsequently re-incorporated into the Ethiopian Empire. The Ogaden War was thus at once a cessation movement, an ethnic nationalist movement, an interstate conflict between Somalia and Ethiopia, and a larger Cold War battle for control of the Horn of Africa.

In 1991 the Tigray[37] People's Liberation Front (TPLF) in Ethiopia, with assistance from other ethnic-based militia groups in Ethiopia, led a coup that toppled Mengitsu's regime and deposed of its centralized dictatorial administration. In the wake of the revolution, an alliance of ethnic groups from across the country formed the Ethiopian People's Revolutionary Democratic Front (EPRDF), led by Tigrayan military

[36] The Derg was a military junta that came to power in Ethiopia following the ousting and kidnapping of Haile Selassie. "Derg," meaning "council" in Amharic, was the name given to the powerful committee of military officers which ruled the country.

[37] Tigray is an ethnic group residing predominantly in northern Ethiopia along the border with Eritrea; along with persons of Amhara, Oromo, and a few other smaller ethnic groups, they are often referred to as "highlanders" by Somalis in Ethiopia.

commander, Meles Zenawi.[38] The EPRDF under Meles Zenawi strategically sought to unite the disparate and oppositional ethnic groups in Ethiopia under one ethnic federalist state (Cohen 1995, Mengisteab 1997).[39] In 1995 the Transitional Government of Ethiopia signed onto a new constitution that established the Federal Democratic Republic of Ethiopia (FDRE) and divided the country into primarily ethnic-based regions, including "the Somali Regional State" or "Region 5" (Cohen 1995). Meles Zenawi was re-elected Prime Minister by the Ethiopian Parliament in 2000, 2005 and 2010; however, each of these elections have been marred by accusations of electoral fraud and by the Government of Ethiopia's repeated arrests of opposition party activists and journalists (Amnesty International 2010, Human Rights Watch 2010).

Below I provide a more detailed timeline of critical historical moments for Somalis and Ethiopians in the Horn of Africa in the fifty years prior to this research. As shown, conflicts led to more conflicts and more conflicts, and droughts and humanitarian emergencies have succeeded each other as well. Here I unite the disparate histories of northern Somalis in the Horn with the various state formation projects (Djibouti, Ethiopia, the Somali Region of Ethiopia, Somaliland, and Somalia[40]) of which they have been part:

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[38] Meles Zenawi has held onto power since the 1991 coup, and is the current Prime Minister of Ethiopia. He was elected by the Ethiopian Parliament in 2005 and again in 2010.

[39] Girma Wolde-Giorgis, an ethnic Oromo, was first elected President of Ethiopia in 2001, then again in 2007, by the Ethiopian Parliament. The Ethiopian presidency is largely a symbolic office with little power; most of governmental power is vested in the hands of the Prime Minister.

[40] The additional histories of Puntland, northeastern Kenya, Somali Bantu populations, and Somalis in the African and other diasporas are beyond the scope of this dissertation; here I focus on the histories most relevant to my informants.

1960: Britain gave independence to its Somali colony, which joined with southern Somalia (formerly an Italian colony) to create the new state of Somalia.

1960: The Ethiopian Emperor Haile Selassie feared that the Issa Somalis residing in the northeastern corner of the Ethiopian Empire also desired independence or secession. Consequently, as mentioned, Ethiopian soldiers and police forces killed between several hundred and three thousand Somalis in Aysha, displaced thousands more Somalis, looted and burned businesses and livestock herds, and for years afterward generally terrorized the remaining population. Many of the surviving Somalis in Aysha fled to Djibouti, present-day Somaliland, and Somalia (Farah et al. 2003).

1963: another major drought ensued, motivating many in Aysha woreda to migrate north and west towards the present-day Afar Region of Ethiopia. This caused subsequent conflicts between Afari and Somali pastoralists over rights to pasture.

1963: The Republic of Somalia under the leadership of Siad Barre accepted a US$30 million military aid offer from the Soviet Union, thereby foiling an attempt by the West to preclude Soviet military aid. During 1962-1963, a consortium of Western powers, led by the United States, presented a series of arms packages of increasing value to Mogadishu. This was done over the strong

protests of Ethiopian Emperor Haile Selassie, Washington's most critical ally in the Horn of Africa. In the end, the Soviets won the bidding war for Somalia by offering more than Western powers were willing to match; the U.S. feared that to offer more support to Somalia, it would jeopardize strategically crucial relationship with and small military presence in Ethiopia (Lefebvre 1998).

1963-1970: in and around the Bale Mountains in southern Ethiopia, Arussi and Oromi ethnic groups clashed with the Ethiopian Empire in a battle to retain local control of pasture and farming resources. Refugees from this conflict (mostly non-Somali) crossed into Somalia, only to find themselves either harassed or imprisoned by Siad Barre's government, that was at the time attempting to maintain outwardly positive relations with Haile Selassie's regime.

1964: Ethiopian authorities clashed with irredentist Somali rebel groups (most from the Ogaden Somali clan) in the southern Somali Region of Ethiopia, in and around the coveted *haud* pastureland. This conflict echoed centuries of clan-based and international conflict over this particular piece of valuable pastureland, cut with fertile rivers and surrounded on the west by mountains and the east and north by desert (Lewis 1965).

1970: Somalia's government under Siad Barre declared Somalia a socialist country and adopted "Scientific Socialism." This signaled a shift towards Soviet

ideology.

1972: Under the direction of Siad Barre, a written script using the Roman orthography for the Somali language was established and promoted countrywide. The institution of a national language was part of a larger project by the government to promote the idea of a united "Greater Somalia" (*Soomaaliweyn*) in the Horn of Africa.

1972: Russia began investing heavily in infrastructure, economic, and military development in Somalia; Somalia also nationalized and reformed the financial and industrial sectors to reflect Marxist-Leninist ideology. The Chinese government increased private investments and infrastructure development in Somalia during the 1970s, especially in the construction of roads and development of oil exploration.

1973-1975: a major drought in the Horn of Africa affected many Somalis; stress migrations throughout the region became commonplace, and international relief efforts intervened with substantial food aid, medical aid and international media. The subsequent famine was known popularly as *dabadeer* (or long-tailed); the worst effects were felt in northern and central Somalia. Siad Barre's government relocated tens of thousands of northern pastoralists to the more verdant southern areas of Somalia.

1974: In Ethiopia, Haile Selassie was overthrown by a socialist military junta called "the Derg," discussed in greater later in this chapter.

1976: severe drought called *bir'as* caused many of Issas to migrate west towards the Erer river (in the northwestern Somali Region) for water and pasture. Ethiopian troops retaliated, and defeated the Somali pastoralists who then fled through the Somali Region back into Somaliland (Farah et al. 2003).

1977: Mengistu Haile Mariam, the military leader of the Derg, was appointed head of state in Ethiopia. The Soviet Union then moved to support and sell arms to Ethiopia, believing Mengistu would be a longer-standing charismatic Marxist-Leninist leader than Siad Barre. At that point, the United States ended its support of Ethiopia, and switched its support to rival Somalia.

1977-1978: The Ogaden War – at once a conflict between Ethiopian and Somalian military forces for control of the *haud* pastureland in Ethiopia and a global cold war battle – caused the displacement of between 300,000 and 400,000 refugees, mostly Somali Ethiopians who regrouped in camps in Somalia. The largest secessionist group in the Ogaden Region called the Western Somali Liberation Front (WSLF) joined with Somalian forces in July of 1977 to invade the area of the *haud* pastureland (known commonly as the Ogaden Region or the

Ogaden). At the peak of the Somali advantage, they occupied an area as far west as the edges of the road between Dire Dawa and Jijiga. UNHCR began a 12-year relief effort to provide basic services for many refugees, including those who fled present-day Aysha woreda for safety across the border. Siad Barre inflated the numbers of refugees and affected persons to garner more humanitarian aid and he even recruited Somali-Ethiopian refugees in the northern-most refugee camps to join his military. Cuban leader Fidel Castro tried to negotiate a loose socialist federation under Soviet patronage in Somalia and Ethiopia, but this did not satisfy the Somalis' aspirations for an independent Somali nation-state uniting all of Greater Somalia. Additionally, contra the Ethiopian government, Oromo groups to the west of Somali territories re-established independent control over the region around the Bale Mountains. The Soviet Union, unable to negotiate a peace treaty, pulled out of the conflict entirely. But several other Cold War powers, including the U.S., continued to support the war effort through 1978. With the help of Cuban military support, Ethiopian soldiers maintained control of Dire Dawa and Jijiga until the Somalian forces, too exhausted, retreated back to the original Ethiopia-Somalia borders. Most refugees in 1978 were Somalis from Ethiopia fleeing into Somalia or present-day Somaliland. At the same time, several other Somali groups were displaced by smaller battles along the borders of the Ogaden-controlled pasturelands and along international borders. The United States continued to supply arms to Somalia, into the 1980s (de Waal 1991, Markakis 1998, Menkhaus 2010).

1978-1984: The defeat of the Somali army in the Ogaden War was followed by approximately six years of covert counter-insurgency warfare against the forces of the WSLF and the Oromo Liberation Front (de Waal 1991).

1984-85: a drought then famine in Ethiopia caused the deaths of between four hundred thousand and one million people; as many as one million refugees fled from Ethiopia into Somalia during the famine and continuing conflicts there.[41] The causes of this famine are disputed, but very likely, a combination of the Government's counter-insurgency offensives (that often destroyed crops and marketplaces), forcible resettlement programs in insurgent areas, agricultural reforms and other socialist policies all contributed to the high number of deaths (de Waal 1991).

Late 1980s: rebel groups began insurrections against Siad Barre's regime in Somalia, including groups in the Ogaden and Somaliland. Political divisions within Somalia instigated smaller regional battles between clan-based groups in Somaliland and the Ethiopian Somali Region, causing flights of refugees and internally displaced persons into the Degago refugee camp, into Djibouti, and

[41] No closer approximations for numbers of killed are available. A Human Rights Watch report says: "The United Nations and other concerned institutions have been remarkably cavalier about the numbers of people who died, especially in the 1983-5 famine. Usually the figure of one million famine deaths is quoted for 1983-5. This figure has absolutely no scientific basis whatsoever. It is a trivialization and dehumanization of human misery for such a figure to be produced without even a minimal pretense at a systematic investigation." (de Waal 1991:iv)

from the southern areas of the Somali Region of Ethiopia further north toward Aysha woreda. Once the government in Somalia collapsed, weapons stored and used by Somalia's military made it into the hands of civilians and some clan leaders, even in Aysha. Then, one informant for this research said, "every clan started to fight its adjacent clan to expand their land. So it was a land ownership dispute." Persons living in Aysha woreda were primarily affected by conflicts between the Issa and Gadabuursi clans. These conflicts also resulted in the deaths of many livestock due to raids, limited mobility, blocked trade routes, and sparse pasture.

1991: a *coup d'etat* in Ethiopia and rise to power of Meles Zenawi led to the division of Ethiopia into ethnic-based administrative regions including the Somali Regional State. The Transitional Government of Ethiopia, dominated by the People's Revolutionary Democratic Front (EPRDF) granted national self-determination to Somali Ethiopians.

1991: Siad Barre was defeated by opposition groups and ousted from power; a counter-revolution took place in Somalia to attempt to reinstate him as leader of the country. The same year, Somaliland declared itself independent (although its sovereignty is still not recognized by the United Nations or most other international organizations.) During the civil war in Somalia, the country was in a state of chaos and lawlessness, with no one group able to assume control over the

entire country. This instigated an exodus of refugees from Somalia into Kenya, Djibouti, and Ethiopia, including refugees into the Degago refugee camp in Aysha woreda. An estimated 240,000 persons – some Somali-Ethiopians – died due to the food crisis that ensued (Refugee Policy Group 1994).

1991: civil war began between the Afar and Issa Somalis for control of government in Djibouti. Issa Somalis had, over the preceding decades, gradually gained control of most of the arms of government. Issas in Djibouti were more educated and wealthy after being more dominant in the commercial and administrative life of the former French colony. Afars from Eritrea and Ethiopia were involved in battling the Somali government in Djibouti, but France stayed uncommitted and largely uninvolved (Markakis 1998).

1992-1994: from December 1992 until May 1993 a US-led military peace operation known as the United Task Force (UNITAF) attempted to maintain order in Somalia. Then in May 1993 The United Nations Operation in Somalia (UNOSOM) took over peacekeeping operations, mostly in Mogadishu and along the Ethiopia-Somalia border (Menkhaus 2010).

1993: the infamous Battle of Mogadishu (the basis for the move *Black Hawk Down*) killed 19 U.S. and 24 Pakistani troops, and began an era of U.S isolationism from conflicts in the Horn of Africa.

1994: Non-Ogaden clans in Ethiopia, including the Issa clan, began to feel marginalized by the Ogaden National Liberation Front (ONLF) and increasingly sought alliance with the Ethiopian Government in case of the Ogaden's succession or conflict. Several ONLF leaders were imprisoned by the Ethiopian federal government or fled into exile, and the capital of the Somali Region moved from Gode (in the fertile heartland of Ogaden-controlled areas) to Jijiga further north. Ethiopian Somali Democratic League (a coalition of non-Ogaden clans including the Issa clan), supported by the Ethiopian People's Revolutionary Democratic Front (EPRDF) dominated the Somali Regional State government (Hagmann 2005). To this day, Somalis of the Ogaden clan are viewed by many habasha with suspicion regardless of their political affiliation or personal history.

1995: a fragile peace was negotiated between the Issa Somali clan and Afari in Djibouti, but the war had already largely bankrupted the Djibouti government (Markakis 1994).

1995: a drought in Aysha woreda ensued called *daso'od* (meaning "close the gate") (Farah et al. 2003)

1998: moderate ONLF members joined the other Somali political groups to form a new larger Somali People's Democratic Party (SPDP).

1999: drought called *fadhikugadh* caused an increase in commodity prices and decrease in livestock prices in the Somali Region of Ethiopia. The UN World Food Program responded to severe food crises in the southern Somali Region around the town of Gode by opening food distribution and therapeutic feeding centers. It was later determined that migrations to Gode for relief aid may have actually contributed to outbreaks of infectious diseases. The relief operation commenced only after the height of child deaths in the feeding centers, and, in the end, did not substantially improve the rates of malnutrition and mortality in the affected Somali population. (Farah et al. 2003, Salama et al. 2001)

2000: on the heels of the 1999 crisis, another drought affected the Somali Region called, *soodhaaf* (or "to kill all the animals")

May 2000: first nation-wide parliamentary election happened in Ethiopia; the EPRDF party led by Meles Zenawi won control of parliament and elected him Prime Minister. The election was seen by most international observers as fraudulent (Amnesty International 2010, Human Rights Watch 2010).

2001: the drought conditions continued, this time called either *gole ka'ade* in which, "men get confused what to do and sit at the homestead" or *daliiga,* "kills all the animals" (Farah et al. 2003).

2003: another major drought afflicted much of the Horn of Africa, including the Somali Region of Ethiopia. Many livestock died, the price for livestock plummeted, and food commodities prices skyrocketed. Early that year the United Nations began its largest relief operation to Ethiopia since the famine in 1984 (de Waal et al. 2006).

2004: the Transitional Federal Government of Somalia (TFG) was founded in Nairobi Kenya. Menkhaus (2010:S331) described the TFG as, "dominated by a narrow coalition, internally split, dysfunctional, and unable to establish a presence in Mogadishu."

2004: Ethiopia began a three-year program to resettle approximately 2.2 million individuals residing in chronically food insecure and food aid-dependent farming communities in the western highlands.

2005: piracy perpetrated by Somalis (mostly from Puntland and Somalia) in the Gulf of Aden began to increase and gain international attention.

2005: a second nation-wide parliamentary election happened in Ethiopia; the EPRDF party led by Meles Zenawi maintained control of parliament and re-elected him Prime Minister. Several opposition parties, including the Somali

People's Democratic Party, complained of voting irregularities and corruption. As election results were released by the Government of Ethiopia, between one and five thousand unarmed protesters marched in downtown Addis Ababa. The demonstrations were quelled by mostly Tigryan military special forces; human rights investigators and journalists found that 193 civilians and six police were killed, nearly 800 persons were injured, across the country at least 30,000 persons were detained, and at least one hundred opposition party activists were jailed. The Government of Ethiopia disputed these figures (Amnesty International 2010, Human Rights Watch 2006, Human Rights Watch 2008, Human Rights Watch 2010, Mitchell 2006).

2006: The Islamic Courts Union (ICU), a consolidation of conservative groups in opposition to the TFG, bent on instituting Islamic law rose to power in Somalia. Conflicts between the ICU and U.S.-backed TFG military forces intensified; by June 2006 the ICU controlled most of Mogadishu and southern Somalia. In these areas, they re-established security forces and governance structures—advances many Somalis welcomed after years of war.

December 2006: the Ethiopian military, with support from the U.S., attacked ICU strongholds in Somalia and drove most of its leadership into exile. The Ethiopian military then occupied much of Mogadishu, helped install the TFG in bureaucratic

offices there (from where they had formed in Nairobi), and facilitated the deployment of African Union peacekeepers (Menkhaus 2010).

2007: In an effort to capture or kill Al-Qaeda supporters within the ICU, the U.S., with the help of Ethiopian soldiers, intervened to support the still-fledgling TFG. Essentially, most of Somalia was occupied by Ethiopian troops with U.S. financial, military and intelligence backing and a few thousand African Union peacekeepers (part of the operation called AMISOM). At the same time, a powerful Islamist insurgency group known as *al-shabaab* began collecting popular support and attacking military targets and international aid workers. Additionally, the U.S. labeled al-shabaab a terrorist group, effectively ending much support to shabaab-controlled areas and placing numerous restrictions on the work of humanitarian agencies (Menkhaus 2010).

2007: Although conflict between Somali rebel groups and the Ethiopian government had been ongoing for years with intermittent allegations of violence and human rights abuses, in April the Ogaden National Liberation Front (ONLF) attacked a Chinese-run oil installation in southern Somali Region, killing more than 70 Chinese and Ethiopian civilians. The Ethiopian government responded by launching a counter-insurgency campaign in the five zones of Somali Region primarily affected by the conflict: Fiiq, Korahe, Gode, Wardheer and Dhagahbur, but not the Shinile Zone or Aysha woreda. Human Rights Watch (2008) finds

that in these zones the Ethiopian National Defense Forces deliberately attacked civilian populations in an effort to quell the insurgency.

April 2007: approximately 700,000 residents of Mogadishu fled to rural areas and the Kenya and Ethiopian borders. The situation was exacerbated by rising food and fuel prices. By 2008, 3.5 million Somalis were in need of humanitarian assistance (Menkhaus 2010).

2008-2009: drought conditions spread throughout the Somali Region of Ethiopia, including in Aysha woreda (World Food Program 2009). An acute watery diarrhea epidemic continued along the Ethiopian-Kenyan borders, especially in the refugee camp Dolo Ado. Cholera outbreaks were suspected and discussed in the Shinile Zone but not verified; measles and diarrheal outbreaks are verified and addressed by the UN World Health Organization (UN OCHA 2009).

2008: Ethiopian soldiers formally withdrew from Somalia, leaving behind an African Union contingent of between 5,000 and 8,000 troops to help the coalition TFG troops enforce their authority.

2009: following Ethiopia's formal withdrawal from Somalia, the southern half of the country rapidly fell into the hands of radical Islamist rebels and remnant factions of the ICU. The rebels quickly defeated the government and AU troops

in several key provinces, establishing a conservative form of Islamic (*shari'a*) law in areas under their control. Several international nongovernmental organizations withdrew from Somalia because of corruption, diversion of aid, manipulation of statistical figures, and difficulty negotiating with the TFG and al-shabaab (Menkhaus 2010).[42] New waves of refugees from Somali entered the southern Somali Region of Ethiopia, mostly into camps on the borderlands between Kenya, Ethiopia, and Somalia.

January 2009: Members of the Ethiopian Parliament passed a bill that banned all foreign agencies from work related to human rights or conflict resolution, and banned all foreign agencies from the country that receive over 10% of their funding from sources external to Ethiopia. Most UN agencies and NGOs active in Ethiopia both publicly and privately expressed outrage (Amnesty International 2010, Human Rights Watch 2010).

July 2009: The federal government of Ethiopia deported 15 American students attending Stanford University who were teaching English in communities in eastern Hararghe region of Oromiya, not far from ONLF-contested areas in the

[42] Menkhaus (2010:S334) notes further: "Key donor states, as well as the UN Special Representative of the Secretary-General (SRSG) in Somalia, Ahmedou Ould-Abdallah, wanted humanitarian relief to be channeled through the TFG to help legitimize it in the eyes of the Somali public. Ould-Abdallah repeatedly emphasized the need for permanent, long-term, political solutions to the Somali crisis, implicitly criticizing humanitarian response as little more than a band-aid and a diversion from the greater task of political reconstruction. Part of this line of argument involved challenging the entire notion of 'humanitarian neutrality' … For many humanitarian agencies, this was an outrage—their view was that the entire humanitarian crisis was due to the abusive Ethiopian and TFG security sector behavior that was uncritically backed by the UN SRSG, and that if anyone was complicit in the vast human suffering in Somalia it was the UN political leadership and key donor states backing the TFG."

Somali Region. Ethiopian police raided civilians' homes, detained the students without notifying the U. S. State Department, questioned them for one day, and transported them to Addis. They were summarily deported. According to VOAnews.com, the students were accused of asking questions about the disputed 2005 and the coming 2010 national elections and of having improper visas. Residents of the communities were later told by governmental officials that the students were deported because they carried the H1N1 virus (Arnold 2009).

December 2009: Ethiopian military withdrew from Somalia (although there were several reports of Ethiopian military and police forces crossing the borders and committing violent acts along the Somalia-Ethiopian border). The TFG began incorporating greater numbers of moderate Islamists formerly associated with the ICU (Menkhaus 2010).

May 2010: The EPRDF again won a vast majority of votes in nation-wide elections. International observers criticized the Government of Ethiopia for a voting irregularities and, more crucially, the imprisonment of several known opposition party members and activists. Despite these controversies, the parliament re-elected Meles Zenawi to another five-year term as Prime Minister.

July 2011: A major drought beset the Horn of Africa. The UN declared famine conditions in several areas of southern Somalia, and new agreements between

> governmental, al-shabaab, and NGO responders were negotiated to facilitate the distribution of relief commodities into contested areas of Somalia and to refugee camps along the borders with Ethiopia and Kenya. Movements of affected persons in search of water, pasture and food has been challenged by ongoing territorial and political contests between various TFG authorities, al-shabaab representatives, the Kenyan and Ethiopian governments, and other Somali factions. Hundreds of thousands of Somalis fled into already crowded camps at the Kenyan and Ethiopian borders. Crime, hunger and infectious disease deaths have risen sharply among displaced populations. By August 2011, the numbers of daily arrivals in camps in the Horn of Africa was declining, while the numbers of refugees arriving in Yemen was increasing. (Hatley 2011, Human Rights Watch 2011)

With each new humanitarian crisis, new disbursements of aid flowed into and around Somali communities throughout the Horn of Africa. Recurrent humanitarian crises and relief operations all importantly shaped the material development of health systems in the northern Somali Region of Ethiopia. Moreover, recurrent incidences of violence, displacement, and dispossession in Somali communities shaped people's expectations of *all* government services and institutions – not just the military and police; Somalis *expected* the worst of habashas and Ethiopian government representatives as they encountered them in clinics as well. In the retelling and remembering of these histories, racialized categories and animosities were reproduced and hardened. As will be

shown especially in Chapter 4 and Chapter 6, these histories have lingered, and are re-worked as persons seek out and discuss health care.

Flows of Medicine: Medicine and Healthcare Supply Systems

This dissertation follows the flows of medications and healthcare providers within the Somali Region of Ethiopia as well as between rural areas and the urban centers of Dire Dawa, Jijiga, Addis Ababa, Djibouti City, and Hargeisa in Somaliland. Flows of pharmaceutical medications moved in three largely separate supply chains: (1) within Ethiopian governmental health facilities such as public hospitals, licensed pharmacies, and small community health posts; (2) within extra-legal[43] economies of unregulated and contraband medications; (3) within and between medical humanitarian organizations and programs, including relief operations administered by the Government of Ethiopia.

Public Health Providers and Facilities

First, since ratification of its constitution in 1994, the Government of Ethiopia has been in the process of decentralizing its health care delivery system by empowering local authorities to manage their own budgets, priorities, and staff to the greatest extent possible (Federal Ministry of Health in Ethiopia 2005, 2008). Accordingly, the Somali

[43] I use the term *extra-legal* the way Ferguson (2006) and Nordstrom (2004, 2007) do, to denote activities that fall outside legality as it is defined by governments and law enforcement. This includes illegal and illicit economies of goods purposefully hidden from taxation and declaration, as well as informal exchanges of commodities such as interpersonal gifts and trades.

Regional State, with a relatively small population but disproportionately large share of morbidity, mortality, illiteracy, violence and poverty, has taken radical and sometimes surreptitious steps to make a range of pharmaceutical medications available to remote locales, even with no supervising nurse or pharmacist. Since 2006, dozens of small, two- or three-room clinics called "heath posts" have been built and local Somalis have been recruited and trained to staff the health posts as "pastoralist health extension workers."[44] These community health workers, typically, had completed a tenth grade Ethiopian public school education plus six months of training in public health, basic disease classification, and referral (but, notably, the workers with whom I spoke for this research were not trained or licensed in curative biomedicine, physiology, nursing, or pharmacology). Health posts in the northern Somali Region contained unreliable and variable supplies of vaccines, antibiotics, anti-malarial medications, analgesics, and first aid kits (Federal Ministry of Health in Ethiopia 2005, 2008).

The jobs of pastoralist health extension workers (PHEWs) were difficult for several reasons. The supply of medications from the woreda and regional levels were unpredictable and insufficient to meet local demand – there were repeatedly shortages of the most popular drugs like tetracycline and amoxicillin. More broadly, many of the PHEWs felt they were stuck between being, on the one hand, proudly able to provide

[44] PHEWs are elsewhere called community health workers for pastoralist populations or just health extension workers. Policymakers in Ethiopia differentiate them because their training is conducted in both English with some Somali translations, and more importantly, they are expected to live in pastoralist areas and move when populations shift or migrate. In Aysha woreda, several health extension workers shifted from one community and one health post to another within the year. Although most PHEWs working in Aysha woreda in 2008-2009 were grew up in the Somali Region of Ethiopia, many were born elsewhere in the Somali Region and had lived for at least one year in either Dire Dawa or Jijiga for their education. Three PHEWs I spoke with spoke of being restless and ready to move to a larger town and work in a larger clinical facility. Health extension workers in other parts of Ethiopia typically reside in one community for at least several years; often they are assigned to work in the community they were originally residing in.

essential medications to their neighbors in need, and on the other hand, being treated by many of their neighbors as if they were children and thus too inexperienced to effectively provide healthcare. PHEWs were indeed young – usually eighteen to twenty five years old – while most of their clientele were the age of their parents or were local leaders. Several extension workers expressed frustration at their powerlessness to make accurate diagnoses or persuasive cases for the "rational use of drugs." Many people would present to the clinic and demand to purchase one or two amoxicillin or tetracycline capsules, without a discussion about their symptoms or a promise to complete the regimen.

In fact, an employee of the Aysha woreda health bureau said that that the Somali Regional Health Bureau based in Jijiga did not, as a policy, give the pastoralist health extension workers the job of dispensing prescription antimicrobial medications, but rather wanted to put more focus on their leading health education campaigns. The woreda official objected to this policy by saying, "Without [providing] antibiotics at the community level, there are no effective treatments and no way people can get medical care." He said that most residents of the rural Aysha woreda were unwilling or unable to travel all the way to the Aysha Medical Center to see clinicians and receive treatments they did not trust anyway. Instead, he surreptitiously provided the PHEWs in his woreda with a much larger supply of prescription medications than the Somali Regional Health Bureau officially recommended. No one within the government had ever questioned his decision, and rather than hiding the practice he lamented that the local provision of essential medications had to remain unsanctioned. He said, "This is the best way to care for the people in this district, which is so remote."

Officially and ideally, the decentralized health system in Ethiopia worked in the following way: health posts in every *kebele* (neighborhood administrative unit) like those in Degago and Elahelay treated patients they could and referred others to larger facilities in every woreda. The woreda-level facilities made referrals to regional facilities for patients who need additional diagnostics or treatments. And cases that could not be treated at regional facilities, such as Dil Chorra public hospital in Dire Dawa, would be referred to public hospitals Addis Ababa. Aysha Medical Center was the woreda-level referral facility for persons residing in the northern Somali Region; when patients there were referred elsewhere, it was often to hospitals in Dire Dawa, Jijiga or Djibouti, depending on where the patient had family who could care for them and assist their travels. Aysha Medical Center and Dil Chorra Hospital, the largest public hospital in Dire Dawa, are described in greater detail in Chapter 4.

The effort to equip extension workers in rural kebeles with so many different prescription drugs was a practical local response, in part, to another exceptional aspect of healthcare in the Somali Region: copious supplies of contraband pharmaceuticals, mostly antibiotics and over-the-counter cold and fever treatments, in nearly every community. Thus, the second pharmaceutical supply system includes both informal and illicit flows of unregulated medications throughout the Horn of Africa and Aysha woreda in particular.

Extra-legal[45] *economies of medications*

[45] I use the term *extra-legal* the way Ferguson (2006) and Nordstrom (2004, 2007) do, to denote activities that fall outside legality as it is defined by governments and law enforcement. This includes illegal and illicit economies of goods purposefully hidden from taxation and declaration, as well as informal exchanges of commodities such as interpersonal gifts and trades.

The northern Somali Region is a hub of contraband trade. Most contraband commodities originate in China, India, Pakistan and Yemen, arrive in ports in Somalia and Puntland, and are driven by truck into Ethiopian cities like Dire Dawa and Jijiga. The unregulated or contraband pharmaceuticals sold in small shops and unlicensed pharmacies in the northern Somali Region were usually obtained by the shopkeeper either from licensed pharmacists who sold both regulated and unregulated medications to smaller vendors, or more often, from petty transnational traders selling sundry items on the black market.

The heart of commercial trade in Dire Dawa is a dense and labyrinthine market called "Taiwan," named for its famous sale of contraband electronics from Asia. A wide variety of pharmaceutical pills, injection medications, and other medical supplies like syringes, latex gloves, IV bags, and first aid kits may be purchased from unlicensed sellers in Taiwan. Most vendors set up shop inside the ramshackle mall or along the crowded surrounding streets. Little effort was made to hide or police these vendors, but their presence was officially illegal. Representatives of the Government of Ethiopia said they planned to increase the regulation and taxation of contraband trade, but few enforcement measures (of medical commodities at least) have yet been taken.

In addition, residents of communities bordering Somaliland, including the village of Elahelay, would often cross the border and travel to towns there to access larger pharmacies and healthcare facilities. From Elahelay, the trip into Somaliland was less expensive and faster than a trip to Dire Dawa, Ethiopia. Somaliland policed few of its

suppliers as well; copious unlicensed pharmacies and shops there sold medications to laypersons without a prescription.

Medical humanitarian relief operations

Foreign relief organizations have had a presence in the northern Somali Region since the Italian occupation in the early 1930s, when the Italian government and affiliated religious organizations built and maintained a clinical facility in Aysha to serve both local Somalis and the Italian and French expatriates working on the railroad. Due to political insecurities, however, few international NGOs had offices or clinics in the northern Somali Region from 1960 until the late 1980s. Then, between 1989 and 2005, in the wake of numerous interstate and interclan conflicts described in the historical timeline, Aysha woreda hosted between 15,000 and 30,000 refugees and internally displaced persons from Somalia, Somaliland and the surrounding area of Ethiopia. Numerous international NGOs temporarily provided materials and programs in Degago during this period – they specialized in everything from home construction, to the promotion of solar cookers, to the provision of piped water. Most of the projects initiated during this time ceased once the aid agencies and refugees departed; today few residents can recall exactly which organizations performed which functions during which years.

Remnants of past clinical relief operations dot the landscape throughout Aysha woreda as well: one clinic was opened in the mid-1980s in the Degago camp by Médecins Sans Frontières-Holland, was later operated by UNHCR, and then was closed

in 2005; in 2002 a small clinic was erected and supplied (but not staffed) for one year in the village of Elahelay by an international NGO called PNMP; and another clinic further west opened in the 1990s by Médecins Sans Frontières then closed five years later. Beginning in 2005, following programs to resettle displaced Somali populations, all of the relief clinics in the northern Somali Region closed, leaving permanent residents without operational clinics or pharmacies. Then beginning in 2007, as humanitarian relief in the Somali Region was increasingly funneled through regional governmental institutions, most of these abandoned clinical spaces reopened to house various public health initiatives.

As already discussed, the rainy seasons in 2007 through 2009 were delayed and significantly lower than normal. By May 2008, most of the NGOs providing emergency nutrition support in the Somali Region had reported a rising number of acutely malnourished children arriving at various clinical or food distribution centers and requiring immediate medical attention (UN OCHA 2008a and 2008b, USAID 2008). Then in September 2008 the UN Office for the Coordination of Humanitarian Affairs declared the existence of severe food and water shortages (IRIN 2009, IRIN 2008, UN OCHA 2008c). Compounding the drought conditions, in 2008 and 2009 multiple epidemics of acute diarrheal disease and measles occurred in Aysha woreda, and rates of severe acute malnutrition among children peaked. To respond, in addition to continuing WFP rations, UNICEF funded the aforementioned mobile team of Somali nurses who traveled by vehicle to remote pastoralist villages in Aysha woreda for six months to provide primary healthcare, preventative care, therapeutic food, and free medications to

needy and sick infants, children and their lactating and pregnant mothers (UNICEF 2008).

Mobile Health & Nutrition Teams (otherwise called in the literature "mobile health units") are a popular contemporary form of medical aid in the Somali Region of Ethiopia. These teams were created in Ethiopia in 2004 to provide care to young children and their mothers during an epidemic of measles in politically insecure and remote pastoralist areas. But today they go beyond this initial mission to also train and supervise PHEWs, train community volunteers in health awareness, provide ambulance services, bridge linguistic and cultural gaps between providers and community members, educate community volunteers on public health concepts, and at times, informally, police contraband pharmaceutical sellers. Thus, although mobile teams are by definition (and funding) temporary humanitarian interventions, they are also the vanguard of efforts to bridge relief with sustainable development of the national health system (Mortier and Coninx 2007). Mobile teams increased the number and diversity of medications available in many parts of the Somali Region, and provided these medications free of charge. Consequently, supplies provided by mobile teams were no longer provided in the small shops or other unlicensed dealers in the northern Somali Region. One man living in Elahelay explained:

> Before the mobile team and health post were in operation, people would go to the shops, where you can get medicine from Somaliland. But the shopkeepers don't have experience with medicine – it's better to go to the health post. The shops only sell you things; they don't have good advice.

United Nations offices of the World Food Program and UNICEF spent more money than other organizations on relief and healthcare programs in the northern Somali Region of Ethiopia (UNICEF 2009). Further south in the Somali Region, additional international NGOs and a few local NGOs had a greater presence. Between 2007 through 2009 these included, but were not limited to: Action Contre la Faim, the Adventist Development and Relief Agency, CARE, CONCERN, Handicap International, the Hararge Catholic Secretariat, Catholic Relief Services, International Medical Corps, Islamic Relief, Merlin, Médecins Sans Frontières, Ogaden Welfare Development Assistance, Samaritan's Purse, Save the Children-US, Save the Children-UK, Oxfam-Great Britain, and the Ethiopian Red Cross. There had been several efforts to coordinate, monitor, and evaluate the work of NGOs in the Somali Region of Ethiopia, led by relevant United Nations organizations and the regional government. For instance, the Mobile Health & Nutrition Teams were funded by several different NGOs, including UNICEF in Aysha woreda, so (with funding from the UN) the Somali Regional Health Bureau held semi-annual conferences to coordinate the efforts of so many different teams.

Other efforts were less well coordinated. Local offices of the Hararge Catholic Secretariat[46] and Oxfam-Great Britain sporadically provided caches of antibiotic medications, water purification kits, and oral rehydration packets to health posts in communities in Aysha woreda affected by elevated levels of diarrheal disease and severe malnutrition. Most often they would arrive in a community unannounced and spend half

[46] The eastern Ethiopian arm of the NGO Catholic Relief Services partnered with the Ethiopian Catholic Church.

of one day distributing medications and speaking with health extension workers about the incidences of diarrheal diseases and acute malnutrition among children. Such intermittent donations were unpredictable and at times did not match local needs as later reported by local health extension workers.

Importantly, as supplies from humanitarian relief clinics, local health posts, mobile teams or from other NGOs declined or disappeared, business picked up at local shops and cross-border markets. Furthermore, residents' *expectations* of biomedical healthcare and pharmaceuticals were importantly shaped by their experiences with relief organizations and the Somali Regional State of which aid was apart – these are subjects I will return to in subsequent chapters.

Summary

This chapter provides an introduction to the political, economic, and historical contexts in which this research took place. I try to paint a picture of the places referenced throughout the dissertation, and I try to convey the palpable sense of continuous population movement and change there – flows of refugees and internally displaced persons; declines in the viability of pastoralism and livestock holdings among northern Somalis; increasing visibility of the Somali regional government; erratic federal enforcement of trade laws and ONLF offensives nearby; and frequent migrations of northern Somalis for work, education, visiting, and pasture. Centuries ago the northern Somali Region was a thriving and cosmopolitan hub of Islamic scholarship and trade, but

today few elders hold onto this legacy. The area instead feels partially abandoned, pockmarked by repeated military interventions, and overlooked with regards to economic and health-system development. Crumbling tanks from the Derg era rest only a few yards away from the crumbling walls of an abandoned clinic from the Italian occupation in the 1930s. Eighteen-wheelers rumble through every day on The Road to Djibouti, but few travelers or merchants find reason enough to stay.

Because this dissertation ethnographically follows the flows of medicines and medical knowledge around the northern Somali Region, this chapter also outlines these flows and describes the dominant healthcare providers. In the next chapter I begin to unpack what happens within these clinical spaces and within other healing and care-giving interactions nearby.

CHAPTER 2.

METHODOLOGY, RESEARCH METHODS, AND DESCRIPTION OF THE SAMPLE

Methodology

Movement is central to daily life, livelihoods, and medicine for persons living in the Somali Region and those tasked with providing healthcare there. Consequently, my methodology attended to the movements of people, medicines, and medical information from the capital Addis Ababa to the cities of Dire Dawa and Jijiga, and to the remote edges of the northern Somali Region. The analytics of this research drew on a classical framework in pharmaceutical anthropology, a "biographical approach to pharmaceuticals." Such an approach outlines the "life cycle" pills follow, including their marketing, prescription, distribution, purchasing, consumption, and measures of efficacy (van der Geest and Whyte 1996; Whyte, van der Geest, and Hardon 2005). This "biographical approach" primarily draws on Appadurai's (1988) manuscript, *The Social Life of Things*, about how certain "things" move through different settings, shape social relations, and retain value even as their meanings shift. In this framework, medications, as consumable and exchangeable commodities, form meaningful and productive networks of social relations, such as trade networks, policy institutions, patient-clinician relations, and informal care-giving relations. Additionally, beyond the contemporary "social lives" of medicines (Whyte et al. 2005) in the Somali Region, this study also follows the biographies of medicines historically, as they move through time as well as

space. In so doing, I both follow the "social lives" as well as the social memories and reverberations of medicines.

Additionally, I draw on "commodity chain analyses," originally formulated as one aspect of world-systems analysis, that allows for examinations of commodity and labor flows in the global economy (Hopkins and Wallerstein 1994). Commodity chains link the physical material of commodities—like pharmaceutical medications or diagnostic tests—to labor markets, consumer demand, and exchanges of information, thereby connecting various individuals, social classes, societies, economies, and geographic regions of the world (Gereffi and Korzeniewicz 1994, Hopkins and Wallerstein 1994, Hughes 2007, Kaplinsky 2001). Moving beyond movements of commodities, technologies and ideas, a "socially embedded commodity chain analysis," described by Rammohan and Sunaresen (2003), harkens back to "biographical" models of pharmaceuticals by emphasizing the importance of social relations around each "node" of the commodity chain. Their framework demands an integrated, political economic examination of transnational *and* local systems of exchange, and requires scrutiny of the historical structural inequalities central to the unequal distribution of treatments and diseases in societies around the world (Nichter 2008).

This methodological framework additionally allowed for the recognition and investigation of diverse kinds of medicines and medical practices within local healthcare economies, beyond the purviews of regulated therapeutics and licensed biomedical healthcare facilities. In the northern Somali Region, boundaries between discrete illness designations and etiologies were contingent and often lacked consensus, and so I draw on

Nichter and Nichter (1996:120) in their use of "taskonomies" of illnesses (instead of "taxonomies") to highlight the ambiguous and dynamic processes of illness reporting, illness labeling, therapy management, and healing. Furthermore, I go beyond an assumption that emic perspectives and indigenous ideologies of healing are predominantly "traditional" or non-biomedical; this data reveals routine ways in which Western biomedical technologies and concepts have been appropriated, changed and used metaphorically by laypersons and so-called "traditional" and spiritual healers alike. Furthermore, the myriad ideas and materials exchanged during medical humanitarian relief operations were vital to dynamic local understandings of healing, medicine and the human body. Thus I studied the social relations and discourses surrounding various biomedical encounters, informal care-giving strategies, nutritional therapies, herbal remedies and Qur'anic healing practices. Each stage in the life cycle of medicine – broadly conceived – presented rich opportunities for ethnographic inquiry.

Several studies in low-income countries demonstrate how extra-legal[47] exchanges of medications are not only important to local health seeking practices, but also central to long-established trade networks and medical systems (Amuyunzu-Nyamongo and Nyamongo 2006, Brugha and Zwi 1998, Chuc and Tomson 1999, Cocks and Dold 2000, Das and Das 2005, Kamat and Nichter 1998, Kloos 1986, Petryna and Kleinman 2006, and Thaver et al. 1998, Trap et al. 2002) and health systems in war-torn, post-conflict, and impoverished settings (Maxwell and Lautze 2006, Nordstrom 2004, Nordstrom

[47] I am using the adjective "extra-legal" the way Nordstrom (2004, 2007) and Ferguson (2006) do, to include informal, illegal, and illicit markets, and to denote systems of exchange and trade not typically regulated by federal or international mechanisms, and not often included in formal economic analyses.

2007). People's fears of bad medicine on the market have material bases. The WHO (2008) estimates that counterfeit medications comprise approximately 10% of global pharmaceutical trade, and 25% of medications in developing countries are thought to be either fake or of substandard quality (Kelesidis et al. 2007, ten Ham 2003). Consequently, while myriad studies have examined the rising popularity of pharmaceuticals in developing countries (van der Geest and Whyte 1988, Obermeyer and Schulein 2001), others uncover deep skepticism about the safety and effectiveness of pills (Nichter and Nichter 1996, Whyte et al. 2002), vaccines (Feldman-Savelsberg 1999, Obadare 2005, Samba et al. 2004), and other biomedical practices (Kroeger 2003, Scheper-Hughes 2002). Uncovering the various and unexpected manifestations and behavioral effects of skepticism about the safety and efficacy of local medical supplies and providers required ethnographic methods (in constrast to survey methods), as well as a historical, political and economic contextualization of ethnographic data.

I chose to view medications in terms of their biographies, and examine the social relations of various stages in the lives of medications rather than view medications as "gifts." In my experience in the Somali Region, most exchanges of medicine—especially those between health professionals or merchants and their patients or clients—are not what Mauss (1924) originally called "gift exchanges" (Oldani 2004; Harrell-Bond, Voutira, and Leopold 1992), even though the exchanges of medicine cannot be divorced from their social meanings and context and were often evidence of care and kinship between individuals. Instead, I consider the exchange of medicinal products, services, and information as central to particular local commodity markets, humanitarian aid

practices, the Government of Ethiopia's policy practices, and personal notions and strategies of care-giving. Rather than accepting pills as a gift, most people who had experienced some form of humanitarian assistance (such as having lived in a refugee camp or received food aid) accepted pills as their right or entitlement from humanitarian and governmental agencies alike. At the same time, according to persons I spoke with, medications purchased in pharmacies and markets were seen as similar to other commodities, and subject to the same concerns about quality as items like electronics and construction materials. "That was a bridge built by the Italians – you see how well it has lasted," one informant explained as we drove to Jijiga. "Now this bridge here [pointing to the concrete bridge collapsed into pieces in the river], this bridge was built by the Chinese. That is typical Chinese construction." Similarly, another man expressed doubt in the quality of the Indian-produced antibiotics he had just purchased: "these medicines are made far away, by Indian people. They are poor like us, so how can they make high-quality medicines? And they come from the black market. Many things on the black market are bad quality. Only God knows how they get here!"

Summary of Methods and Data Sources

This dissertation draws on data gathered during multi-sited ethnographic research completed over twelve months between July 2007 and August 2009. I developed a combination of ethnographic methods in order to study pharmaceutical practices and medical insecurity at multiple levels and positions within health systems in the Somali

Region of Ethiopia. Interviews with governmental and nongovernmental policymakers and analysis of various policy documents provide multiple perspectives on the development, implementation, and evaluation of health and humanitarian policies. To complement the interviews with policymakers, I interviewed persons involved in the distribution of pharmaceutical medicines around the Somali Region, including pharmacists in large licensed pharmacies, businessmen responsible for the supply chains of regulated medications, merchants along the major trade routes in the Shinile Zone, and health professionals providing medications to individuals there. Initial interviews with lay participants and lay health experts[48] delved into local flows of medicines, common local diseases and non-biomedical treatments, Qur'anic healing, and common beliefs about bodily states and health. Subsequent interviews with laypersons focused on pharmaceuticals and health facilities, using elicitation devices with samples of locally available medicines. The Institutional Review Board at The University of Arizona approved this research.

I employed two Somali research assistants. I hired a woman named Nimo Ahmed,[49] who primarily assisted with interviewing women and transcribing interviews. Nimo has lived further south in the Somali Region most of her life, and formerly worked for the aid organization Médecins Sans Frontières-Holland in the town of Degahabur as a translator. In recent years, she has lived in Dire Dawa and Jijiga. By accepting this

[48] By using the terms "lay participants" and "laypersons" I refer to persons without formal biomedical training or education, nor a state-issued license to practice biomedicine or sell pharmaceutical medications. By the term "lay health experts" I refer to persons who lack formal biomedical training or a license to practice medicine, but are regarded by their peers as experts on illnesses, healing, and health in general.
[49] With all their permission, I use the actual names of my research assistants, Nimco and Farah, and David is the name of my husband, but all other personal names in this paper are pseudonyms.

research position, Nimo demonstrated she is a pioneering woman; according to many, very few young Somali women in Ethiopia would be willing to travel and stay in these remote locations for work, and even fewer women there are fluent in Somali, English, and Amharic languages.

I also hired a male assistant, Farah Mussa, for assistance during interviews with men, logistical support, transcription, translation, and language instruction. Farah Mussa was born in Biyoqobobe, a small village along The Road to Djibouti. His father owned a shop along The Road, but it was bombed and burned by Ethiopian troops in the late 1970s, during the war between Somalia and Ethiopia. After his family was dispossessed, they fled as refugees to Somaliland, then a few years later, crossed back into Ethiopia as refugees from internal clan conflicts within Somaliland. Then when local interclan conflicts bled into Ethiopia, he, his mother, and his siblings fled to Degago, the refugee settlement site along The Road to Djibouti (described in Chapter 1). He lived in Degago for several years, first as a displaced person in the refugee camp there, then later as an adult working for various humanitarian and development organizations. Farah knew numerous people in each town we encountered in the Somali Region, and had worked as a teacher, community health worker, NGO staffer, and community organizer in many of them. Both research assistants became close friends and key informants, and both are referenced by name in this dissertation when I had permission to use our conversations.

Collection of data for this research is divided into three (often chronologically overlapping) phases: exploratory research, institutional ethnographic research, and

community-based ethnographic research. Table 2 provides a summary of the sample and other data sources.

Table 2. Summary of sample and other data sources

Phase	*Data Source*	*#Males*	*#Females*	*#Total*
Phase 1.	Participants in exploratory interviews	11	4	15
Phase 2.	Governmental policymakers and staff of government bureaus and state-owned trade agencies who participated in at least one interview	11	0	11
	Nongovernmental policymakers and staff of NGOs who participated in at least one interview	8	2	10
	Licensed clinical health providers and licensed pharmacists who participated in at least one interview	18	3	21
	Shopkeepers, petty traders, and other unlicensed distributors who participated mapping exercises and a structured interview	10	5	15
	Collection of governmental and nongovernmental policy documents, project evaluations, and reports			
	Notes from structured observations and participant observation in clinics and markets providing pharmaceutical medications			
Phase 3.	Lay adults who participated in individual interviews	25	49	74
	Notes from participant observations and structured observations in communities			
TOTAL	Participants in at least one individual interview	83	63	**146**
	Number of individual interviews conducted	101	92	**193**

Phases of Field Research

Phase 1. Exploratory Research

In July 2007, I spent four weeks in Ethiopia conducting unstructured, exploratory interviews with pharmaceutical vendors, laypersons, licensed health providers, and aid workers active in Dire Dawa and the northern Somali Region of Ethiopia (n=20). Early on, several of these informants expressed uncertainty about the efficacy and safety of pills obtained from the black market. People in rural communities in the northern Somali Region said they felt as if they were "abandoned" by relief organizations, and left to choose between obtaining medications from untrained shopkeepers who provided a limited array of contraband medications, and obtaining medicine from young, recently trained community health workers with too little knowledge or experience.

Most of the pills available from these shops and health posts were antibiotics (including tetracycline, amoxicillin, ampicillin, and chloramphenicol among others), antimalarial medications, and over-the-counter analgesics (mostly paracetamol or acetaminophen). Supplies were unpredictable and spotty. Most smaller and unlicensed vendors in the northern Somali Region obtained medications, vitamin tonics, and over-the-counter syrups for re-sale from large markets in Dire Dawa (especially the one called "Taiwan," described in Chapter 1); most of these vendors were unlicensed, and most medications for sale there were neither regulated nor prescribed. Typically, they derived from Somalia, and before then, from China, India, Yemen, other Middle Eastern

countries, and Europe. Occasionally small shopkeepers obtained regulated medications from larger licensed pharmacies, but usually only inexpensive over-the-counter remedies and vitamins. Licensed pharmacies that sold medications "out the back door" were officially illegal, but few enforcement measures took place in the time I lived in Dire Dawa.

Yet even where antibiotic and antimalarial medications were available in smaller shops and clinics in the northern Somali Region, I found they were very often taken inappropriately. People would typically only purchase two or three pills at a time for the treatment of everything from stomachaches to respiratory infections to infertility. In these cases I initially assumed that people consumed less than a full course because they lacked money or started feeling better. However, further interviews suggested people might be consuming shortened regimens or lessened doses of medications primarily because they feared the local drug supplies contained counterfeit or substandard pills. Secondarily, people reported rising distrust in many of the local and historical suppliers of medicine, such as community health workers and small merchants unlicensed for the sale for pharmaceutical products.

In response to local concerns about counterfeit or substandard medications, in July 2007 I collected samples of pills in small markets or shops from each village I visited (n=30), and with technical support from the College of Pharmacy at The University of Arizona, tested the antibiotic and antimalarial pills for their drug content. Interestingly, all of the pills collected contained adequate amounts of the advertised drug,

although none of the medications were purchased from licensed pharmaceutical vendors or health facilities (Carruth 2008).

Given these circumstances, I designed this dissertation to examine the lasting social effects of temporary medical interventions, and to interrogate whether and under what conditions such temporary interventions actually increased the inappropriate purchase and consumption of pills, distrust in medical facilities, and the availability of unregulated medications rather than increase sustainable supplies of essential drugs. Plus, more broadly, I wanted to understand how temporary medical interventions shaped people's trust in biomedical and public health professionals, their evaluations and uses of new healthcare facilities, their uses of so-called "traditional" medicine (*dawo dhaqmeedka*), and Qur'anic healing, and their notions of belonging to the Ethiopian federal and Somali regional governments. Although demand for and knowledge about pharmaceuticals had reportedly increased over time in the Somali Region, and although people were making purposive medical migrations to access healthcare at new relief operations, most local consumption remained inadequate to treat common infectious diseases or inappropriate for the medical presentation. In fact, what I call *medical insecurity* seemed to abound in the aftermath of certain health and humanitarian interventions, importantly shaping the local social relations of medicine, health behaviors, responses to future health interventions, and transnational flows of unregulated, non-prescribed of pharmaceutical medications.

Phase 2. Institutional and Clinical Ethnography

Interviews with Policymakers and Clinical Health Providers

The ethnographic research I conducted made the most of professional connections I made while working at the Addis Ababa offices of UNICEF and WFP between 2003 and 2005. Upon arriving again in Ethiopia in September 2008, I visited the headquarters of UNICEF Ethiopia in Addis Ababa, Save the Children-US in Addis Ababa, regional headquarters of the Feinstein International Center in Addis Ababa, regional headquarters of Save the Children-UK in Dire Dawa, the Hararge Catholic Secretariat (an arm of the Catholic Church in Ethiopia that provides development and humanitarian assistance in the eastern part of the country), and Somali regional offices of UNICEF and UNHCR in Jijiga. At each organization I met with a range of non-clinical staff and policymakers responsible for designing and implementing health and humanitarian initiatives in the Somali Regional State (n=14). Semi-structured interviews with these policymakers explored recent health and humanitarian programs, the challenges of clinical intervention, policy stances toward the use and regulation of pharmaceutical medications, best pharmacy practices, exit strategies, the role of the federal government and non-governmental organizations in providing (or not providing) curative medical services, and attempts to understand the effects of medical aid on healthcare through project evaluation.

I then conducted interviews with federal employees of the Ethiopian Ministry of Health, the Federal Drug Administration and Control Authority, the (state-owned) Pharmaceutical Fund and Supply Agency (that controls the supplies of medications flowing into government programs and facilities), and employees of the Ministry of Health who train health workers deployed to the Somali Region (n=10). On eight occasions I visited the Somali Regional Health Bureau in Jijiga, the regional arm of the Ministry of Health in Ethiopia, to speak with policymakers there about a broad range of topics. Semi-structured interviews with all these staff helped me understand the division of labor and expertise between nongovernmental institutions and the government agencies, the relationships between federal Ministry of Health officials and regional Bureau employees, recent efforts to develop health systems in the Somali Region, and the balance and articulations between humanitarian relief programs (and funding) and more sustainable improvements of the health system.

I also interviewed licensed clinical providers and licensed pharmacists who provided care to persons in the northern Somali Region (n=21). Interviews with these participants delved into their personal histories and training, local health facilities, how medicines are obtained by the local population, the articulations between nongovernmental organizations and the Ministry of Health, the relationships between unlicensed private drug sellers and licensed providers, relevant problems they perceived with the local supply and consumption of medications, and challenges to clinical care.

Almost all health providers and policymakers in Ethiopia, I found, had some English language proficiency, and the majority of the healthcare providers sampled for

this study were fluent in English. Therefore, most of the provider interviews were conducted in English, but often with Somali words used for particular Somali expressions for illnesses, treatments, or symptoms. For interviewees not fluent or comfortable speaking in English, the interviews combined both Somali and English languages, and translation was provided as needed by a research assistant.

Mapping Exercises and Surveys of Local Pharmaceutical Medicines

From October 2008 until January 2009, I conducted a series mapping exercises and private surveys with a purposive sample of petty traders and shopkeepers in Dire Dawa and in each of the seven woredas of the Shinile Zone (n=18). These interviews inquired about trading routes for both legal and contraband medications; the locations of various markets and clinics where medications were available; the variations in supplies of pharmaceuticals, vitamins and syrups in various locations over time; and the effects of medical humanitarian interventions (such as refugee clinics) on these economies and more broadly, on local health systems.

Card Sort Interviews with Somali Health Providers

With all of the (licensed) Somali clinical healthcare providers in the sample (n=9, including one woman and eight men), I conducted at least two separate interviews. The first interview was semi-structured, as per the description of interviews with all

healthcare providers summarized above. The second interview was done using the card sort method (one type of a "pile sort" interview method, Bernard 2002). For this, I provided each participant small cards with the names of diseases in Somali language on one side, and English translations or descriptions, for their commentary, on the other side. I compiled a list of 93 common illness terms, ranging from different types of diarrheal disease, to several illnesses caused by evil spirits, to what might be classified in English as depression, HIV/AIDS, and 'failure to thrive' in infancy. A glossary of Somali terms and their approximate English translations are provided in Appendix A.

Then, I asked each participant to categorize the cards, or sort them into piles representing different categories. Categories for sorting included: severity of the illness (e.g. normal or uncomplicated illnesses (*xanuuno yaryar*), serious illnesses (*xanuuno khatara*), illnesses that could develop from normal to serious if not properly treated, etc.); type of person that can and is more likely to get a certain illness (e.g. males, females, the elderly, children, all persons, etc.); type of causation (e.g. attack or possession by a *jin*, or an invisible spiritual being, bacteria and viruses, other contagious people (*isqaadsiin*), overwork *(culays badan*), undernutrition (*cunto la'aan*), or contaminated water sources, etc.); treatments for the illness (e.g. herbal remedies, spiritual or Qur'anic healing, biomedicine, etc.); and the various transformations and semantic boundaries between illnesses. We discussed when certain illnesses or symptoms morphed from being uncomplicated (*yaryar*) to quite serious, and cause for alarm (*khatara*), and which disease were likely to spur in appropriate or delayed health-seeking actions, in their opinions. The card sort interviews were longer than other interviews, lasting from one and a half to

four hours. They were not audio-recorded, but I took notes by hand. Data from the card sorts enabled me to improve my Somali language and consider future questions for laypersons about various illnesses, symptoms, illness categories, and treatments.

Because all but one of the Somali health providers in my sample were men, although the card sorts provided immense data on many local illnesses, the card sorts did not provide much information on the illnesses only experienced and managed by women, especially illnesses associated with women's sexual function, reproductive systems, and overexertion. Female lay health experts, including traditional birth attendants (*ummuliso*) and rural doctors (*dhakhtar baaddiye*) in various communities in the Shinile Zone along The Road to Djibouti provided the richest data on these illnesses, the causes of women' experiences of illness and pain (often, having to do with circumcision and child birth), and the treatments women often sought. Both Somali health providers and lay health experts became key informants in their respective villages, and I interviewed and spoke informally with a majority of them repeatedly in order to inquire about emerging themes of the research and new events. More information on interviews with laypersons and lay health providers is provided later in this chapter, and a detailed discussion of data from these Somali provider interviews is provided in Chapter 3.

Structured Observations in Markets and Clinical Spaces

I conducted 21 structured observations in various clinical and market locations in Dire Dawa, Jijiga, and communities in Aysha woreda. These were designed to document

various healthcare-seeking and pharmaceutical-seeking processes in real time, and therefore without the bias of recall. Observations occurred throughout the research period and always occurred with at least one of my research assistants in attendance. I shadowed a mobile team of Somali nurses based in Aysha on seven separate days as they traveled to community clinic sites in Aysha woreda, observing their entire day of work plus their afterhours and informal work within Aysha town (these teams are described in greater detail below). I attended a three-day Mobile Health & Nutrition Team review meeting in Jijiga, hosted by UNICEF, other active NGOs, and Ethiopian government representatives. Twice I observed community education initiatives organized by local health workers in Degago and Elahelay. On five separate occasions in Aysha, Degago, Elahelay (twice), and Jijiga, I spent one day in the local health facility (in Jijiga, the largest government-run hospital), observing what happened there and speaking briefly with patients and pastoralist health extension workers. On three occasions I spent the morning hours (the typical hours for trade) in the local markets of Aysha, Degago, and Elahelay. Finally, I observed one healthcare-seeking episode with at least one sick individual in four different locations: Aysha town, Elahelay, Degago, and Dire Dawa. On these occasions, when a person where I was staying became ill, at least one research assistant and I accompanied whoever attempted to access treatments. I took notes on the health-seeking, care-giving, and extended treatment process, and led subsequent 'de-briefing' discussions with the individuals involved to probe about the chain of events and the motivations and perceptions underpinning their decisions.[50]

[50] Although not publicly advertised, if a person was ill or could not afford or access needed medical aid, I

Document collection

Documents in the grey literature describing the various medical and humanitarian interventions in the Somali Region of Ethiopia were collected from July 2007 until August 2009 from the Ethiopian offices and local sub-offices of UNICEF, WHO, UNHCR, the Somali Regional Health Bureau, the Ethiopian Ministry of Health, Save the Children-US, Save the Children-UK, the Feinstein International Center, and the Hararge Catholic Secretariat. Several documents were available online from the Ethiopian Ministry of Health, but the rest of the documents were only available in hard copy or electronic form, from the offices of these organizations. These included the planning documents for various programs (such as the Mobile Health & Nutrition teams and the Pastoralist Health Extension Workers Program), evaluations of past and ongoing health and humanitarian programs, needs assessment studies, and other pertinent research conducted by the organizations. All collection of documents was done with the permission and help of the organizations' staff; Ministry of Health documents are all accessible to the public on their website and on shared files open to internet users at UNICEF offices in Addis Ababa. The collection of policy documents allowed me to map the recent history of aid operations and understand how medicines and medical systems are internally analyzed and represented.

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provided payments or other assistance. One informant became seriously ill during research and required hospital tests and treatment; I paid his expenses, and with an assistant, accompanied him to the hospital and pharmacy in Dire Dawa twice.

Phase 3. Community-based Ethnography

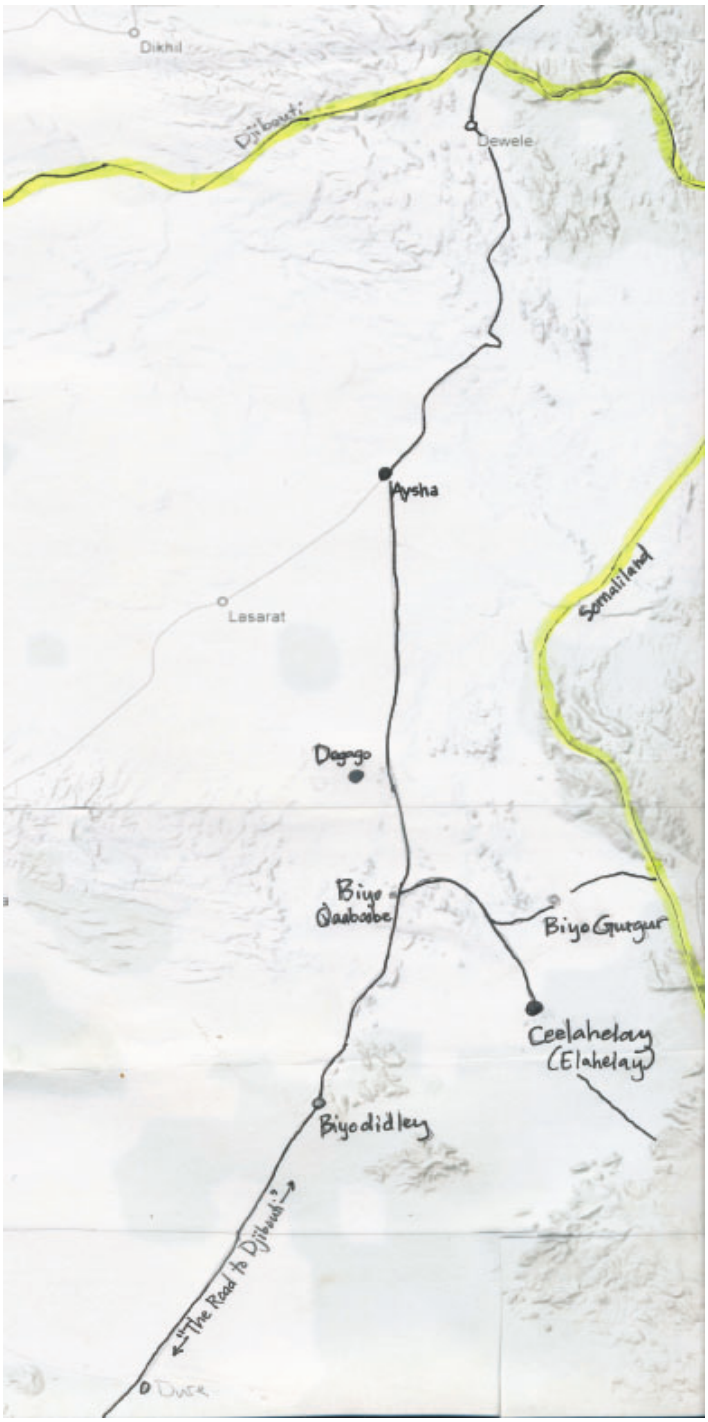
The community-based portion of this research focused on ethnographic interviews with lay adults, and took place in three locations in Aysha woreda: Aysha town (*Caa'isha*), Degago (*Dhegagoo*), and Elahelay (*Ceelahelay*), selected because of their contrasting medical systems yet comparable demographic and social characteristics. In order to experience how seasonal migration, water resources, temporary aid interventions, and fluctuations in local disease prevalence shaped everyday life and medical systems in these communities, I lived and conducted interviews in each community during each of the different seasons (described in Chapter 1). This required that the research team adopt a nomadic existence.

Although this kind of nomadic existence meant I did not see how life and healthcare changed day-to-day in one community over the course of an extended period, it highlighted other important aspects of life pertinent to understanding the local health systems and popular health cultures. First, our own nomadic movements mirrored other population movements in and through these locales, particularly the movement of adult men for temporary wage labor with humanitarian and governmental organizations (a topic discussed at greater length in Chapter 5). Everywhere we traveled—Dire Dawa, Jijiga, Addis Ababa, Aysha, and even the smaller villages throughout the Aysha woreda—we saw persons we knew from other places. Wage labor and livestock care require relentless travel by much of the population; and this mobility is made easier and

more enjoyable by the central Somali ethic of hospitality and their practices of staying over with clan relations wherever they are. Second, our existence on The Road to Djibouti, struggling to find safe and affordable transportation, provided a view of the constant challenges of transportation and geographic isolation all people in Aysha woreda face. We knew many of the people who were killed on the road; we all used khat trucks and international NGO vehicles to our advantage whenever possible; and together, we experienced changes in access to transportation when aid agencies left a particular location or contraband truckers changed their routes to avoid the police.

There are few detailed maps of the northern Somali Region, and from what I could find, no published detailed maps of Aysha woreda (a conundrum I discuss again in Chapter 6). From data gathered via mapping exercises with traders and other laypersons in the Shinile Zone, maps drawn by staff at the Woreda Health Bureau in Aysha, and outdated satellite photographs from Google Earth™ I have drawn the following map (see Figure 4) of The Road to Djibouti in Aysha woreda; the community field sites are labeled.

Figure 4. Location of Community Field Sites in the Northern Somali Region of Ethiopia



Each of the community field sites and the healthcare facilities found along The Road to Djibouti are described in Chapter 1. To summarize, the Aysha Medical Center was the largest healthcare facility in the northern Somali Region and was located in the county seat of Aysha, but interactions within facility highlighted consequential rifts between residential Somalis, Somali staff of the woreda health bureau, and the non-Somali medical staff. Idioms of distrust and popular rumors about malpractice in Aysha worsened ethnic tensions and segregation between Somalis and ethnic *habashas*[51] there. The health system in Degago was a case study in the lasting effects of one temporary medical humanitarian intervention, namely, the refugee clinic that closed in 2005. The Degago case was enriched by the thriving private unlicensed pharmacy there, the characters that staffed in the pharmacy, and the fledgling health post in town attempting to fill gaps in care. The case study of Elahelay was chosen because it revealed change over time in one community experiencing a temporary medical intervention – the Mobile Health & Nutrition Team described in Chapter 1 – and because the mobile team's practices of medical care provided a stark contrast to healthcare practices in the Aysha medical center.

Interviews with Lay Adults and Participant Observation

[51] "Habasha" (otherwise spelled "habesha" or ሐበሻ in Amharic) is colloquially defined as persons of Amhara or Tigrynia ethnicities residing in Ethiopia or Eritrea. The term habasha for many rural Somalis in eastern Ethiopia indexed not just ethnicity and language group but political support of the current Ethiopian government, although many habashas would object to this usage and association.

Excluding the exploratory interviews with laypersons in 2007, in 2008-2009 I spoke to a total of 72 lay adults at least once, and conducted at least two interviews on separate occasions with 15 of these participants. I purposively sampled a diverse group of women and men for both kinds of interviews (see Table 3 for details on the residency and gender of lay participants). Because people in the northern Somali Region had showed eagerness to participate in my prior exploratory research on healthcare in 2007, in 2008-2009 I selected community research participants by purposive sampling via word of mouth. I first recruited community leaders, midwives, rural doctors, mullahs and spiritual healers, herbalists, and persons who had reportedly been recently seriously ill; I then recruited other individuals these people knew. Because the communities where I worked were so small, I found that engaging local leaders, health experts, health providers, and community members to recruit their peers in each location was an effective method for recruiting a socioeconomically and demographically diverse group of lay adults (Guest et al. 2006, Bernard 2002). There is an overrepresentation of females in the lay sample because in prior research in the Somali Region, I determined that women have a greater responsibility for care-giving and health-seeking, especially for their children. Plus, fewer women could be recruited for the health provider interviews described previously. Although there few women were licensed and trained in clinical healthcare or policymaking in Ethiopia, I did not find significant barriers to lay women's ability to access their household's cash or other resources for healthcare.

Most lay participants were recruited from the three community field sites in Aysha woreda: Aysha town, Degago, and Elahelay. In addition, to supplement my

knowledge of women's informal care-giving practices, perceptions of healing and medicine, and bodily complaints, I also recruited female lay health experts from other villages along The Road to Djibouti, with similar ethnic and livelihoods characteristics to the three major community field sites. Such lay health experts were present in most health emergencies in their communities – they were present in all the health emergencies I witnessed living there – and they often had disproportionate responsibility for accessing and deciding between various biomedical and alternative healing approaches. These lay experts were typically the most trusted authorities on illness and healing in their communities, and thus were crucial to my understanding of dynamic local health systems.

I conducted two different kinds of interviews with lay adults: first, interviews focusing on common illnesses and treatments (n=45), and second, interviews focusing on pharmaceuticals, biomedicine, and health facilities (n=37). The first set of interviews was designed to build on the information from Somali health providers in the card sort interviews, and thus to get more information on local terms for, beliefs about, and treatments of various illnesses and symptomatic complaints.

The second set of interviews inquired about uses of and knowledge about locally available pharmaceutical medications, diagnostic technologies, and personal experiences at health facilities. These second interviews were designed to be evocative, and were facilitated with elicitation devices I modeled on ones that were developed by Carolyn Bledsoe and her colleagues working in West Africa (Bledsoe and Goubaud 1985) and subsequently used by Patterson and colleagues (Patterson et al. 2006).

During earlier research and mapping exercises with pharmaceutical vendors and pharmacists I collected samples of medications and vitamins commonly sold and consumed in the Shinile Zone from clinics, pharmacies, and unlicensed shops. Pill samples and corresponding packaging boxes or blister packets were glued to cards so each participant could respond to the physical characteristics of the pills and packaging materials rather than just the name (see Figure 5). Most persons in the Somali Region are illiterate, and so these visual triggers were key to the differentiation between medications and the elicitation of specific treatment-seeking episodes.

These interviews began with basic introductions (if I did not already know the person well, or if I had not already conducted one interview with them), the collection of demographic information, and the collection of a basic life and reproductive history. Then, as the interviews continued, I had persons categorize (or make piles of) the various treatments based on several different criteria, including: whether or not the person had consumed the medicine; where the medicines were available (health posts, unlicensed local shop, pharmacies in Somaliland, Dire Dawa hospitals, Djibouti hospitals, etc.); basic indications for each medication (for stomach problems, body pain, colds and coughs, etc.); and appropriate population for medications (those indicated for children versus adults). The sorting of these samples was fluid, and often halting, as persons would exclaim recognition and begin telling a story about someone's experience with a certain medication or a certain supplier. Building on what information or stories emerged during the sorting process, I also inquired about local treatment-seeking processes, experiences at local and regional health facilities, perceptions about quality of and trust in

pills, ideas about the conditions under which pills are produced and traded, and perceptions about the side effects and safety of various available pills (Etkin 1992; van der Geest and Hardon 2006). Despite all these structured sorting activities, the most interesting stories and data emerged due to the evocative nature of the pill samples themselves. As persons thumbed through my collection, they volunteered memories of their own experiences with the products or what they had heard from others. Beginning with these volunteered bits of information and stories, I was able to probe for longer narratives. Several interviewees took this opportunity to ask me questions as well, regarding the medications' source, safety, and indications. Their questions about my own usage and the availability of similar medications in the United States led to the elicitation of additional stories and opinions.

Figure 5. Ethnographic Interview Using Samples of Local Medications.

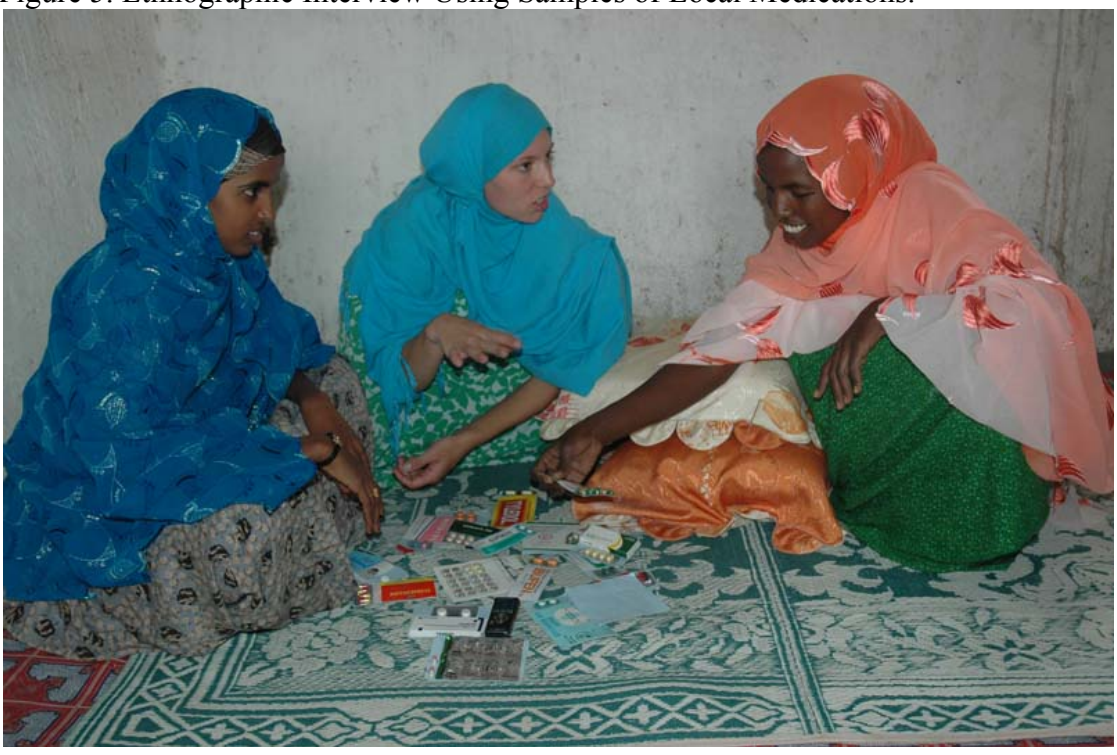
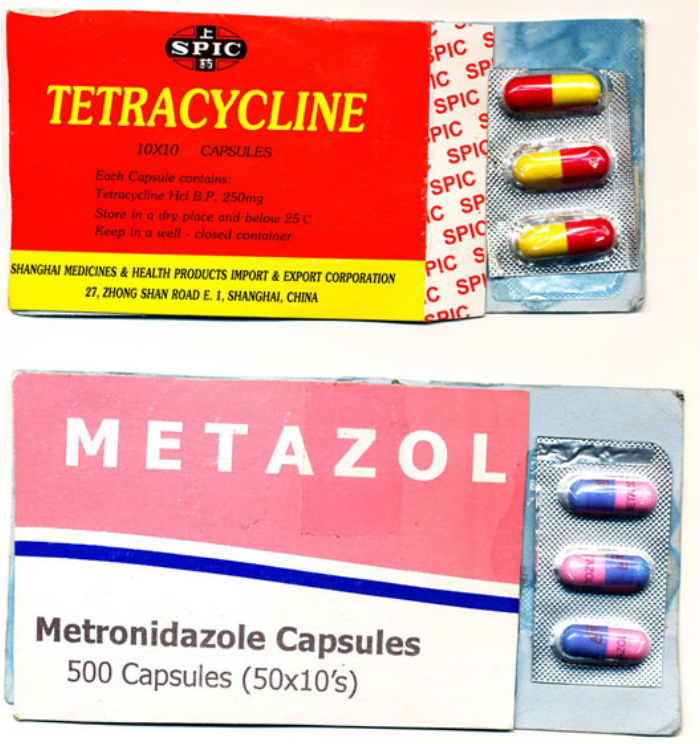


Figure 6. Samples of pills I used as elicitation devices during interviews.



Finally, participant observation was conducted in each of the communities as I went about daily activities gathering water, purchasing food in the market, spending time with women during market hours, and building rapport within the communities for future interviews. My husband, David, also an anthropologist, lived with me in each field site, and was able to provide additional insights into men's daily activities and concerns. Both research assistants lived in the community field sites during the research period (although they both resided in Dire Dawa or Jijiga at other times). In each of the community field sites, my husband and I stayed in the local health facility—typically the only space available for us in town. Our association with health facilities generated some interest and confusion at first as to our role in the community (at first, many people thought we

were doctors), but once the confusion was cleared up, the health facilities provided a comfortable, private space for interviews.

Characteristics of the Lay Sample

As stated, the community-based research focused on interviews with lay adults, both male and female, and both lay health expert and not. Table 3 summarizes the gender and community roles for all lay participants in Phase 3 of data collection.

Table 3. Description of the sample of lay interviews during community-based research.

Participants' Location	*Gender*	*N*	*Lay Health Expert Descriptions*	*N*
Aysha (town)	Female	11	Female lay health experts	1
	Male	6	Spiritual healers, or mullahs	1
			Herbalists and Traditional medicine experts	1
Degago, Aysha woreda	Female	10	Female lay health experts	3
	Male	7	Spiritual healers, or mullahs	2
			Herbalists and Traditional medicine experts	1
Elahelay, Aysha woreda	Female	15	Female lay health experts	1
	Male	5	Spiritual healers, or mullahs	1
			Herbalists and Traditional medicine experts	1
Other small towns in the Shinile Zone along The Road to Djibouti	Female	11	Female lay health experts	5
	Male	4	Spiritual healers, or mullahs	1
			Herbalists and Traditional medicine experts	1
Dire Dawa city	Female	2	Female lay health experts	0
	Male	1	Spiritual healers, or mullahs	0
			Herbalists and Traditional medicine experts	0
Total	Female	49	Female lay health experts	10
	Male	23	Spiritual healers, or mullahs	5
			Herbalists and Traditional medicine experts	4
	Total	72	Total lay health experts	38

Child survival was a struggle in the rural Somali Region; the Somali Regional State lags behind other regions of the country with regards to its child survival, chronic malnutrition, acute malnutrition, and vaccination rates (Central Statistical Agency, Ethiopia and ORC Macro 2006). In the course of lay interviews in each of the community field sites, Aysha, Degago, and Elahelay, I collected reproductive histories for all lay female participants (n=36), including numbers of pregnancies, miscarriages and stillbirths, infant deaths, and deaths of children under five years old. I did not conduct a representative survey of households in any of the community locations. Instead, I collected basic fertility and child survival data for the women in my lay sample in order to compare them to larger population statistics from regionally and nationally representative databases and to provide basic descriptive statistics. I divided the number of infant plus child deaths each woman had experienced by the total number of their live births to estimate how many infants and children had died, on average, for the women in my sample.[52] Twenty seven percent of my sample of laywomen, or more than one in four, experienced the death of at least one child before his or her fifth birthday (see Table 4).

Not unexpectedly, mortality figures for the women in my lay sample are higher than the national and regional infant and child mortality rates in either the Somali Region or nationwide (Central Statistical Agency, Ethiopia and ORC Macro 2006). The families in my sample were mostly drawn from remote locations, far from adequate health

[52] More specifically, the number of infant and child deaths was calculated first by clarifying how many total pregnancies each woman had, then the number of pregnancies ended in stillbirth or miscarriage, then subtracting this from the number of total pregnancies. I would then ask if any children had died after they were born; I then I clarified the approximate age of the child who died, and recorded it as a "child death" if was probably before they were five years of age.

facilities, and many women lacked either literacy or educational opportunities (both of which are statistically associated with higher child survival rates in Ethiopia). Additionally, my sample captured reproductive histories only up until my research, for a range of women's ages—several women were far past reproductive age, and had children and infants die many years before. Thus, this should not be interpreted as a representation of current child mortality rates or incidence of child death in these communities, but rather a basic indication of the hardship many families in the northern Somali Region endure.

Table 4. Birth and child mortality figures for lay female participants

Age group[53]	*N*	*# live births*	*# deaths of infants and children <5 years*	*Average # of live births per woman*	*% of children (live births) that died before their fifth birthday*
Pre-reproductive or pre-marriage years	2	0	0	0	-
Reproductively active years	21	99	18	4.7	18%
Post-reproductive years	14	100	36	7.1	36%
Total	36	199	54	5.5	27%

[53] Most women did not know their age in number of years and found this to be an inappropriate data collection method (as Bledsoe 2002 also found), so I grouped the women in my sample into three general categories: "pre-reproductive years" or before marriage, usually between 18 and 24 years old; "reproductively active years," including those women who were married but had not (yet) been pregnant; and "post-reproductive years," or women over approximately age 45, most of whom said they were no longer able to have children. These categories corresponded better with women's own expressions of their stage of life than an attempt to document age in years. More research would need to be conducted to divide these age groups into finer categories based on indigenous notions of aging.

Analysis of Data

I utilized a "formative" approach to developing and refining all qualitative research instruments (Nichter et al. 2002). Throughout the research period, data were compiled, transcribed, and reviewed, and research instruments were fine-tuned to account for emerging themes and questions. For example, although I began research focused on people's uses and perceptions of pharmaceutical pills, over time I asked more questions about traditional medical practices, jinns and Qur'anic healing, and the centrality of camel milk and *dacar* (digestive bile or bitterness) in conceptions of bodily health and healing.

Transcripts of interviews, notes taken during interviews, notes taken during mapping exercises, all other field notes from structured observations and participant observation, and policy documents were saved in text format then thematically coded for analysis using ATLAS.ti, a qualitative data management and analysis software tool (ATLAS.ti 2007). If the interview was audio-recorded, one research assistant would transcribe the complete interview, and the other research assistant would re-translate the substantive Somali language dialogue from the written transcript. I would then review and re-translate portions of the Somali language dialogue a second time. This method increased inter-reviewer and inter-translator reliability and improved the English translation of Somali language.

In order to ensure the anonymity of participants, I used unique identifiers, such as "pmay101" to identify and describe each person, in this case, where "p" indicated it was

a healthcare provider, “m” indicated he was male, “ay” indicated his geographic location in Aysha town, and “101” gave his unique participant identification number. Throughout this dissertation, I refer to all participants with pseudonyms to protect their identity.

During the interviewing and translating processes, I developed and continually revised a codebook, listing emergent topics or themes, such as “avianflu” (discussions about the presumed avian flu outbreak), “dacar” (discussions of the concept, *dacar*), and “clinicclosure” (discussions of what happens during and after the closure of a clinic). Data were closely read, then inductively coded based on the code book and my interview guides in order to meet the aims of this research (Guest et al. 2006; Ryan and Bernard 2000). Data were then labeled and grouped for comparison by characteristics of the data source, including: exposure to humanitarian relief, exposure to various health facilities, geographic location, illness discussed, treatment sought, gender, age, occupation, and so on. The triangulation of data between the different data sources, field sites, and demographic groups then allowed for areas of corroboration, inconsistency, and surprise to emerge. Further analysis of the dataset allowed me to extract exemplars of illness narratives, health decision-making processes, experiences with relief operations, experiences with various health facilities, expressions of medical insecurity and trust, and finally, salient metaphors and stories about antibiotics, biomedicine, medical risk, and various local health providers (Farmer et al. 2006; Ryan and Bernard 2000).

My Position as a Researcher

This dissertation builds on prior work and research in nutrition and humanitarian policy. Prior to commencing dissertation research, I worked in Ethiopia for three different periods: once in 2003 with the UN World Food Program as an intern, and twice with UNICEF, in 2004 and 2005, as a researcher. In 2004 I joined a team at UNICEF Ethiopia to investigate the effects of a drought in 2002-2003 on subsequent food security and child mortality in rural locations (de Waal et al. 2006). Although we found no surge in mortality during the drought years, questions remained as to why rates of chronic child malnutrition and morbidity in the general population remained high despite ongoing child survival interventions. Consequently, in the summer of 2005 I was the lead investigator for a UNICEF qualitative study to investigate the immediate and indirect causes of child death in drought-affected locales. One outcome of this research was the designation of the previous crisis as a "protracted livelihoods emergency" (in donor appeals and news briefs) enabling a practical differentiation between historical "famines" in Ethiopia that are associated with high mortality, and the emergency in 2002-2004, which was characterized by livelihood collapse and widespread inability to pay healthcare costs[54] (Carruth 2007, 2005).

On these research trips through rural Ethiopia, I noted the ubiquitous trade in and consumption of contraband pharmaceutical pills, especially where relief agencies had previously opened and administered temporary clinics and feeding centers. However, because the use and sale of unregulated medicines fell outside the scope of the UNICEF

[54] Plus this allowed us to continue to 'sell' to donors an idea that the crisis in Ethiopia was dire and in need of aid, at a time when most media and donor attention at that time was shifting to, what was termed by the media in 2005, "famine" in Niger.

study, these observations were not included in UNICEF's summaries to media outlets or donors. These trips made me aware of a disjuncture between the experiences of people I met in Ethiopia and the often-narrow conception of "disaster": namely, that it primarily manifests as a crisis of food insecurity and malnutrition, and can be quantified and aided as such. Further, I realized that research dependent upon quantitative health and economic statistics alone misses how humanitarian crises and interventions shape and are shaped by the social relations of medicine, pluralistic and dynamic medical systems, and informal health economies.

In addition, due to political insecurity in the Somali Region and logistical difficulties coordinating permission for research with the Somali Regional government, drought-affected communities in the Somali Region were not included in this UNICEF study of child survival and food security. The UNICEF study I participated in was neither the first nor the last to exclude populations in the Somali Regional State (SRS). Other aid organizations operating in the SRS during and after the drought, including Save the Children-UK, Samaritans Purse, Médecins Sans Frontières, the Hararge Catholic Secretariat (one arm of Catholic Relief Services and the Ethiopian Catholic Church), and others, did not publish region-wide representative data (beyond single, small communities where aid organizations were deployed) that investigated mortality, stress migration, or population health changes.

Challenges and Limitations of the Project

I experienced several challenges during field research. The most important of these were: local epidemics of infectious disease, local expectations of what "research" entailed, the omnipresence and social effects of khat, decisions about following gender norms and dress codes, and political insecurity.

Epidemics of Infectious disease

During the research stint, there were several local epidemics of infectious disease. From November 2008 until January 2009, the WHO regional office in Dire Dawa reported a measles outbreak throughout the northern Somali Region, concentrated in Aysha woreda (the exact number of cases is unknown). This instigated a regional immunization campaign in December 2009, administered by the WHO local staff, community health workers and mobile team nurses. Laypersons' self-diagnoses and descriptions of measles (*jadeeco*), were imprecise, but typically involved the practice of keeping a sick child at home rather than travelling with them in search of healthcare. Exposure to air and the weather were presumed by many to worsen measles cases, demonstrated by worsening skin rashes and fevers. Thus, local health extension workers were usually responsible for confirming a (clinical) diagnosis at the family's home. Because our research team was traveling in rural areas in the Shinile Zone and speaking with these community health workers, we were able to communicate new reports of clinical presentations of measles symptoms to the regional WHO office.

In Elahelay, there was an epidemic of dysentery in December 2008 through January 2009 that killed eleven residents and sickened many more. The mobile team was serving Elahelay village at the time, and increased the distribution of antibiotics, water filters, and Oral Rehydration Solution packets to affected families. A few additional sporadically high rates of non-specific diarrheal diseases were reported in Degago and other small villages in the Aysha woreda during our stay, prompting increased distribution of Oral Rehydration Solution packets and therapeutic foods to affected locales by the woreda health office and mobile teams. The specific causes of these diarrheal outbreaks were unknown, but popularly blamed on contamination of water sources and lack of adequate sanitary measures (which is understandable given the lack of water and soap to clean water storage containers). *Participant* observation, I realized, was risky but important; our own experiences dealing with disease outbreaks and bad water supplies highlighted the lack of options we all had when stranded there without transportation or emergency healthcare services.

From April 2009 at least until I left the area in late August 2009, Dire Dawa city experienced regular water shortages. The Government of Ethiopia was unable to supply regular electricity to the country, due to two unfinished dam construction projects and concomitant rural electrification projects that sent the demand for electricity far above available supplies. Every other day, there was no electricity, even to the city's water pump. Therefore, every other day, there was no water in the city. Most of the time, even when there was water, the pressure was very low or nonexistent. Therefore, the residents of Dire Dawa hoarded water, storing it in large barrels and cisterns for days or even

weeks at a time. According to two physicians I spoke with in Dire Dawa, these containers often became contaminated, causing citywide outbreaks of giardia and amoebic dysentery among other diarrheal diseases.

Local Expectations of Aid, Local Expectations of Research

Aysha town has been a target location for myriad humanitarian and development assistance programs over the last four decades. In 2008 and 2009, most of the Somali households in Aysha woreda received food aid from the UN World Food Program, and Oxfam-GB based their water and infrastructure projects there in Aysha town. Additionally, there have long been frequent surveys of population health and food security indicators, including studies of child malnutrition rates, mortality rates, livestock holdings, and other variables. These surveys have usually been administered jointly by the Government of Ethiopia and other NGOs, UNICEF, and the World Health Organization. Many residents I spoke to in Aysha have participated in these aid organizations' research efforts, for example, in focus group discussions, and for their time, they have often been given a cash compensation called a "per diem." Other residents have been hired on a temporary basis to assist with surveys in the region, and typically receive a per diem amount plus a salary for their work. As a result, over the years, local residents have raised the so-called "per diem" payment they demand for all kinds of participation in research efforts. Research for NGOs was not an insignificant

source of cash income for families in Aysha town; few other jobs existed, and no other local employers paid as much in salaries and per diems.

While I was in Aysha, Save the Children-UK, assisted by other organizations, conducted a survey of child chronic and acute malnutrition rates, child growth rates, and food security in rural Aysha woreda in order to assess the local need for food assistance. A few adult men from the area were hired to assist with this effort, and spent a few days at the beginning of the project in Aysha town learning how to measure and weigh children and interview the children's parents. For this training, (non-Somali Ethiopian) staff of Save the Children recruited mothers within the town limits to visit the team and let trainees test their new skills. Two women arrived the next day, with toddlers in tow. But they refused to allow people to measure their children, unless they were paid a 100birr "per diem" amount (approximately 10 times the daily wage for a manual laborer in Dire Dawa). Save the Children would have been unable to pay all participants in their study this kind of per diem, and so they refused to pay these women. Frustrated, the staff closed training activities for the day.[55] Unaware this had just happened, I was in the market in Aysha with Nimo recruiting more women for participation in ethnographic interviews. The same women who had left Save the Children plus a few others came running up to me, demanding the same 100birr payment for an interview. When I

[55] According to regional and national staff in the Somali Region, for other forms of research, including individual interviews and focus groups, the WHO and UNICEF pay all participants in the Shinile Zone at least 100birr per hour. Smaller NGOs, like Save the Children, and NGOs administering large representative surveys regularly face recruitment challenges when they cannot pay "per diems" for participation. In this case, Save the Children's job was to measure and interview persons outside Aysha town first, then later sample individuals within the urban area. By the time the team had returned to Aysha for recruitment, the women were not staying in the town, and no participants made demands for "per diems."

refused, explaining that I had gifts for participants instead of cash, they said angrily that I didn't care about the poor people living there.

As it turns out, this was a scheme developed by only a few women in town, and on this particular occasion, they had conflated my work with the work of Save the Children. On explaining the goals of my research and my position as a student and independent researcher, these women still refused to participate. This predicament was telling, although thankfully in my case, isolated. In most locations I visited, people often assumed I worked with an aid organization because of what I looked like and the rented vehicle we drove. But everyone I later spoke with about my research seemed to understand my position as a student, and was eager to participate in interviews. In fact, most people I interviewed—women especially, who often expressed delight in an independent woman leading a research team—seemed proud I had chosen to live with and study them. What I learned was that my research was conducted within an existing market for humanitarian aid, and within a regime of humanitarian aid that demands constant data via monitoring and evaluation, needs assessments, population surveys, and qualitative research methods that provide insightful quotations from chosen beneficiaries. Residents of Aysha and other towns in the northern Somali Region of Ethiopia have been socialized into a particular way of behaving and receiving compensation for their participation in research. The ramifications of their expectations and demands on research teams and aid organizations warrant further investigation, but are subjects beyond the scope of this dissertation.

Khat Chewing

In the northern Somali Region, most men who can afford to (and even most of those who cannot) chew khat leaves every day. For most men, the arrival of the khat truck or the khat courier (where there were no vehicles) was the most highly anticipated event of the day, and more than anything else, governed their daily schedules. Khat was an important gift exchange, a way to demonstrate one's financial and social status, and to pay back others for past gifts or cash loans. It was the centerpiece of male social relations and conversations. Every night the research team and I stayed in small villages in the Somali Region, the khat arrived in the afternoon. Men would gather in the town waiting, and then disperse to the place where they would chew. Where you chewed and with whom you chewed and shared khat mattered terribly.

Chewing a bundle of fresh khat leaves produces a mild sense of euphoria, energy, and social connection—in Somali, *mirqaan.* As such, it undoubtedly facilitated flows of conversations and interviews with men. Much information gathered for this research was collected as men chewed khat around me, even though I did not participate. (I "tasted" khat leaves twice, for the mere experience at men's insistence, but I did not "eat" khat or experience a mirqaan.) The social, psychological, and physical effects of khat chewing are understudied in the medical literature (Odenwald et al. 2009), but still, most people we met assumed there were both mild unintended side effects, such as decreased appetite, and more serious side effects, such as psychological disturbances.

My primary gifts to compensate male informants were batteries (for the

omnipresent radios and flashlights), coffee, and pens. Farah Mussa, who chewed every day, would share an extra large khat bundle with a few informants who he said were "addicted" to khat, were leaders of the community or extended family members, and were people that already expected to get khat during the interview. He shared his khat independently (or as independently as possible) of our compensations for interviews. The centrality of khat to life in the northern Somali Region was evident in the ways in which men cared for their bodies, treated illness, decided between work opportunities, and prioritized cash spending. This is a topic for future research in its own right.

Khat chewing was viewed as inappropriate for women primarily due to its ability to exploit or cause "holes" in the human mind. Chewing khat was not viewed as an appropriate activity for women (a subject I will turn briefly to in Chapter 3). Men's minds were also perceived to be (variably) vulnerable to both spiritual and psychological disturbances due to their frequent consumption of khat leaves.[56] Several instances of illness among men were caused by "weaknesses" or "holes" in their minds brought on by excessive and prolonged khat chewing or the mirqaan. One conversation about khat between my husband, Farah Muusa and Yonis, a man from Degago, continued long after an ethnographic interview had finished. Yonis addressed many popular concerns about khat. Farah Mussa took notes on their conversation, and later wrote,

> Yonis said khat is a bad thing. Even worse than beer. "It is like changing your money with a problem," he said. He also mentioned that some people become aggressive against their wives and children when they stop chewing chat. Yonis is addicted to khat and now he recognizes why his mother used to advise him not to chew. He said that some people can't move their bowels if they do not chew,

[56] Consequently, Somali women I knew did not chew *khat,* and a few men I met abstained from chewing after reportedly having bad experiences.

> but that's just what they made their mind up (it is an excuse) but it's not true. David asked if there are diseases that are associated with khat chewing other than constipation. Yonis did not mention that disease, but said that khat impacts mainly the financial expenses and behavioral changes, adding that he is planning to stop chewing and he advises his smaller brothers and sisters never to chew. David also asked, "how long do the behavioral changes from khat last, like stopping anger against family?" Yonis said, "it takes around five to six months to forget the impacts and it also depends on ones intention of how of the extent he wants to forget it."

Gender Dilemmas

While conducting interviews with various shopkeepers, health providers, and policymakers, my clothing and modesty were never explicitly or rudely made issues; I was considered a professional, American woman, and my dress reflected as much. I wore pants and long sleeves, and resembled other Americans and Europeans people had known or seen at work and on television. However, during the times I stayed in the rural community field sites, my clothing decisions became much more important. Women would very politely take me aside and whisper that I should, "close" (*xidh*), or cover my hair and body, in order to show proper respect for Allah. "What does your husband think of you?" they would ask nicely, but coyly. On the second day staying in Degago for a lengthy period, I began to wear a scarf to cover my hair. On the third day, I wore a Somali-style dress, or a *shiit* (pronounced like "sheet"), and a long scarf or hijab completely covering my shoulders and hair. That day, while in the market, the women ran up to me, laughing and smiling, saying, "*TODAY* [with emphasis] you look beautiful."

Although men in Aysha woreda were very respectful toward me, most were not accustomed to interacting with women outside their family, even when modestly dressed. During much of the day, men and women existed separately, taking part in different activities, and spending most time with their own gender. It was therefore unusual—although not wrong or taboo—for me to spend private time with men in the context of an interview. I noticed this right away from men's sideways glances, lack of eye contact, and reticence to speak openly about the subject at hand. In order to make men more comfortable, and to enable them to speak freely about the topics of the research, I engaged both my male research assistant, Farah, and my husband David in the interviews. I gave Farah more control over the conversation, allowing his translations to include general explanations of the research process and introductions to my husband and to me. Then David would typically begin the interview, asking the initial questions about personal history, clan relations, employment, livestock, and recent illnesses. After experimenting with David and Farah largely leading the beginning of the interview, and then me chiming in with more questions further along, we were able to make men feel more at ease.

Despite these and other adjustments to alternative gender expectations, roles, and appearances, I did not develop as close relationships with male informants as with female informants. However, my husband did, and his observations of daily life, gender roles, and gender relations have been invaluable to this research. Farah Mussa also became a very close friend to us both through the course of this research; unlike other men I knew less well, by the final months of research he was able to talk openly to me about the

dynamics of sexual relationships, domestic violence, gender roles, and even female genital mutilation/circumcision.

Political Insecurity

For the duration of this research between 2007 and 2009, persons residing in the northern Somali Region and persons who identified as in the Issa clan remained largely uninvolved in conflicts between the Ethiopian government and the Ogaden National Liberation Front (ONLF) and between Somalia, Ethiopia, and Eritrea. The Issa clan leadership has maintained relatively positive relationships with Ethiopian government officials and the Ethiopian People's Revolutionary Democratic Front (or EPRDF, the ruling coalition of political parties in Ethiopia), and Issas, in general, are considered allies of the Ethiopian government contra the positions of leaders from the Ogaden clan further south. Travel and research within the northern Somali Region was safe throughout the research period, although there were movements of Ethiopian soldiers and ONLF fighters within 50 miles of Aysha woreda, in the area surrounding Jijiga, closer to the border with Somaliland, and south of Harar.

There remained an air of insecurity though, not generated by Somali insurgents but primarily by the actions of the Government of Ethiopia. In January 2009 the Members of the Ethiopian Parliament passed a bill that banned all foreign agencies from work related to human rights, civil rights or conflict resolution, and also banned all foreign agencies from the country that receive over 10% of their funding from sources

external to Ethiopia (Amnesty International 2010). Of course, this meant that many humanitarian and development NGOs in Ethiopia had to retool their missions – or at least effectively re-word them – in order to stay in the country. A few weeks later while I was in Jijiga, a staff member of UNHCR there warned me that a Harvard University graduate student had recently gotten into trouble for asking research questions about "human dignity" in the refugee camps in Ethiopia and in Jijiga. She had suddenly disappeared after only two weeks, and as it turned out later, her visa was revoked and she had to leave the country.

Then in July 2009 the federal government of Ethiopia deported 15 American students attending Stanford University who were teaching English in communities in the eastern Oromiya Region for the summer. Although far from Aysha, they were located near ONLF-contested areas southwest of Jijiga. Ethiopian police raided the homes where the students were staying, detained the students without notifying the U.S. State Department, questioned them for one day, and then transported them to Addis Ababa. They were summarily deported. According to VOAnews.com, the students were accused by the police and investigators of asking questions about the disputed 2005 election and the upcoming 2010 national elections, and officially they were charged with having improper visas. Residents of the communities were later told by governmental officials that the students were deported because they carried the swine flu virus (Arnold 2009). Around the same time, Human Rights Watch (2008, 2010) reported unlawful detention of hundreds of politicians and activists who opposed the Federal Democratic Republic of Ethiopia or the dominant EPRDF. Journalists who followed up on these detentions by

interviewing neighbors and family members were also arrested and deported.

To avoid trouble or misunderstanding, prior to commencing research, I obtained from the Ethiopian Ministry of Health at federal, regional, and local levels both permission for research and assurance that regulatory authorities are not enforcing the certification of drug vendors. The unregulated sale and use of non-prescribed pills are normative practices there, and the limitations and ethics of this kind of research are well established (Kamat and Mark Nichter 1998; Hardon 1987; Hardon and al. 2004; Bledsoe and Goubaud 1987; van der Geest and Whyte n.d.). Additionally, and importantly, I did not ask Ethiopian citizens direct questions about how they voted, how they felt about the Government of Ethiopia or the ONLF, or how they felt about various parliamentary measures. On the one hand I regret not being able to supplement Chapter 6 and other parts of the dissertation with political opinions and commentary from Somalis, yet on the other hand, I was glad to avoid harm to or investigation of the research participants.

CHAPTER 3.

CAMEL MILK, AMOXICILLIN, AND A PRAYER: MEDICAL PLURALISM AND CHANGING POPULAR HEALTH CULTURES

Throughout this dissertation, I explore ways in which popular health cultures and health systems are shifting due to the expansion of global health and humanitarian regimes into rural health systems, rising knowledge about and popularity of certain biomedical technologies and treatments, government campaigns to supply essential medications in remote communities, and rampant crises of trust in many local providers. More broadly, this dissertation argues that Somalis' experiences of humanitarian crises and ethnic-based violence as well as their historical marginalization from Ethiopian sources of power shape how they perceive and negotiate medical choices and expertise. In order to understand these larger processes, in this chapter I discuss a series of popular health topics and shifting demands for various forms of medicine in the aftermath of medical humanitarian interventions.

I begin by framing my discussion with a portrait of the Mobile Health & Nutrition Team operation Elahelay[57] and their work to bridge the conceptual spaces and incongruities within northern Somalis' pluralistic and dynamic popular health cultures. In the northern Somali Region, boundaries between discrete illness designations and etiologies were contingent and often lacked consensus, and so I draw on Nichter and Nichter (1996:120) in their use of "taskonomies" of illnesses (instead of "taxonomies") to

[57] The community of Elahelay, and all geographical features mentioned in this chapter are described fully in Chapter 1 and 2.

highlight the ambiguous processes of illness reporting, illness labeling, therapy management, and healing.[58] Furthermore, I go beyond an assumption that emic perspectives and indigenous ideologies of healing are predominantly "traditional" or non-biomedical; this data reveals routine ways in which Western biomedical technologies and concepts have been appropriated, changed and used metaphorically by laypersons and so-called "traditional" healers alike. Furthermore, the myriad ideas and materials exchanged during medical humanitarian relief operations were vital to dynamic local understandings of healing, medicine and the human body. So rather than providing a compendium of contemporary "traditional" versus "spiritual" versus "biomedical" practices, in this chapter I discuss five topics vital to people's experiences and management of illness and health. These topics include: camel milk and the management of digestive bile (*dacar*); women's experiences of pain in their reproductive organs; Qur'anic healing rituals for the alleviation of spirit possession; perceptions of popular pharmaceutical medications; and the rising popularity of diagnostic tests (*imtixaan*). Each of these topics arose time and again in informal conversations as well as ethnographic interviews; their near constant consideration by northern Somalis reveals both the diversity of simultaneous medical practices prevalent in eastern Ethiopia today as well as important contemporary changes in how people negotiate and use the various

[58] Nichter and Nichter (1996:120) provide a broad definition of "taskonomy" as a term that, "draws attention to the flexibility of illness labeling influenced by social relations, the relative advantages of representing illness in coextensive ways, and emergent knowledge associated with the practical task of caring for the ill. It recognizes performative aspects of discourse which influence the levels of specificity used to describe an illness episode as well as practical dimensions of illness treatment which influence how it is identified in relation to treatment options. Illness labeling and symptom reporting are invested with meaning and emotion. They are also strategic. …"

medical resources at their disposal. A glossary of common illness, healing and body terminology is provided in Appendix A.

The Mobile Team in Elahelay

In selections from my field notes below, I provide a glimpse into a typical day with the UNICEF-funded government administered Mobile Health & Nutrition Team (or more simply "mobile team"), in the small community of Elahelay.[59] In the previous year, Elahelay had experienced consecutive delays and declines in rainfall totals, recurrent epidemics of diarrheal disease, and a rise in the number of severely malnourished children. At the time of the particular visit I describe below, the mobile team to Elahelay consisted of three clinicians: Abdul, Hussein and Maryan. Abdul and Hussein were both young Somali nurses who had previously worked on other mobile teams elsewhere in the Somali Region of Ethiopia. Maryan, a twenty-year-old single Somali woman, had graduated one year before from a vocational training program in Dire Dawa to be a pastoralist health extension worker. She accompanied the mobile team for six weeks in November and December 2008 in order to gain practice in disease classification and the administration of vaccinations. In January 2009 she returned to her post in the town of

[59] Specific research methods, including ethnographic research with the mobile team and in the community of Elahelay are outlined in Chapter 2. A description of the mobile team intervention may be found in Chapter 1.

Degago where she was one of two pastoralist health extension workers staffing the small health post there.[60]

The mobile team was lauded by residents of Aysha *woreda* (district) for providing free medications and nutritional supplements in targeted communities – but not everyone qualified for treatment. As discussed in Chapter 1, mobile teams were designed to provide vaccinations, a few essential medications, BP-5 supplementary biscuits, and PlumpyNut™ therapeutic food to malnourished infants, children under five years of age, and their pregnant and lactating mothers. Communities as a whole qualified for mobile team visits based on local rates of acute malnutrition in children under five years – as expected, the mobile team visited vastly underserved and impoverished locales. Consequently, mobile team nurses had to repeatedly negotiate and explain the rationale behind such limited beneficiary groups and material donations to numerous sick and impoverished men and older women without access to other medicines or facilities.

> *Field Notes November 22, 2008 Elahelay with the Mobile Team*
> *...*
> *The four mobile team members have been sitting in the clinic for four hours without a break. Suddenly, Hussein rises and runs out of the building to get some water from our car, pouring it into his mouth. Before he can turn around, 15 people surround him asking him to look at them. He jogs back into the clinic with his head down, ignoring the growing mass.*
> *...*
> *There is one woman here now, probably 40 years old. She has been coughing for a long time and is experiencing night sweats. Abdul and Hussein think she might have TB, and want to take her with them to Aysha for a sputum test. Abdul checked her out, Hussein confirmed, and then everything was translated, without*

[60] Most Somali pastoralist health extension workers in Ethiopia spent at least one four-week stint with a mobile team in their area; this was coordinated by the Somali Regional Health Bureau as a way to supplement the extension workers' training beyond their initial education.

a single mention of "TB" or its synonyms – instead the symptoms were mentioned in English ("coughing," etc.) as well as the need for "a test" somewhere else.

There is another mother behind her in the queue with three children between one and eight years old – all of whom have bloody diarrhea or dysentery. The mom has a MUAC [mid-upper arm circumference] *of 18, and so is severely malnourished. They check her blood pressure and then the color of her eyelids for iron-deficiency anemia. Then she gets a RDT* [rapid diagnostic blood test] *for malaria. She waits for the results a few feet away from the table. The result was negative, but the whole family receives courses of antibiotics for the diarrhea and several BP-5 supplementary biscuits to take home.*

A few moments later, a middle aged man shoves his way into the clinic, shouting, letting everyone know he needs to be seen but there are all these women and children in line in front of him. Hussein takes him aside and talks to him about his problem. Afterwards, as work resumes, Hussein and Abdul chuckle and shake their heads at what they call a desperate and rude man.

Another young mother is talking to Abdul about her abdominal pain [mindheeli]*; she shows him on the outside of her dress where it hurts (her uterus). Ali suspects she has a UTI* [urinary tract infection] *and prescribes and provides a short course of doxycycline.*

...

Next, a beautiful, tall woman, 28 years old, walks in with an infant wrapped in the scarf at her waist. She is also complaining of pain in her uterus. She gave birth six days ago, and so they assume (without the ability to perform a proper examination) she has an infection from the birth. Abdul screens her for malnutrition and anemia (both negative), and then prescribes amoxicillin since she's breastfeeding. As the woman leaves she picks up a piece of rusty rebar, half a meter long, and takes this with her out the door. Abdul says in an aside to me that this is to protect her and her baby from the evil eye and a malevolent jin [demon].

Another woman is forcing a toddler to walk into the clinic, and then forcing the child to sit on the chair next to Hussein's examination area. The child screams and resists. Hussein picks the child up by the arms and hastily takes him outside. The mother follows, reluctantly. Hussein says loudly [to me, in English]*, rolling his eyes, "This child is healthy! Why has she brought him here? She just wants medicine!"*

...

There is a man here now that keeps pulling down his eyelids with one finger as Abdul speaks to him, in what Abdul assumes to be an enactment of the screening for iron-deficiency anemia. He legitimately looks as if he has an eye infection

though, so gets one application of an antibiotic eye ointment designed for children.

…

Maryan is in the hallway on a wooden bench giving immunizations and growth charts to a long line of children and mothers. … Maryan works with both of her gloves torn and falling apart. Even so, she uses the same gloves nearly the whole day, until a baby vomits on her hands, and she is forced to change. There is a woman next to her that doesn't want an injection of any kind, but wants another kind of pill from the mobile team. Maryan says she won't be able to give the woman any medicines if she refuses to get a vaccination, and in response, the woman threatens to buy drugs in the market instead. Hussein joins in the discussion, and there is much laughter and loud commands and back and forth. Hussein insists she at least give the baby a vaccination, but she says that she and the baby are "the same" — neither one needs a vaccination! Finally the woman agrees to get a shot from Maryan, and takes it bravely with her head turned away to the side.

…

Even though the clinic is nowhere near empty, Abdul and Hussein start to load the truck and close down their operation. They are obviously both exhausted and hungry.

Mobile teams, in the Somali Region of Ethiopia at least, were the vanguard of efforts to transform provisional funding for humanitarian emergencies into sustainable developments of the health system (UNICEF 2008). In my time observing them in the northern Somali Region, they accomplished even more than that: they faced a huge array of patient presentations as well as numerous heated social confrontations, and through it all, they garnered high esteem and trust from local populations. As shown in this excerpt from my field notes, the mobile team did constant translational work between what were oftentimes incommensurate and vexing illness presentations and labels, while at the same time repeatedly explaining and apologizing for the limitations of their mission and target population. Many times, the mandate of UNICEF and the government agencies and programs it funded – to prioritize the material needs of mothers and children above all

others – conflicted with local opinions about triage and levels of need. In fact, according to local leaders and the mobile team members themselves, many of the sickest and neediest persons crowding into the health post that day were middle-aged tuberculosis sufferers, physically disabled individuals, and severely arthritic elders. Mobile team nurses frequently bent the guidelines of the mobile team program in order to provide nutritional supplements, medical referrals, essential medications and medical advice to such individuals who did not officially qualify for aid. The antagonisms and equivocations so common during the mobile team clinical encounters both highlight the broader challenges of providing (necessarily temporary and limited) medical humanitarian assistance to impoverished populations, and underscore the eclecticism and ambiguity of the popular health cultures in which such humanitarian operations unfold.

At the same time, the mobile team nurses were not callous or austere; they never ministered merely to what Agamben (1998) called the "bare life" of victims – physical bodies and physiological pathologies, devoid of sociality and sentiment. Instead, even by the end of their second week living in the northern Somali Region of Ethiopia, Abdul and Hussein had shared evening *khat* with most village elders, kebele presidents, and religious leaders. And beyond filling in the necessary patient logs and vaccination cards, they had begun remembering their patients' names, kinship relations, and personal histories. Because of their roles as respected clinicians and equally because of their affability, Abdul and Hussein were intimately interpolated into community life, local politics, and local interpersonal relations.

Medical Pluralism in the Northern Somali Region

This whirlwind with the mobile team in Elahelay highlighted for me several aspects of the pluralistic and changing popular health cultures in the northern Somali Region. Much of Somalis' activities to manage illness draw on systems of Islamic medicine and Sufi healing practices (Lewis 1998). Somalis' notion of health (*ladnaan*) is largely dependent upon two forces: ultimate divine causality ("Allah is the cause of all diseases") and balance between bodily fluids or humors (Lewis 1998, Sengers 2002). As outlined in Appendix A., I follow Sengers (2002) in her categorization (not without exceptions and overlaps) of commonly reported illnesses within such a system: functional illnesses caused by humoral imbalances; structural illnesses or disorders of bodily organs (i.e. the heart, kidney, or skin); psychological illnesses or disorders of the mind and brain; and spiritual illnesses caused by the actions of an invisible *jin*[61] (a demon or spiritual being, spelled jinn, djinn or in Arabic جني) or satan (*shayddaan*). As will be shown, the composition of and relationship between these categories were changing due to the increasing numbers and variety of pharmaceutical medications and diagnostic tests available (and indeed marketed) to Somalis in governmental healthcare facilities, humanitarian interventions, and unlicensed pharmacies.

[61] Drieskens (2006:13) defines jinns as: "invisible creatures, not absolutely evil but rather unpredictable. The Qur'an states that Allah created three kinds of intelligent creatures: angels made of light, humans made of clay and djinns created from smokeless fire. Belief in djinns is therefore not really superstition; it is an integral, though somewhat controversial, part of religion." Here she is speaking jinns affecting Cairenes in Egypt, but the definition she provides applies aptly to northern Somalis as well.

Humoral pathologies – primary among these illnesses resulting from excessive digestive bile (*dacar*)[62] and stoppage of blood flow (*dhiig* or *caado,* in the case of menstrual blood) – are managed by triggering diarrhea or vomiting, inducing bleeding, consuming camel milk, feasting or otherwise changing the diet (*buulee*), and increasingly, consuming certain pharmaceutical medications. Additionally, many northern Somalis looked to the traditional nomadic pastoralist diet – one consisting of daily camel milk, occasional goat's and cow's milk, sorghum and sweet hot tea plus occasional supplements of meat – as one that generally promotes health and strength (*xoog*). The ideal male body was described as similar to that of a camel: sinewy, indefatigable, and capable of surviving on limited natural resources. By contrast, diets associated with urbanization and sedentization – consisting of "oily" (*saliid leh*) or "soft" (*jilicsan*) foods such as pasta, potatoes and rice, as well as sugar (*sonkor*) and sweets (*macmacaan*) – were perceived to be the primary causes of adults' bouts of indigestion, diabetes, heart disease, and chronic fatigue among other ailments. In particular, when levels of *dacar* rise or are uncontrolled, bodies are more vulnerable to both malnutrition and infection.

Possession and attack by malevolent jinns are serious occurrences for a majority of northern Somalis at some point in their life. Spiritual illnesses and disorders are typically diagnosed and treated by local mullahs or sheikhs who are able to discern the etiology of a given presentation, then dominate and dispel the jinn through invocation of the Holy Qur'an and words of the Prophet Mohammad. Accordingly, most Somali

[62] *Dacar* has several meanings: yellow digestive bile, an aloe plant, a bitter taste, or a disease of excess bile in the body.

residents of the Aysha woreda of the Somali Region of Ethiopia subscribe to Qur'anic healing for the treatment of spiritual illnesses, or what Sengers (2002:175) calls in the Egyptian context a Qur'anic "exorcism cult." Spiritual disorders primarily affect women, as women's bodies are perceived to be more prone to "openness" and "attack" by demons than men (as noted elsewhere in Boddy 1987, Drieskens 2006, Fadlalla 2005, Inhorn 1994, Sengers 2002). Mullahs who performed Qur'anic healing in the northern Somali Region during this research were well regarded and highly trusted; they were often local leaders.

Additionally, memories of past humanitarian relief operations, in which expatriate doctors or Somali mobile team nurses provided highly effective and free therapies, were repeatedly mentioned in comparison both to young community health workers staffing rural health posts and *habasha*[63] clinical care providers in public health facilities in Aysha and Dire Dawa. Often, people desired spiritual guidance or biomedical treatments over herbal remedies (*geedo*) or other so-called "traditional" healing practices (*dawo dhaqmeedka*), but were unsure of whom or what to trust. Furthermore, people frequently disagreed about courses of action and the reputations of various providers. And many persons admitted to changing their minds about the quality, safety and efficacy of various therapies.

In sum, popular health cultures were at once pluralistic and ambiguous. Treatments for a range of commonplace illnesses – everything from indigestion to

[63] "Habasha" (otherwise spelled "habesha" or ሐበሻ in Amharic) is colloquially defined as persons of Amhara or Tigrynia ethnicities residing in Ethiopia or Eritrea. The term habasha for many rural Somalis in eastern Ethiopia indexed not just ethnicity and language group but political support of the current Ethiopian government, although many habashas would object to this usage and association.

infertility to tuberculosis – drew upon multiple strategies at once or in close succession: consultation with the mobile team or other trusted biomedical provider; consumption of camel milk to trigger vomiting or diarrhea of excess *dacar*; hands-on traditional therapies such as massage and burning the skin at the perceived site of pathology; consumption of over-the-counter medications and vitamin tonics; and Qur'anic healing. Many persons preferred to drink raw camel milk to manage levels of digestive bile (*dacar*) but simultaneously also consumed short courses of antibiotics. Many continued to seek spiritual healing even as they increasingly demurred herbal remedies (*geedo*) and other non-biomedical healing modalities. Several women with whom I spoke struggled with infertility, and in an effort to conceive they sought both counsel with local mullahs to exorcise a *jin*, as well as biomedical counsel and abdominal ultrasounds at private hospitals. Numerous persons wondered more generally: pharmaceuticals are potentially powerful, but which ones are the best, and from whom should I obtain them? Who should I trust to understand my symptoms and properly diagnose and treat illness? How do pharmaceuticals interact with digestive flows, monthly menstrual cycles, fertility, and even *khat* consumption? For many, such questions transcended the perceived expertise of most biomedical clinicians in Ethiopia. In the face of sparse trusted biomedical healthcare providers, they instead most often and first turned to local experts: mullahs who also provided antibiotics or birth attendants who accompanied women to get sonograms.

What is "Traditional Medicine"?

So-called "traditional medicine" and medical pluralism have a long documented history both in Ethiopia and Somalia (Abebe 1991, Beshaw 1991, Hassan et al. 1984, Kebede et al. 2006, Kloos et al. 1986, Lewis 1971, Vecchiato 1997, Young 1975, 1976, 1977, and 1980). For many persons residing in Ethiopia and Somalia, what the public health and social science literature call "traditional medicine" as well as a range of biomedical procedures, have long been open to multiple appropriations. Often, healers and herbalists in the Somali Region recommended or provided pharmaceuticals or used biomedical diagnostic criteria (also shown in Hassan et al. 1984). At the same time, persons trained in biomedicine and public health frequently professed adherence to a regimen of camel milk for the prevention or treatment of gastrointestinal disorders and general malaise. Nearly all Somalis I spoke with – whether they trusted herbal therapies or biomedicine or both – acknowledged the divine source of all illnesses, the influence of supernatural beings on the physical bodies of humans, as well as the necessity of Qur'anic healing in response.

The Somali-language term *dawo dhaqmeedka*, literally translated as, "traditional medicine," was used almost exclusively in contradistinction to biomedical treatments, and was spoken mostly by Somali biomedical providers, policymakers and young adults. In conversation, it set pharmaceutical medications, hospital experiences and diagnostic biotechnologies apart from other local, historically commonplace therapies. The phrase referenced a range of general *practices* and *materials*, but not typically practitioners,

since as previously stated, most practitioners drew on multiple therapeutic strategies and healing modalities. Medical practices that were described by Somali laypersons and healthcare providers as "traditional" included consumption of herbal teas and mixtures; the placement of herbal lotions on the fontanel or skin; massaging of the body with animal fat to cure swelling and pain; burning or branding (*gub*) the skin at the site of perceived pathology in order to resume the flow of bodily fluids; and scraping or scratching (*xoq*) the inside of children's anus or nose to induce bleeding.

All of these except the various herbal remedies were considered by staff of the Somali Regional Health Bureau in Jijiga to be "harmful traditional practices."[64] Several public health initiatives in the Somali Region of Ethiopia during the year of this research were designed to combat traditional forms of healing: the Somali mobile teams provided information and educational materials on the harms of traditional medicine to local pastoralist health extension workers; clinicians in the Aysha Medical Center were provided information on the prevalence of various "harmful traditional practices" during their vocational training; and Somali policymakers within the Regional Health Bureau and UNICEF were in the process of designing community-wide outreach and educational efforts to supplement the (largely informal) work of mobile teams. As such, *dawo dhaqmeedka* was a concept and a discourse that had risen in popularity and usage by policymakers and biomedical clinicians in their critiques of certain medical practices and

[64] "Harmful traditional practices," in the public health and policy literature about Ethiopia, usually only refer to female genital circumcision/mutilation or early marriages practices (Assefa et al. 2005, FDRE 2006, Ministry of Health 2006, Jeppsson et al. 2003, Kebede 2006). However, in conversations and interviews with Somali staff at the Somali Regional Health Bureau and UNICEF in Jijiga, the practices of scraping the anus and nasal cavities of children and burning the skin at the suspected location of pathology were also considered "harmful traditional practices.

popular health cultures in Ethiopia. The term was also increasingly common among northern Somalis who publicly demurred or questioned the efficacy and legitimacy of non-biomedical forms of healing, in particular during qualitative interviews or focus groups with aid agencies.[65] Somali laypersons occasionally used this language during initial ethnographic interviews for this research. Several men and women used the term "*dawo dhaqmeedka*" early in our conversations to index their knowledge of and preference for biomedicine over "traditional" modalities. Later in these interviews or conversations, the phrase "*dawo dhaqmeedka*" would fall out of use, and vocabulary would instead include more specific terminology such as herbalists (*geedole*), religious healers (*wadaaddo*), local midwives or birth attendants (*ummuliso*), and unlicensed rural doctors (*dhakhtar baaddiye*).

Characteristics and Supplies of Popular Pharmaceutical Medications

Only a small selection of essential pharmaceutical medications was available to persons in Ethiopia who lived outside major urban areas. In Aysha woreda, for instance, medications available either from the small health posts or from the larger Aysha Medical Center included, variably: basic antibiotics (tetracycline, ampicillin, chloramphenicol, antibiotic ointments, co-trimoxazole, amoxicillin until it ran out, and rarely, ciprofloxin), anti-malarial medications (coartem and chloroquine), anti-parasitic medications

[65] These statements are based on numerous ethnographic interviews and conversations with habasha and Somali policymakers working in the Somali Regional Health Bureau, UNICEF Ethiopia, as well as the UN World Health Organization.

(metronidazole, tinidazole, and occasionally mebendazole), analgesics (acetaminophen, aspirin, and more rarely, metamizole), hormone birth control pills (even though, in my observations in the northern Somali Region, these packages were never opened or used), plus a small selection of antacids. Many of these pharmaceutical medications could be obtained from small private vendors or unlicensed pharmacies in villages throughout the woreda; and many had been available to the local populations in the northern Somali Region for three decades or more.

The most popular and well-known medications to Somali laypersons had Somali names or colloquialisms. These included: *imbi oofeed* (co-trimoxazole capsules used for diseases of the lungs), *imbi caloole* (co-trimoxazole capsules used for stomach problems), *qormadobe* (ampicillin capsules, which means literally, "black necks"), *qorcase* (tetracycline capsules, which means literally, "red necks"), *baasalin* and *baasalin irbad* (penicillin and penicillin injections, the latter phrase literally translated as "broken penicillin"), and *kiniin* (formerly this word referred to quinine, but now refers to chloroquine, or is used as the Somali word for "pill" or "capsule" in general).

Several of the pharmaceuticals commonly sold in the Somali Region were largely indistinguishable from each other: the most common forms of co-trimoxazole antibiotics in government clinics, magnesium antacids, and acetaminophen were all white, chalky in texture, bitter tasting, and approximately the same size and shape. Plus, all tetracycline capsules, whether purchased on the black market or in government clinics, were red and yellow. Such ambiguity generated anxiety. A few informants openly mused about whether inexpensive contraband prescription pills were responsible for instances of

poisoning or death in sick individuals; others speculated about whether or not the Ethiopian generic pills had adequate active ingredients to effectively treat disease. Furthermore, medications from unlicensed vendors were frequently sold without packaging materials or instructions; most persons used the medications according to advice given them by relatives or other trusted lay health advisors. When obtained from a distrusted or unlicensed vendor, the ambiguity of packaging compounded the uncertainty people felt about that medicines' origins and safety. These issues will be discussed in greater detail in Chapter 4.

Camel Milk and the Management of *Dacar* (Digestive Bile)

One warm May evening in Elahelay, while a few local men chewed chat leaves and Nimco and I rested on mats under the stars, conversation turned to the wonders of camel milk. The men present began lamenting the current dearth of local camel milk. Although the rains had begun in some towns nearby, Elahelay had not had a drenching rain since long before the last *jiilal* (long dry season between November and March). Only one milking camel had been grazed in the dry riverbed nearby, but a lightning strike a week before killed the boy herding her, leaving the camel vulnerable to attack. Sure enough, a hyena bit the camel's Achilles tendon and the camel had to be slaughtered. All of us enjoyed her meat that day, even under the terrible circumstances, but now a week later there was no milk anywhere. A portion of the conversation went:

> Hassan: [Camel milk] is important for all diseases. It takes the *dacar* [excess bile] out of the body; it gives the body energy as well.
>
> Abdirahman: Camels eat different tree species, each with its own value and vitamins, so the camels get these as well. Most important thing is the diarrhea, which decreases disease in the body and lubricates digestion.
>
> Muusa: Camel milk plus medicine [*dawo*, meaning biomedicine or pharmaceuticals] is the perfect cure for disease. … Worms and sugar in the fresh milk [*daay*] give it the healing properties and its ability to induce diarrhea. Fresh milk is more likely to cause effective evacuation of dacar than older milk [*karuur*]. The milk in general has less effect on people that drink it daily for a long time; pastoralists don't get diarrhea from it because they are used to it. For other people, every time they take camel milk they have diarrhea, but this is seen as a positive thing for your health.
>
> …
>
> Abdirahman: Camels, even if there is a drought, like now, still produce milk. Even if the acacias are dry, there are other tree species the camels will eat.

Camel milk was central – symbolically more than materially – to proper bodily functioning, growth, and digestion. As such, regular camel milk consumption was seen to protect the body from a host of infections diseases and diseases caused by malnutrition. Soured or stored camel milk (*karuur*) and sweet fresh camel milk (*daay*) were both contributors to the caloric and protein intake of northern Somalis on the rare occasions when milk was plentiful.[66] But even when camel milk was lacking – as it was much of the time in the northern Somali Region – it was eulogized and remembered in countless stories, songs and proverbs.

[66] Depending on the weather and humidity, after one to three days, unrefrigerated fresh camel milk begins to sour. Most camel milk is stored in gourds, rinsed and re-used plastic water bottles, metal canisters, or plastic or metal thermoses. Fresh milk is often kept cool for a few hours by using wet cloths wrapped around the storage container.

Dacar (digestive bile) was also a preoccupation for many persons, especially persons who were already ill, were sedentary, or lived in urban areas and had a diet high in oily, soft and sweet foods. Dacar was often referred to in the plural form as a fluid mass of individual beings, or tiny worms,[67] that reside in a person's gut and consume food. Dacar, like all animals, had to be fed or else they would become agitated and rise up through the throat. The term *dacar* also at times referred to a disease state, when food and bile stagnates inside the body too long or the entire body is flooded or swarming with excess bile. Symptoms of excessive dacar included heartburn, diarrhea, fever and vomiting, and these symptoms helped the body purge excess dacar and return to a state of health. Attention to the color of diarrhea helped people distinguish pathological or harmful diarrhea (e.g. *shuban, daacuun, geed sare* among other types) from that which was normal and cleansing. Malayka, an articulate evangelist for camel milk consumption and a mother from Degago in her thirties said,

> Diarrhea when you're drinking the camel milk is green in color, and that is a healthy kind of diarrhea. Diarrhea that is a disease is different in color. Green color is healthy. If you drink the goat and cow milk, and if you want the dacar to come, they [the dacar] will not because when you drink those milks, the dacar just sits there in the milk. And if you want to vomit, you cannot because dacar just sits in the stomach.

Stabilization of dacar levels occurs through vomiting or diarrhea was euphemistically phrased as *isdacar-bixin* (literally paying up the dacar) or alternatively *dacarka imanayaa* (the dacar coming up). Camel milk still warm from milking (*caano*

[67] However, in my experience, people did not confuse *dacar* with parasitic intestinal worms (*gooryan*). *Dacar* was fundamentally a liquid – it was the word for digestive bile despite its sometimes description as possibly containing smaller beings.

kulul or *daay kulul*) was preferred as a treatment for humoral imbalances, whereas older soured milk was consumed when possible as a dietary staple or supplement. Hassan, a father in his forties, had long suffered from a recurrent and often severe acid reflux. He explained the use of camel milk as follows:

> Many people have *laabdoox* [heart burn or acid reflux] because of the dacar rising up from their stomachs. You have to keep drinking the camel milk after the first time, or the dacar will become angry and cause even worse diseases. If you stop drinking the camel milk too soon, the dacar will wake up and become active again, because it hasn't been fully evacuated [out of the body via diarrhea or vomiting]. It takes a while to evacuate as much dacar as you need to. As soon as it's [the dacar] gone down, after evacuation, you feel light, dizzy, and weak. At that time, you know you've gotten rid of enough, and so you can begin to eat solid foods again.

Persons residing in Elahelay and Degago – most of whom had been nomadic prior to outbreak of interclan and interstate conflicts in the late 1980s and 1990s – frequently bemoaned their diet structured primarily by UN World Food Program rations (including bags of corn-soy blended flour, whole wheat grains and vegetable oil), pasta fixings and sweets purchased in small shops. It was a diet very low or lacking in camel milk during the *jiilal* and other dry times of the year. Goat's and cow's milk were viewed by most persons as nutritionally inferior to and less tasty than camel milk; commercial powered milks referred to by their brand-names like "Coast" and "Nido" were prized for their taste but like other cow milks were seen to bestow the lowest amount of nutrition (*nafaqo*).[68] Camel milk was also viewed as the most convenient and versatile type of food: travelers

[68] Coast and Nido were also exorbitantly expensive compared to milks collected from livestock. Only a few mothers I met regularly fed infants or children powdered milk; such products were typically purchased in bulk by husbands or uncles who resided for work in Dire Dawa or Jijiga.

or men herding animals more than a one day walk from town might carry camel milk enclosed in a gourd for up to three weeks (although most persons only drank stored camel milk for ten days because the taste becomes strongly sour). Again Malayka explained:

> If a person has come from Dire Dawa up to here [Degago] or to Djibouti, if he has camel milk and his is coming by foot, he can drink the camel milk every time, for every meal, even if he takes a long time. But the other milk like goat's, he cannot use because after one day it heats up and it becomes bad or rotten [*xumaano*].

Camel milk is said to derive its healing properties not just from its ability to normalize dacar and resume gastrointestinal movement, but also, as Hassan mentioned, because of its nutritional composition. Camels graze on anything remotely green – even during a drought or when most plants are browned. Two herbal practitioners I knew could recite at least 80 species of plants camels normally consume in the arid Aysha woreda. Consequently, camel milk was assumed to contain the nutrition of all these different leaves in the surrounding areas, including several species of trees with healing or therapeutic properties (e.g. the *qood* tree). Some persons equated drinking camel milk with drinking a vitamin tonic containing nutrients as well as therapeutic compounds. As such, milk was not drunk merely to empty and the digestive system, but also to reconstitute the gut with essential nutrients.[69]

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[69] Several expatriate staff at the UN World Food Program in Ethiopia, who spent days or weeks travelling to monitor or manage food distributions discussed the benefits of consumption of camel milk as well. Camel milk consumption was viewed as necessary for the expatriate field worker in Somali Region to adapt to the local diet and gain the trust of locals. Long discussions in Addis Ababa centered around how one should consume camel milk as an outsider: (1) do it first thing upon arriving in a community with fresh camel milk, (2) do not consume camel milk when you will not have a toilet for 24 hours, (3) do not travel for two days after drinking it, (4) be prepared to have your entire digestive system emptied within a few hours, and be prepared to have no control over this process, and finally, (5) enjoy the rest of your stay drinking camel milk as desired with no problem.

Some mothers – especially those living further south in the Somali Region or outside settled communities who have greater access to fresh camel milk – promoted the introduction of camel milk to infants as soon as possible after birth. In one group discussion at Malayka's home several women attested that nomadic pastoralist families will often give newborn babies camel milk before the mother's breast milk or colostrum let down. By contrast, when Malayka and her peers in Degago and Elahelay fed their newborns for the first time (*anqartirtaa*), they said they often provided holy water (*biyaha taxaliishalaa*) prepared by the local mullah in lieu of camel milk.[70] Camel milk was the best thing to start [a newborn's life] with (*bilaabanayaa*), she argued, but holy water was seen as the next best substitute.

Khat and Camel Milk

Camel milk was not the only substance used to decrease or normalize levels of dacar. Some men who chewed khat leaves on a regular basis claimed they did so, in part, to regulate their levels of dacar. Abdirahman, for one, found khat was more effective for the prevention and treatment of *laabdoox* (heart burn or acid reflux) than over-the-counter antacids and purgatives. He maintained that as long as he kept a schedule of daily chewing, he had no gastrointestinal problems. Even so, when he enjoyed a fatty meal without afterwards finishing with khat, he said his dacar would rise. Another man

[70] *Biyo taxaliil* or *biyo tahaliil* is holy water that the local mullah's use for various prayers and in the splashing of persons during the reading of the Holy Qur'an. Ceremonies that utilize water or washing for the purposes of spiritual healing or cleansing or protection from devils and jinns are discussed later in this chapter.

explained, "The khat kills the fat in the stomach. … Dacar is grown [or nourished] by fat and other milks [like cow or goat milk] that have more fat in them. Camel milk does not have fat, so it does not feed the dacar."

Chewing khat leaves causes one's mouth to feel dry and sticky.[71] Consequently, men always drank liquid while they chewed. Sometimes there was only water available, but most often, men drank Coca-Cola, sweet hot tea with goat's milk prepared by women in thermoses, or boxes of commercial nonperishable cow's milk purchased from local shops. Notably, men did not drink camel milk while they chewed. As discussed, either camel milk was ingested for nourishment as a meal or snack by itself or with sorghum grains, or more frequently in the northern Somali Region, it was drunk quickly – a half a liter to a liter at a time – in order to trigger the evacuation of dacar.

Pharmaceuticals, Camel Milk, and Dacar

The year of this research, from 2008-2009, the monsoon rains were late and sparse, and Abdirahman's family like other residents of Aysha woreda had access to little camel milk. The dearth of camel milk in Elahelay and Degago was said to have contributed to the local incidences of illnesses and digestive problems, and these had compounded all the other stresses associated with drought such as livestock loss, higher commodity prices, and difficult migrations discussed in Chapter 1. Most of the last several years people could not drink milk daily or even weekly, even if they would have

[71] Khat is also an appetite suppressant, and in lieu of an evening meal, men would often simply chew khat and drink sweet beverages.

liked to. Instead, camel milk consumption was limited to that which could be purchased or brought from afar in the event of a health emergency, and then it was used as a complement to other treatments such as pharmaceutical regimens.

In lieu of or in addition to camel milk or khat leaves, several persons consumed pharmaceutical medications in order to manage levels of dacar. Abdirahman's mother, for one, had long struggled with excessive dacar, but khat consumption was for her an inappropriate and undesirable remedy. First thing every morning, she felt like she had to make herself vomit. But often she could not adequately purge the dacar on her own, so she consumed a variety of over-the-counter antacids, purgatives or laxatives purchased in a small shop in the center of Elahelay. However, such strategies only provided temporary relief from her symptoms, and failed to address the underlying problem of her chronically riotous dacar. Another male informant said,

> U-Lax [a commercial laxative commonly sold in local shops] some people use to get rid of dacar. The private pharmacy open during the refugee time in Degago plus Ali's [private unlicensed] pharmacy in Degago have both sold it. Another alternative to camel milk is *xabag-xaarus* [the sap, literally the stool, of the tree]. But this is also very poisonous and very bitter tasting. Camel milk is nourishing; it leaves some nutrients in your stomach whereas the pills evacuate everything and give you watery diarrhea [*shuban biyoot*] and you have to have additional nourishment to survive the diarrhea.

Again, camel milk was not consumed as a purgative or laxative to entirely cleanse the digestive system. Unlike pharmaceutical medications, it also reconstituted the body with nourishment and normalized levels of dacar.

Camel milk was seen by most persons as a medicine of sorts, yet there was disagreement between individuals about the proper use of camel milk in conjunction with

pharmaceuticals. Dayibo, a young mother living in Elahelay said: "Camel milk is very good [at treating disease]. Milk is better than [pharmaceutical] medicine." But, she warned carefully, you should not take them together for the same illness. I asked, "why can't you take both?" And she replied:

> The camel milk is a medicine [*dawo*] and the pills are medicine, so it is not good to take together because they are two different medicines. So if you take at the same time, maybe you will become seriously ill and the diarrhea [for purging the dacar] will not stop. So it is just like mixing two other medicines – it is very dangerous. You can use … camel milk or you can use the medicines.

Other persons used camel milk to complement and enhance the action of pharmaceutical medications for various maladies besides excess dacar. Malayka explained:

> Malayka: The last disease I had was the malaria [*kaniico xanuunka*]. When I had malaria, I became seriously sick and feverish and so finally I went to the doctor [the health extension worker at the Degago health post]. He gave me the tablet for malaria, and then I took three in succession. And after that, my relative found me some milk [fresh camel milk, she clarified later]. When they brought it, first I vomited the milk, and then I drank and drank, and then I vomited the dacar. After that I felt better.
>
> Me: So, was it the medicine that helped or the milk? [Laughing] or both?
>
> Malayka: [Laughing] If you eat a medicine and if you don't eat [*cuno*], you don't get better. But if you eat medicine and then you drink milk or have other nutrition [*nafaqo*] together, after that you may become better. Milk needs medicine and medicine needs nutrition [to work].

Later in the same conversation Malayka compared the action of camel milk to intravenous glucose (*nafaqo ahaan dee ruuxii* or literally, "nutrition that is inserted into the body") because of its ability to both treat disease and provide immediate nutrition. Camel milk is healing, many said, because of its capacity to trigger diarrhea and thus rid

the body of pathological levels of dacar*,* germs (*geermis*) in the gut, intestinal worms (*gooryan*), and other disease forms. Consequently, my research suggests that pharmaceutical and other biomedical treatments – even oral rehydration therapy – *may* at times be evaluated in terms of their ability to trigger diarrhea. Malayka hinted at this concept in her answer to my question about how people treat pathological "soft" or "watery" diarrhea (not diarrhea deliberately used to normalize dacar):

> There are some tree species that are used to treat diarrhea [*shuban*] – and these are in the camel milk. Other people take ORS [oral rehydration solution, provided in packets to by aid agencies and the government during outbreaks of acute diarrhea] and that [also] passes the diarrhea.
>
> Doctors [clinicians staffing the Degago refugee clinic as well as the community health workers in the subsequent health post] sometimes advise us not to take tetracycline [*qorcase*] and other pills and also fatty meats with the camel milk. But some drugs are better with camel milk. For example, U-Lax [the laxative] is better to take with camel milk so you can pass the diarrhea more quickly [and then be healthy].

Several of the habasha nurses staffing Aysha Medical Center disregarded their Somali patients' desires for intravenous glucose, assuming they demanded it because they erroneously thought contained a greater volume of medicine than pills or injections. None of the habasha staff mentioned a connection between the perceived action of IV drips and the trusted and regular treatment of disease with camel milk.[72] Furthermore, importantly, medications prescribed to Somali patients may have an altogether different perceived mode of action or efficacy – namely, the medications' ability to induce diarrhea or vomiting and therefore purge the body of disease and stabalize humoral flows.

[72] This is a topic I will turn to in greater detail in Chapter 5.

I am not arguing that all Somalis misinterpret the indications or purposes of prescribed medications; however, medications' efficacy and side effects may be interpreted and evaluated differently based on persons' use of the metaphor of camel milk and their conceptions of bodily illnesses – especially, possibly, digestive illnesses and other humoral imbalances or blockages. More research would help elucidate these findings.

Illnesses within Women's Reproductive Systems

Central to women's popular health cultures – and indeed their lives – were experiences and management of pain (*xanuun*) and disability (*naafada*) related to their reproductive systems. Although female genital circumcision/mutilation practices[73] were changing, most women in the rural northern Somali Region of Ethiopia still endured excruciating infibulation and re-closure surgeries throughout their reproductive lives. Most women give birth at home, and many experienced complications and fistulas. Even so, many women claimed that their daily routines fetching and pouring 20 liter jugs of water, chopping and hauling firewood, cooking over fires in small smoky enclosures, and tending to livestock all while raising several children engendered even greater physical tribulations and vulnerabilities to disease. Compounding injuries they suffered from infibulation procedures and complications in childbirth, routine levels of exertion contributed to women's frequent presentations to clinics with non-specific or misunderstood complaints of pain and illness.

[73] Female genital mutilation/circumcision in Ethiopia is discussed in the following documents: Dawit et al. 2005, Federal Ministry of Health in Ethiopia 2006a and 2006b, Jeppsson 2003, WHO 2011.

In addition, sexually transmitted infections were apparently very common yet difficult to diagnose or treat, according to the mobile health team nurses and nurses staffing Aysha Medical Center. The mobile team nurses, like nearly all biomedical clinicians available to rural women, were male, and furthermore, most clinical facilities (like the mobile team operations in health posts) provided little privacy. These factors severely limited women's willingness to speak openly or have a thorough physical examination. Most women sought care and a physical exam from a male clinician only as a last resort and then only from private facilities far from their home communities. Still, fertility was a major concern for women; abdominal ultrasounds and private specialty clinics were increasing in popularity in eastern Ethiopia. Such emerging technologies and facilities[74] to combat women's infertility augmented a range of popular self-care practices and traditional healing modalities focused on the health of women's reproductive systems. Fardosa, a young mother from Aysha, tried to explain:

> Fardosa: All the people they have different cultures, so when the people go to the hospital, some people they are ashamed and they don't tell exactly the problems. Like women. They don't tell [a doctor] about their problems. If the woman sees a female doctor she may tell her problem, but if she sees a male doctor, she won't tell the problem. If the woman sees [and talks to] the doctor, they can help and give medicine, but if they don't talk [openly], [the doctor] cannot understand them, and cannot give any medicine or help.
>
> Me: What health problems do women feel shame about? …
>
> Fardosa: Women, if they have a problem with their vagina, they don't talk about it, and if they have stomach or uterus problems [*xanuuna makaan*] they don't tell.

[74] In particular, a fertility clinic that had opened in recent years in Harar, a city in eastern Ethiopia approximately two days by bus or khat truck from Aysha woreda, was rising in popularity among Somali women. It was operated by a German NGO, and both treated infertility with a range of technologies as well as treated fistulas and other childbirth and circumcision injuries.

> There are so many problems like this that women experience and they cannot talk about.

Several types of culture-bound folk illnesses were widespread among the women with whom I lived, but, perhaps largely due to a dearth of opportunities for women to have medical examinations or speak with female providers, such medical presentations were often considered too ambiguous and less serious than other illnesses, such as respiratory illnesses or malnutrition. Two of the most common ailments were: *mindheeli* (a structural injury to the uterus) and *uruuq, hindo hindhuro,* or *sorati* (humoral pathologies, in their severest forms due to the buildup of menstrual blood).

Mindheeli: *Shifted uterus*

Mindheeli was perhaps the most common complaint women reported to the mobile team in Elahelay, the health extension workers in health posts, local midwives (*ummuliso*) and female rural doctors (*dhakhtar baaddiye*). Men and women both recognized women's agonizing workloads and the consequent disability and pain they faced over the years. In fact, although it was beyond the scope of this study, an entire category of illness or semantic illness network[75] emerged surrounding the concepts of women's exhaustion and over-exertion, of which mindheeli was one part. A male informant described its etiology in the following way:

> Women usually suffer mindheeli after having a miscarriage or abnormal delivery or after carrying heavy materials. Symptoms of mindheeli include pain at one

[75] The concept of semantic illness network was developed by Byron Good (1977).

> side of the lower belly above where the uterus is located. They say that the uterus has moved from its position of origin, they also they do not conceive [a baby] when they have mindheeli. However, women believe that having mindheeli for a long period of time can affect the reproductive system. … Women say that mindheeli is not treated with [bio]medicine but the traditional professional women massagers (*duugto*) treat the mindheeli by massaging all around the belly and the back of the affected woman.

Saada, a fifty-year-old midwife from the town of Harmukale along The Road to Djibouti[76] was given training for one month to be an officially recognized "traditional birth attendant" by the Government of Ethiopia in Jijiga. Although she had attended numerous women during and after childbirth, she said she was not an expert in therapeutic massages for mindheeli. Yet many of her peers had suffered from this type of pain, and she hoped to one day understand its causes and treatments better. She described mindheeli in the following way:

> Saada: Mindheeli comes after the woman delivers a baby, when she tries to lift something very heavy, like a jerrican [a 20 or 25 liter plastic jug]. This hurts her stomach, or her uterus, and makes her uterus move over [she shows me with her hand]. The woman will have to rest, and then eventually will get better. But usually, this is difficult because the woman will become very sick – she will have a high fever, feel cold, and then she'll want to only sleep. After that, especially in places where there is no doctor, people will call an old woman with experience in such things. This duugto will use an oil to massage the stomach, will feed her hot food, and then let her sleep. After she's rested, she will likely become well again. If there is a hospital, the woman will go there, and they will give her pills for the mindheeli. They don't have any of these pills here in Harmukale, and they aren't in the shop either. You have to get them in Dire Dawa.
>
> Me: Do you know someone who's gone to the hospital for mindheeli?
>
> Saada: Yes.

[76] The Road to Djibouti transects the northern Somali Region of Ethiopia; Harmukale is a town along this road one third of the way between Dire Dawa and the border of Djibouti.

M: What happened?

S: The doctor tests (*imtixaantay*) the woman's stomach with a computer. He can see the problems in the stomach with the computer, and he will say there has been a change or a movement inside, and give her two pills [unsure what kind of pills]. She must eat one multiple times, even when she goes home, and he will also give her a pill to put up her vagina. Typically, women will only get this one time, not again and again.

Despite a relatively high level of local consensus among laypersons about what constituted mindheeli, most clinicians and community health workers with whom I spoke – Somali and non-Somali alike – were unsure of mindheeli's exact etiology or definition. They assumed women had many different problems they glossed as "mindheeli" in the context of awkward clinical interactions. Consequently, several women presenting to the mobile team with mindheeli were prescribed antibiotics primarily for the treatment of urinary tract infections, although their reported symptom was severe pain in the abdomen after lifting a heavy object or giving birth.[77] Mobile team nurses were aware of women's reluctance to have more thorough physical exams, and despite lacking adequate diagnostics, they maintained that UTIs and sexually transmitted infectious diseases – not a combination of structural injuries to the uterus, chronic over-exertion and childbirth – were the most likely causes of women's discomfort and much of their infertility.

Hibo, for one, was frustrated by these ambiguities and uncertainties. Hibo was a young mother from Harmukale and a friend of Saada; her experience typified many women's dissatisfaction over lack of diagnoses and effective treatments for mindheeli. Hibo had two young children, but for five years had been unable to conceive again. Her

[77] I asked the mobile team clinicians if mindheeli might also indicate a hernia or similar injury, but they answered by reciting the high rates of urinary tract and kidney infections in eastern Ethiopia, as well as the reluctance many women feel in carefully describing their symptoms.

infertility, she guessed, was caused by mindheeli – in fact, she could pinpoint two times when she had hurt herself lifting full jerricans and tending livestock while her second child was still a small infant. Two years before we met, a duugto was called from another town several miles away to massage Hibo's abdomen, but the treatment did not change anything. Next Hibo called another woman who massaged her, but still there was no change. And just 20 days or so before we spoke, in desperation she had called a third practitioner from several miles away, but there had been no change. Hibo said that her friend had success with duugto massages, and that is why she wanted to try as well.

> Before I believed (*aamina*) in other types of medicine [traditional therapies such as massage]. I saw other women had seen changes [in their mindheeli]. … Before now, I saw a girl who had gone without a baby for a long time; she also called a duugto to massage her, and now this girl is pregnant. After I saw that, I tried [the massage] again too.

When the second massage apparently failed, a few months before our conversation, Saada accompanied Hibo to a hospital in Dire Dawa, hoping that the "new" kinds of medicine there would cure her. But Hibo said, "When I went to the hospital [for mindheeli] they said I didn't have a problem. 'You are normal,' they [the doctors] said." She shook her head sadly, "But they did not even test me with the computer [presumably an ultrasound]." Hibo hoped to save her money and return to Dire Dawa and visit another hospital, maybe Bilal Hospital,[78] for another consultation and another set of diagnostic tests.

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[78] Bilal is the largest private hospital in eastern Ethiopia, and is staffed by numerous Somalis. Consequently, as mentioned in Chapter 1, Bilal is relatively expensive, but seen by Somali laypersons as one of the best clinical facilities in the Horn of Africa.

Cases of mindheeli highlight the incommensurability of biomedical diagnostic or treatment procedures and the lived experiences and folk illnesses in the northern Somali Region.[79] For many women, mindheeli simultaneously indexed a non-specific but sharp pain in their abdomen and, in conversations, indexed fears of over-exertion, reproductive mishap, and infertility.[80] Thus mindheeli was more than a UTI, STI, pulled abdominal muscle or hernia, but instead was foremost the embodiment of a lifetime of over-exertion and the painful and ambiguous personal experiences of reproduction. It was, consequently, often a centerpiece of women's conversations about their bodies, and a frequent presentation to local clinical facilities. But a biomedical diagnostic classification or test of mindheeli – without consideration of its social etiology and social work – may be largely devoid of meaning and may spur inappropriate medical advice or therapeutic regimens.

Uruuq: Menstrual blood build-up after infibulation

Uruuq (otherwise pronounced *cubuuq* or *ubuuq,* and less commonly called *hindo hundhuro* or *sorati*) is another common ailment many women reportedly faced. Uruuq was described as abdominal pain during the period of menstruation that is exacerbated by the build-up of menstrual blood (*caado*) and potential infection. Women who have not yet had sexual intercourse, and who have undergone infibulation or Type III Female

[79] Here I draw on the argument developed by Pigg 2001.
[80] The central importance of reproductive mishaps and management of fertility for women who plan to bear "as many children as God gives me" is discussed by Bledsoe 2002 – although based on data from West Africa the concepts of body, fertility and family planning apply in this case as well.

Genital Mutilation/Circumcision, are more likely to experience severe pain, the build-up of blood, and infection, compared to married women or women who have had alternative genital surgeries.

Type III female genital circumcision or female genital mutilation (WHO 2008) – *xidhnayn,* meaning closed or *fircooni*, meaning Pharaonic in Somali – was the norm in the rural northern Somali Region of Ethiopia.[81] Girls were normally circumcised between six and ten years of age by older women with prior experience. During a typical infibulation procedure, a girl's clitoris is excised and the outer labia and vulva scraped and stitched together with acacia thorns, leaving one small opening. Her legs are bound together with ropes for up to two weeks while the scar heals, during which time she sits indoors, urinates and defecates into a hole in the floor, and attempts to remain as clean as possible. Because infibulation leaves only one small hole to drain both urinary and vaginal flows, long after the scar heals the opening may become partially or entirely

[81] Prevalence statistics for female genital circumcision/mutilation for the Somali Region of Ethiopia are unreliable due to the populations' reluctance to answer questions and the perceived biases of non-Somali survey administrators, among other likely reasons. An estimated 96% of women in Somalia are circumcised according to the World Health Organization, and a vast majority of these procedures were Type III, or infibulations (WHO 2008). Notably, in the last ten years in eastern Ethiopia, mothers of young daughters have, in increasingly numbers, chosen less invasive or drastic closure procedures. Many families residing in Dire Dawa and other urban areas of Ethiopia increasingly advocate for excision of the clitoris and outer labia, but not full closure of the vulva (Type I, according to the WHO classification system). The stitching together with acacia thorns of the vaginal opening likely occurs less commonly in Dire Dawa today compared to ten years ago. One informant in the town of Harmukale – halfway between Aysha and Dire Dawa on The Road to Djibouti – described how and why circumcision practices were changing: "Before now, they would totally close the woman, but now people understand the health problems associated with closure, and so now they make the woman open. Three years ago they stopped closing women here. There were big problems with women's health here, and an organization [its was unknown name] came and told the people about all the health problems, but by this time they had already stopped. There were both Ethiopian and international organizations campaigning for the practice to stop. Before now, when women were closed (*xidhayn*), the old woman would perform the practice then tie the girl's legs together with rope, tie her hands behind her black, and make her sit like that for 7 days. Our religion," she says, "and the Qur'an, doesn't want us to close (*xidh*) – the Mullahs would say to stop the closing of girls in many places as well. Some people still want to be closed, even today though."

blocked. Alternatively, the hole may even initially be too small to drain fluids quickly enough to prevent buildup and thus infection. Any sort of stoppage, blockage, or buildup of bodily humors is interpreted as pathological and dangerous;[82] as such, the suspected pooling of menstrual blood in the reproductive system and the greater risk of infection were both seen to threaten women's fertility and overall health. A male health extension worker explained the concept in the following way:

> Blood builds up in the stomach, and the stomach becomes like a stone. … Young women here are totally closed – no blood can come out. When the woman gets married, the people call an old woman before the first night. The old woman does the operation with a knife – she cuts the pieces that hold the woman closed. After seven days, the woman will be better. … After that, when she is married …she will become pregnant, and then she won't have this problem any more.

Several women I knew were temporarily disabled for days during their menstrual cycles from pain; all of these women complained that the blood could not flow or escape due to the fact they were tightly "closed." One close friend – an unmarried woman in her mid-twenties – had such severe monthly pain that she finally visited a private hospital in Jijiga for more answers. She said that the clinical encounter was extremely frightening. A Somali male doctor reportedly "looked inside" her abdomen with an ultrasound machine, massaged her stomach, and concluded that the only cure was "marriage" (and thus to "open" her) – which she flatly declined. Instead, she continued to pay for occasional massages by old women nearby, and she continued to consume several

[82] Additional illnesses that manifest or cause the stoppage of blood or other humors include: *sanboor* (sinus infection) and *calool istaag* (constipation, or literally, "stopped stomach"). These and other similar ailments are often treated by attempting to induce bleeding or bowel movements – sometimes through diet (*buulee*) other times, as previously mentioned, through scraping the insides of the nose or anus (*xoq*). These and other illnesses and treatments are listed in Appendix A.

acetaminophen tablets plus several other over-the-counter medications (ones indicated for coughs, colds, and headaches) in hopes of finding one that helped. Although she was happy that she was fully closed, or infibulated, she bemoaned the regular pain she endured. But, she said, "Allah knows best. I will wait [until marriage] to open."

Qur'anic Healing

Qur'anic healing, mostly in the form of a local mullah calling on verses from the Holy Qur'an and the teachings of the Prophet Mohammad in the presence of the ill person, is viewed as a completely different illness category from illnesses caused by germs, malnutrition, over-exertion, or humoral abnormalities. Spiritual illness was perceived to mostly be a consequence of possession or attack by a particular jinn, and as mentioned, women are far more vulnerable to affliction than men. Spiritual healing rituals were more nuanced and tailored than simply offering prayers for the divine intervention of God to heal a person; in the Somali Region, illnesses were diagnosed and treated according to the specific formulas outlined in various popular hadiths (*kitab*), or small Qur'anic manuals, as well as characteristics and symptoms of the patient.

Several conditions were suspected to *occasionally* – but not universally – derive from the malevolent behavior of demons. These included: paralysis, seizure disorders, psychological disturbances, infertility, non-specific joint or bone pain, edema, and headaches. Often, people expressed uncertainty about the causes of their pain or sickness, and so they sought spiritual healing as well as a host of biomedical and herbal

remedies. In such cases, people diagnosed their illness by way of treatment failure: when one therapy failed, an incorrect diagnosis was blamed and another diagnosis and therapy sought. Sara's story provides such an example. Sara is a young mother and wife of the local mullah in Elahelay, and had suffered from seizures for years. At first she feared her seizures were the fault of a jinn, but after several healing ceremonies and consultations, she became convinced her sickness was from *suuxdin* (epilepsy), a disease of the brain and not caused by a jinn, but ultimately in the hands of God. Her narrative reveals a pluralistic approach to illness labeling and etiology, and at the same time highlights the structural limitations on healing due to poverty.

> I know that [I have] epilepsy (*suuxdin*). When God brings something, we human beings call it various names, but God does not call it such names. I have been going to [biomedical] doctors and religious healers have checked the book [the Holy Qur'an]. They all have said the signs and symptoms say that this epilepsy disease comes from heaven... The book [a hadith] recommended many medicines, and the Qur'an was recited over me, many things were written for me [scriptures and prayers] from the holy book.
>
> Surely to God it was as recently as 3 or 4 months ago when I also went somewhere called Midda [in Ethiopia]. An Oromo Mullah has done many things for me there, this Mullah from Midda. For our people [*dhaqankeena*] there is no other treatment for epilepsy but the Mullah's treatment. Surely to God the real experts in epilepsy do not stay around here, except those that read The Holy Qur'an over me, there is no other alternative than what these Mullahs do.
>
> [*Before her visit to the Mullah of Midda, she visited Dil Chorra Hospital in Dire Dawa on the advice of several religious leaders and family members in Elahelay. She continued on this topic:*]
>
> ...So the doctor in Dil Chorra [Hospital] said to me, 'there are pills for epilepsy.' And I took them and felt better. But when it [the medicine] goes out of my body, [the seizures] start back like before. …And I now have a shortage of pills. … The shortages of pills are because you are coming from a distant place and your house is here [somewhere remote like Elahelay]. So when you are ordered to take these [pills] for a number of months, the doctor examines you, then he says to

> you, 'take two months or three months [of pills].' When you finish that amount, you know you are not always near to the doctor. But if he is nearby, every time you could you go to him because you are near. But when you are here, you are responsible for taking care of your home, you cannot be outside it. That has caused the problem with me… and the hospital is far from me, and the doctor is giving me pills only for a limited period of time.

There are several different types of jinn in the world. Some are malevolent while others are not. So-called "Christian jinns" usually act maliciously toward Muslims, and must be expelled or disabled through Qur'anic healing; "Muslim jinns" are neutral and do not usually cause harm to Muslims. Jinn of all sorts live under houses and underground – these can anger and attack humans when boiling water is spilled, someone stands on top of them, or heavy objects are dropped. They also reside in the giant termite mounds and anthills that dot the northern Somali Region, and can escape at night and attack humans if they get too close. Jinns reside in latrines, so numerous rituals exist to protect people or conceal their presence as they urinate, defecate, and bathe inside. Women try to avoid using latrines altogether, especially in remote areas when they can find privacy out of doors. Jinns are perceived to enter the human body primarily through its orifices and are attracted to bodily pollution (such as *caado,* or menstrual blood), stress, jealously, khat highs (*mirqaan)* and even disobedience to God. In women's cases, jinns most often reside or wreak havoc in their uteruses – they kill fetuses and prevent pregnancies. Consequently, expulsion of and protection from malevolent jinns are crucial for married women in order to maintain their fertility. As Sengers (2002:175) points out, possession is also frequently associated with moments of social anxiety. For women in the Somali Region, heightened concern about jinn attacks as well as reports of jinn interferences

happened most often at the age when girls are circumcised, during courting, marriage, career or educational advancements, during droughts and other family crises, and during women's struggles to conceive a child.

In the northern Somali Region of Ethiopia, mullahs – the leaders of local mosques – perform most Qur'anic healing rituals. Occasionally persons traveled to visit renowned healers from elsewhere, particularly when advised to do so by a local practitioner. In Sara's case, for instance, she visited a famous mullah from another region because he had expertise in diagnosing and treating seizure disorders. Qur'anic healing requires mullahs either to exorcise or pacify the jinn, then provide a modicum of protection as the person recovers. Qur'anic healers are holy men; they call on their relationship with God as well as their expertise in diagnosis and treatment using the hadiths and Holy Qur'an. Sometimes, according to discussions I had with two mullahs, they realize a person's illness is not due to demons or satan, but should be treated through biomedicine (as in Sara's case) or through the application of various herbal remedies as outlined in the hadiths. Mullahs often recommend someone visit with other practitioners for the treatment of illnesses that fall outside the realm of Qur'anic healing and spirit possession.

A typical Qur'anic healing ceremony in the northern Somali Region might unfold in the following way: first the mullah prays and calls on the guidance of God. Then, he references either a number of hadiths that contain the words of the Prophet Mohammad in order to compare the patient's symptoms to their personal history, their birthday, and the letters of their name among other variables. The mullahs I met each owned a small collection of worn paperback hadiths they had purchased or been given during their

religions scholarship elsewhere, including the famous book on prophetic medicine by Sunni Islamic theologian Ibn al-Qayyim, called Al-Tibb al-Nabawiya. Depending on the etiology and prescribed treatment outlined in the hadiths, a mullah has several therapeutic options. First he might write, recite, or shout specific verses of the Qur'an (although shouting is common only when the patient is screaming, convulsing or unresponsive). Second, the mullah might write a series of verses or words of the Prophet Mohammad outlined in the hadiths or from the Qur'an in the presence of the patient. Third, the verses or spells might be written onto special paper (*qardhaas*), rolled or folded up, wrapped around a stone, or placed within an amulet to be worn by the person for their ongoing protection. Finally, many therapeutic rituals call for the mullah to write out verses or spells in ink, then wash or rinse the paper with holy water (*taxaliil)*, drink the taxaliil, splash or spit the taxaliil onto the person, have the patient drink the water, or spit their saliva onto the written words. Patients are usually exhausted after a healing ritual, and so rest and nutritious food are recommended.

Jinns and Infertility

Many women struggled with infertility (rarely spoken of directly, but sometimes called *ma dalays* or literally, being without pregnancy) – and many times, an attack or possession by demons was blamed. Often in such cases, Qur'anic healing was used for the treatment of infertility and restoration of the uterus to health. Still, several women with whom I spoke who had undergone Qur'anic healing for the treatment of infertility also suspected they had an infection in their reproductive organs, an injury due to prior

miscarriage, or some other physiological malfunction (e.g. mindheeli). Yet women were reluctant to visit most biomedical facilities in Ethiopia (Aysha Medical Center, Dil Chorra Hospital and Bilal Hospital in Dire Dawa, or any facility in Jijiga) for the treatment of their reproductive disorders. The only desirable option women spoke of was a newly opened private fertility clinic in the town of Harar in eastern Ethiopia, but for most residents of the northern Somali Region it was prohibitively expensive. Thus although many women experiencing infertility accepted the possibility that their problems might be physiological in nature, local mullahs were the closest, easiest, least expensive, and most trusted first resort.

Two mullahs I interviewed extensively about Qur'anic healing also acknowledged the roles of physiological malfunctions and infections in women's inability to conceive or bring a fetus to full term. In addition to exorcising jinns from the bodies of affected women, Awli – a well-respected local mullah and healing expert – explained that Qur'anic healing plus occasional regimens of antibiotic medications were sometimes the best way to treat infertility. During an explanation of diagnostic procedures using various hadiths, he said:

> Awli: For infertility, I sometimes also prescribe medications (*kiniini*).
>
> Me: Which medications?
>
> A: Ampicillin (*ambasaliinka*). One times three [one pill three times per day] for seven days for the five hundred milligrams of ampicillin capsule means twenty one pieces.
>
> M: What are some causes of infertility, do you think?

> A: believe there is one jinn – a female devil (*qoon*). During menstruation, this jinn will anticipate the woman's blood, and suddenly attack them because devils like unclean people. And then they settle in the uterus of the women. Then they will refuse to allow a conception until something is done to remove that jinn – until then she will not give birth.[83]

For such healers, ampicillin consumption was not designed to kill the jinn or prevent future attacks, but I argue, after years of receiving basic public health messages and interventions (through nongovernmental organizations and the new health extension worker program) uterine and urinary infections were widely acknowledge to be a problem for women *in addition* to jinns. Although Awli was not trained or certified in biomedicine or pharmacology, he made sure that he both rid women's reproductive organs of jinn and rid their bodies of harmful germs as well. And similarly, although jinn were invisible spiritual creatures, their damage to women's wombs was thought to be obvious in a sonogram or abdominal examination at hospitals – as long as the clinician understood what to look for.[84] Again, more research would help illuminate these connections.

Imtixaanka (Tests): Ways of Dealing with Ambiguity and Anxiety

Thirty years ago residents of Aysha woreda rarely expected to receive diagnostic tests using microscopes, x-rays, finger pricks, or ultrasound machines. But during this

[83] He also explained later that the *qoon* very rarely will attack men and kill their sperm.
[84] Boddy (1989, 1994) and Sengers (2003) draw connections between the *zar* possession cults and women's maintenance of their fertility; more research would need to be done in order to examine the relationships between spirit possession, *zar* cult participation, the use of ritual dramas and exorcisms, and fertility as such. Women did not mention *zar* cults during this research, despite its rich history (and likely origin) in Ethiopia.

research these technologies were commonplace, symbolic of superior care, and therefore highly desirable. Many of people's first experiences of biomedical technology included diagnostic tests in the Degago refugee clinic or in large private hospitals in Dire Dawa, Jijiga or Djibouti City. Hassan, a survivor of active pulmonary tuberculosis and a resident of Aysha told us the following story:

> Our people, we have a culture that when we are afflicted by a disease, especially serious cough or TB, we do not target or choose the correct doctors. Sometimes people will go to a religious or traditional healer (*wadaado*) and they [the healers] mismanage the problem. In that case, maybe the person will die because they did not go to the right doctor.
>
> So I told my mother, [who was sick] 'Mother, this is the same disease I had, so you can't be treated by healers, so please let me take you [to the hospital].' I was begging her, and finally she accepted my advice. And I took her. … Many times she had used the [non-prescribed, unregulated] medicines from the shop. She used to always have a fever, and when she felt hot, she would only take drugs from the shop. … It was just killing the pain or disease at that time, the fever, but after [she had finished the pills] it would start over again.
>
> *[After describing a typical Qur'anic healing procedure, he continued:]*
>
> When the person does not recover after [being healed with the Qur'an] the person should go to the hospital, or maybe they will die.
>
> *[I asked where one should go – to the clinic here, another clinic farther away, or to a shop first?]*
>
> [My mother] would not go to the [Aysha Medical Center] because there was not a laboratory there. I knew there was no laboratory but I went to the clinic anyway and I told [in Amharic] the health worker there the symptoms and signs of my mother as a report, and then he [the nurse] handed me the drug and I brought back home and I gave it to my mother. But she did not take all the pills. At that time [the health worker] had suspected that she was only sick with pneumonia. But after two months, she was still not getting better, and so I took her to a doctor in Djibouti, where she was tested for TB.
>
> The people here and in Djibouti are one culture [all Somali]. Here [at Aysha Medical Center] there are no quality treatments, and because there is no x-ray

> [*raajo* or *raajito*] it is not a reliable diagnosis from [the workers here]. The people here believe in x-rays.
>
> … So some people even in the case of suspected TB they won't recover from the treatment in this [Aysha] hospital, even though Aysha could provide them medicines, but after that the people must go to Djibouti.

Imtixaanka were barometers of the quality of medical care as much as they were barometers of health. Additionally, tests provided northern Somalis new vocabulary and imagery to describe their illness experiences, clinical encounters, and anxieties about illness and biomedicine. Aysha Medical Center and the small health posts in every kebele lacked most diagnostic technologies. Many men, like Hassan, travelled to Dire Dawa or Djibouti or other cities in order to obtain stool, blood and x-ray tests when locally available remedies were perceived to be ineffective. Similarly, women travelled to many of the same cities for private fertility or reproductive health consultations. Upon returning home, they recounted to friends and family exactly which diagnostic tests were performed, how the internal organs looked if imaging technology was used, how the technologies and samples were managed, and finally how the tests allowed the doctors to make a confident diagnosis.

When persons described differences between the quality of care from international relief agencies and Aysha Medical Center or the health post in their community, the first thing mentioned, often, was the dearth of diagnostic tests in local clinical facilities. Of course, on top of this, most Somalis I spoke with feared that the clinicians in Aysha Medical Center misunderstood and disregarded many of their symptoms or complaints, and diagnostic tests were seen to potentially help Somalis

obtain a proper diagnosis despite these limitations.[85] More generally, diagnostic tests assuaged people's anxieties about the trustworthiness of habasha clinicians in Aysha and the erudition of health extension workers in small health posts. Hassan, the man from Aysha mentioned earlier who survived tuberculosis said,

> The health posts, they have only become functional in the last two years or maybe one year and a half. But you know the professionals deployed in these health posts [the health extension workers] are only six months trained, and there are no laboratory tests or other equipment.

Interviews with residents of Degago, in particular, frequently provoked comparisons between contemporary sources of medicine and medical care available when the refugee camp clinic was open. For example, when I spoke with Malayka about where different medicines in the pharmacies and health post in Degago come from, she replied:

> We do not know [where pills come from], we just buy them simply. But before when the organization [UNHCR] was here, they provided good medicines. But after the organization left, we do not have any idea about where medicines are from. … When they [UNHCR] left we felt a big problem because if you have a problem about the kidneys, or malaria, or a severe cough, if you have those diseases you cannot get just go to the clinic [health post] … they do not have a laboratory [at the health post] so we had a big problem then.

Malayka's friend, Sara, similarly said:

> When the government [of Ethiopia] came in here, they put medicine [for sale] in the clinic [health post]. … Maryan and Mahamood [the two Somali health extension workers in Degago], they took the training, but they don't have a microscope. If you tell them your problem, you cannot get any effective help, and consequently their medicine is much cheaper than in the [private] pharmacy here too …

[85] Misunderstandings happened for a range of reasons – from language barriers to racial animosities. These topics are discussed in greater detail in Chapter 5.

> *[I asked: So what happened when the refugee clinic closed? What did the people do for medicine?]*
>
> At that time the organization [UNHCR] – the person who doesn't have money if they become sick they [UNHCR will] give [them] medicine. They will also test the person and if [the patient] becomes serious[ly sick] they refer them to [a hospital in] Dire Dawa. If they don't have medicine in Dire Dawa, they refer them to Addis Ababa, and also in Addis Ababa they don't have medicine they may refer them abroad.[86] So the people they have many problems, and many people don't have money, they are poor and cannot go to Dire Dawa or Addis Ababa.

The private unlicensed pharmacy in Degago was run by two lifelong residents of Degago: Ali, a former staff of relief agencies and a businessman, and Abdi, a local herbalist. Prior to opening the pharmacy, Ali worked for approximately ten years in the Degago refugee camp clinic for two nongovernmental organizations – first Médecins Sans Frontières then UNHCR. Both organizations provided him informal training in how to administer injections, treat wounds, and monitor pharmaceutical regimens. He worked as a medical assistant to foreign physicians most of this time, caring for patients in the wards and assisting expatriate clinicians in language translation. When the refugee camp closed its doors in 2005, he opened a private pharmacy to fill gaps in care – he cleaned and cared for wounds, he travelled to remote areas to set people's broken bones, he ensured tuberculosis and diabetes patients had a proper diagnosis and stayed on their medications, and he took older persons' blood pressure and made sure they had ibuprofen to lessen the pain of arthritis. Recently Ali had hired Abdi, a known herbalist, to help him run the business. Ali was well respected and well liked by most people in Degago, up

[86] Indeed, two families we knew of had gained refugee asylum based on the medical needs of their children, and today both families reside in Canada.

until June 2009 when he left Degago to run a pharmacy in Harirat, Somaliland. One woman lamented the fact Ali (she called him a doctor, or *Cali Dhakhtar*) had recently left the pharmacy in the hands of Abdi:

> Ali, when he was here, all the people trusted (*kalsoonayd*) him because he had good knowledge. But now, since he left, there is a big difference and it is a critical situation. … People say now there is the health post [she called it the hospital, *isbataalka)* and the pharmacy open in Degago [now that the refugee camp clinic is gone] but they believe in Ali and when he went away, they stopped going to the pharmacy. If Ali is gone, we don't need [to go there], because this man [Abdi] he does not know [things]. He is a rural person [*qof baaddiye*].

When the refugee camp closed, medications, thermometers, scales, blood pressure gauges, and other materials were left behind (the health post did not open for two and a half years after the refugee camp closed). Likely aware of the symbolic importance of such materials, many were appropriated – in various ways – by Ali and more recently, Abdi. The following field notes paraphrase a portion of one ethnographic interview with Abdi in which he discusses and dramatically performs how he used a thermometer:

> *Field notes February 26, 2009*
> *…*
> *Recently a pastoralist man from Zeila [on the northern coast of Somaliland] was traveling through Aysha to see his family – but he did not make it. Other people from outside the town of Degago found him nearby, lying on the ground, sick. Ali had already left town for a while so Abdi was the only person who operated the pharmacy. The people who found the man came and retrieved Abdi at night from his home. By this time the man was so sick he was not able to breathe at all. Abdi conducted what he called a "pneumonia-malaria" test using a small machine with little numbers in the middle. At this time Abdi mimed to us his procedure: he held a stick up in the air, and then held it close to my husband's body to indicate how the machine read the diagnosis (he was presumably referring to a thermometer but he wasn't sure of the name). The test indicated the man had pneumonia. Apparently it wasn't pneumonia that had reached the liver, but it was still a serious pneumonia. Abdi sold him three bottles of injectable*

> *penicillin [baasalin irbad] and gave him the first injection—all for only 35 birr (approximately $3.50 at the time).*

Several persons we spoke with regarded Abdi a charlatan and a lousy replacement for Ali. Ali had gained people's confidence through his experience with relief operations and his subsequent devotion to caring for sick and injured persons. Many residents of Degago were disappointed that he had left the pharmacy in the hands of Abdi, who was a "rural person" (*qof baaddiye*) – and thus apparently lacked experience with or education in how to use diagnostic equipment and pharmaceuticals. Abdi's appropriation of the test failed because he, unlike Ali, did not have any training in how to interpret biomedical technologies.

In addition to a rise in desires for diagnostic tests, Abdirahman described how medications from an unlicensed pharmacy in Harirat, Somaliland were informally "tested" by local residents:

> Medications for the treatment of snakebites, poisoning, and for the treatment burns are not available here [in Elahelay] but are available instead from an unlicensed pharmacy in the town of Harirat [along the Ethiopia-Somaliland border, only 18 kilometers away]. So the person who has been bitten or burned will not go, but their relative will go on foot or with a donkey to buy drugs from Harirat and bring them back here. …
>
> There was one event that happened here, a small girl was bitten by a snake, but at that time there happened to be a health [policy] professional visiting us from the Jijiga level [of the Somali Regional Health Bureau]. So we told that man that we often get drugs for snakebites from Harirat. And so he…said, "I will crosscheck if the drugs you are getting from Harirat are the right drugs for snakebites." So he wrote a note as a prescription: buy this drug for me. And they [the family of the girl who was bitten] also killed the snake and took it with them as a sample. [So]…when that man went to Harirat he gave the prescription to the pharmacy, saying, "I need this drug, I also need the drug for this snake" and held up the snake. So he said, the name you have on this prescription is the same for the

> drugs you need for the snakebites. So when the guy came back with the two drugs [the two same drugs], one he bought for the snakebite for himself and the other for the guy [from Jijiga] who was going to crosscheck. So then this guy [from Jijiga] said we do get the correct drugs from Harirat.

Even this kind of informal test reveals the extent to which persons were unsure about their healthcare when it did not derive from private urban hospitals or international relief efforts. In this case, the use of the Somali Regional Health Bureau bureaucrat to help people negotiate (even extra-legal) sources of medicine again foreshadows arguments I make in Chapter 6. There I delve into the ways in which medical decision-making motivates people to use Ethiopian state resources in new ways.

Conclusions

Popular health cultures in the northern Somali Region were pluralistic and in flux; recurrent humanitarian crises and medical humanitarian interventions have long been a part of these local dynamics. After positive experiences with clinicians in the Degago refugee camp and the mobile team of nurses, many persons desired more and better biomedical healthcare. As will be discussed at length in Chapter 6, changing demands for and ideas about medicine are also intertwined with people's changing relationship to nation-states vis-à-vis their inclusion in various federal humanitarian and health policies. Although many Somalis increasingly turned to biomedical technologies and treatments, even alongside herbal and spiritual therapies, they often did so in ways that circumvented Ethiopian or state-controlled sources of care. One female traditional birth attendant who

was, crucially, neither a beneficiary nor a healthcare provider that day, said impassively as the mobile team intervention swirled around her:

> I birth babies. We use our hands. We don't have other materials. We don't have any knowledge [expertise] here. We need training from the government too.… The hospital is better than healing with fire (*gubashada*).

Provisional humanitarian programs have on the one hand raised local expectations for the potential benefits of biomedicine, yet on the other hand, have repeatedly exited – or abandoned – communities lacking other sources of comparable care. Many Somalis regretted that their therapy management choices and their ability to access high-quality facilities were both limited. Humanitarian operations were never permanent, private hospitals were frequently too expensive and distant, and local biomedical healthcare providers seemed to lack either capacity (in the case of the health posts) or empathy (in the case of the Aysha Medical Center) or both.

Furthermore, non-Somali habasha clinicians in Aysha Medical Center did not effectively resolve the disparities between their own recent biomedical and public health education with the presentations and complaints they faced in the Somali Region. Compounding their lack of language skills, most clinicians in Aysha and public hospitals in Dire Dawa lacked a basic understanding of Somalis' popular health cultures, health beliefs, and expectations of biomedicine. Consequently, many Somali patients gave their healthcare providers the impression they were ignorant, recalcitrant, and indecisive. Some patients demanded expensive biomedical technologies and therapies, while others either outright rejected habasha clinicians' advice or chose to stay home, close to long-

trusted herbal and spiritual healers. These are themes I return to and develop in Chapters 4 and 5.

Finally, women's experiences of pain were often either misdiagnosed or missed altogether. Accordingly, there is a dire need for health reforms and capacity building in the Somali Region, including: the provision of privacy during all clinical encounters (even in the midst of understaffed, rushed, and chaotic humanitarian operations); a greater understanding among Somali and non-Somali clinicians about the ways in which women may express anxieties about fertility and physical suffering through bodily complaints; highly trained female clinicians to staff woreda-level healthcare facilities in the Somali Region; and scholarships to incentivize Somali women who desire a graduate or professional degree in the health sciences. As will be discussed in the next chapter, increasing numbers of young Somali women were already opting to enter the workforce in public health and development aid; such trends should be fostered, and, given the likely future increase in the numbers of aid and refugee relief programs in the Somali Region, should be made a higher priority for the Ethiopian Ministry of Health. This topics is raised again in Appendix B.

CHAPTER 4.

FLOWS OF STORIES:
CIRCULATIONS OF MEDICAL INFORMATION AND IDIOMS OF DISTRUST

Foreign humanitarian aid is vital to the functioning and funding of local and federal health systems in Ethiopia. Millions of dollars are spent annually on humanitarian interventions there, much in the form of temporary clinical care and donations of pharmaceutical medications (Global Humanitarian Assistance 2011, Sphere Project 2011). Foreign medical aid, as such, can introduce new biotechnologies, enhance local clinical capacities, and increase the breadth of available treatments in impoverished and underserved locales. Such interventions in the northern Somali Region of Ethiopia have long shaped the frameworks within which medicine and healing are locally imagined and discussed. But typically, medical aid programs only last a few months or at most, a few years. In the nadir of funding, donations of medications dry up, clinics close their doors, and clinicians depart.

This chapter examines the social relations of illness and healthcare in the interstices of foreign medical operations by taking a set of popular stories and emblematic medical narratives – reports, rumors, jokes, and cautionary tales – as points of departure. Stories told in the Somali Region of Ethiopia frequently voiced a generalized sense of what I call *medical insecurity*,[87] or an inability to access trusted, lasting, and adequate medical care. Such stories are far more than anecdotes; in the

[87] The term "medical insecurity" draws primarily on the term "food insecurity" as defined by the UN Food and Agriculture Organization (2011). As they define it, food security is a multidimensional problem that, at its core, "is about risks and uncertainty."

absence of foreign medical aid, they articulate increasingly attenuated boundaries of trust between Somali patient populations and their mostly Ethiopian health providers. Further, they reveal how enduring racial hostilities and ethnic-based conflicts in the Somali Region of Ethiopia – specifically between *habasha*[88] Ethiopians and ethnic Somalis – are reworked and reinforced as people negotiate and talk about limited and suspicious sources of medicine and healthcare. Here I examine the "social life," (Whyte 2005) social work, and even the social memory of medicines. By providing an ethnographic account of both the historical and material circumstances in which people tell stories, and by providing an account of multiple perspectives, I bring to the fore their ideological significance and their significance to the development of future health and humanitarian policies.

The Meanings and Functions of Medical Narratives and Idioms

One afternoon I was riding toward on the main road through the northeastern Somali Region of Ethiopia with my research assistants Farah and Nimo, my husband David, and Ali, who co-owned and operated the popular unlicensed pharmacy in Degago. We were gossiping about reports of a hyena attack in the mountains between Elahelay and Degago near the Somaliland-Ethiopia border. From the front of the truck, Ali glanced back at us and proclaimed, "Somalis love to tell stories. They talk all the time!

[88] The term "habasha" refers to persons of Amhara or Tigrinya ethnicities who speak Amhara and/or Tigrinya languages.

Somalis will believe anything someone tells them." Chuckling and shaking his head he added, "That is a problem with our people."

Although not always a "problem," it is true that Somalis love to tell stories; their traditions of oral history and oral poetic recitation are famous (Laitin and Samatar 1987; Andrzejewski and Lewis 1964). The humorous construction of a narrative, invocations of proverbs, and references to historical and mythical figures are vital to many Somalis' notions of oral discourse. Narratives and evocative idioms within narratives about illness and medicine also figure prominently in everyday, informal conversations and matter deeply to people. Throughout ethnographic research in the Somali Region, I found that numerous stories – peppered with irony, dry humor, and occasionally, corporeal fear – expressed common anxieties about the integrity of local medicine, health providers, and health facilities.

Ethnographers have long studied the structures, functions, and meanings of popular stories and narratives, including jokes, rumors and gossip. Such informal discourses can help people work through dilemmas as well as enforce or create boundaries of intimacy, belonging, responsibility, and virtue (e.g. Colson 1953, Gluckman 1963, Gluckman 1967, Kluckhohn 1944, Paine 1967, Rosnow 1976, Shibutani 1966, Smith et al. 1998). Historian Luise White (1994) argues that, "the very act of talking about others – or oneself – disciplines" (1994:77). Engaging in private, compelling, and even secretive discourse subtly establishes and enforces boundaries of socially acceptable and ethical behavior (White 2000:64-65). Often the proliferation of a rumor or cautionary tale is rooted in collective anxiety and social upheaval, and can

provide an informal and safe social space for speakers to weigh decisions, assess the validity of information, and solicit others' opinions and advice (Shibutani 1965). As Kapferer (2003) notes, "Rumors do not *take off* from the truth but rather *seek out* the truth."

Thus stories are, to some extent, instrumental; they communicate messages and perform social functions. Beyond this, narratives are often emotive, symbolic, and intertwined with related discourses about state politics, racialized hostilities, histories of violence, or even biomedicine (Briggs and Martini-Briggs 2003, Feldman-Savelsberg 1999, Kaler 2009, Kroeber 2003, Obadare 2005, Scheper-Hughes 2003, Smith et al. 1998). Accordingly, cautionary tales and gossip about medical malpractice and misfortune at particular health care facilities or with certain providers have been shown to both express and exacerbate historical grievances (Manderson and Allotey 2009). Likewise, in his ethnographic examination of psychosocial distress among women in South India, Nichter (1981:379) argues that distress is verbally expressed in a variety of locally meaningful and subtle ways. As such, "idioms of distress" frequently "index past traumatic memories as well as present stressors, such as anger, powerlessness, social marginalization and insecurity, and possible future sources of anxiety, loss and angst" (Nichter 2010:405).[89] Accordingly, idioms of *distrust* within commonly told stories in

[89] Nichter coined the term "idiom of distress" and it has since been taken up by various scholars and disciplines including psychology and clinical psychiatry. Nichter states, "[idioms of distress] are indicative of psychopathological states…" and utilized in the DSM-IV as "cultural idioms of distress" (Nichter 2010:405). In contrast to the condition more narrowly utilized for clinical psychiatry and interpretation of certain somatic experiences by Hinton and Lewis-Fernández (2010), I follow Nichter (1981, 2010) in his focus on acts of taking medicine and uses of diagnostic tests for elucidating how idioms of distress express, structure, and generate particular observable behaviors. Idioms are key utterances and phrases within various stories and rumors.

the Somali Region of Ethiopia evoked specific racialized anxieties about the integrity of local forms of medicine. These verbalized subjective experiences of racialized forms of vulnerability within clinical settings and during moments of health crisis.

Recent anthropological projects ethnographically trace the emergence of particular medical stories in particular places in order to reveal hidden aspects or effects of larger social processes. To name a few, Scheper-Hughes (2003) examines how organ-stealing rumors elucidate power relations generated from global systems of capitalist exchange and exploitation, even beyond the organ trade business. Kroeber (2003:244) argues that "AIDS club" rumors in Indonesia reflect more general fears about the vulnerability of bodies to invasion by a dysfunctional Indonesian state and foreign sources of disease. Feldman-Savelsberg (1999) demonstrates how rumors about polio vaccines causing infertility in Cameroon are expressions of popular mistrust in and resistance to the government. These ethnographic studies importantly challenge official discourses and histories. Further, they reveal instances in which collective anxieties, expressed as contextually relevant and contingent rumors, have observable social, biosocial, and behavioral effects. My ethnographic research builds on these studies to illustrate how collective anxieties about healthcare and particular subject vulnerabilities have emerged in the northern Somali Region of Ethiopia, in part from the unreliable and temporary nature of humanitarian sources of biomedical healthcare, and in part from the unreliable governmental and informal health systems left when humanitarian operations cease.

However, in this case, collective anxieties and personal vulnerabilities cannot be accurately examined through an analytic focus on one medical rumor or a narrow set of medical discourses. Originally, my research set out to investigate a narrow set of rumors I had previously heard in the Somali Region of Ethiopia, namely, that there were poisonous, counterfeit pharmaceutical pills being sold on the black market from India and China. Early on I sought to determine how these rumors of bad medicine articulated general anxieties about local healthcare, and how they affected health behaviors. Yet, after living in and around the northern Somali Region for a year, I found there was not one single rumor or narrow set of rumors I could effectively analyze or trace. A few individuals expressed anxiety that pills from contraband supplies were of inferior quality, but these stories usually accompanied additional anxieties that generic Ethiopian brand medicines were of substandard quality, and that local health providers lacked the knowledge of how and when to use powerful pharmaceuticals. Instead of hearing one rumor frantically repeated, I heard smatterings of numerous stories and anecdotes about risky medicine on the market, incompetent and racist health providers, and inadequate healthcare facilities. An analysis of one narrative or one rumor, without reference to either the remarkable variability in narratives or the diverse spectrum of medical stories told on a regular basis, would have constituted, in this case, cherry picking.

Instead, I examine a broad range of medical narratives – jokes, stories, and information exchanges – within both clinical and informal settings. Methodologically, I follow folklorist Patricia Turner (1993) in her study of black urban legends in the United States. She examines rumors among African Americans to determine the pervasiveness

of various social "texts" – as she phrases it, "what in the texts themselves or in the circumstances surrounding their dissemination gave them life" (1993:5-6). She presents a sample of various formulaic rumors and cautionary tales known to many African Americans from around the country in order to demonstrate how these rumors, in their various forms with variable details, express a common set of themes, including historical anxieties about stereotyping, fears of genocide or violence against African Americans, and sexual competition between black and white males. Narratives like these, gathered through ethnographic fieldwork, do not articulate how people in certain bounded cultures or groups think about the world in general; rumors and gossip are not seen as keys to understanding thought patterns. Rather, such narratives are typically shown to challenge, add nuance to, or provide alternative perspectives on common sense notions or dominant discourses. The formulaic elements of salient narratives, including popular idioms, rumors and turns of phrase, are recognizable to those familiar with the context or the speaker's perspective, and as such also reveal and re-work local concerns (White 2000).

Further, unlike questions answered in the context of a structured interview, quantitative surveys, or news stories (which are typically narrowed for the benefit of coherent narrative), the rumor and gossip narratives I collected were messy and nonlinear. I did not explicitly ask people about particular rumors or my own speculations; instead, I discussed with persons their experiences at various healthcare facilities and with various healthcare providers. Although not directly solicited, a set of formulaic plots and idioms were mentioned in nearly every ethnographic interview and in many informal conversations throughout the research period; I mention each of these

subsequently in this chapter. These narratives were more contradictory than coherent, and the gossip and banter I heard was highly variable and often involved a dynamic cast of characters and details.

Additionally, most social science research on rumor and gossip provides or analyzes one perspective – usually, that of the person telling a rumor or gossiping about a mysterious or more powerful person, institution, or event (Stewart and Strathern 2004:51). Stories circulating within and through the upper echelons of society, staff of international aid organizations, staff of healthcare bureaucracies, staff of healthcare facilities, written policy documents and the global media, I argue, are as telling as those more quietly whispered between Somali laypersons. NGOs, journalists, and writers for aid organizations told stories about "Somalis" and "the Somali Region" mainly through the invocation of statistics, epidemiological research and sensational exemplars. Briggs and Nichter (2009) point out that stories about certain populations (such as "Somalis" or aid "beneficiaries") are constructed by powerful institutions and stakeholders all the time; such stories have real effects on these populations' lives and subjectivities. This chapter describes and connects these diverse stories told about people and medicine in the northern Somali Region by various actors in various contexts. For example, I provide alternative perspectives on the very same canards about the health care provided in the Aysha Medical Center; therein I demonstrate how several of the health providers there differentially perceived and responded to stories circulating among local residents about malpractice, bad medicine, and mistrust.

Grapevines and Mobile Phones: Popular Flows of Medical Information

Medical information is disseminated primarily via word of mouth in the northern Somali Region, where few televisions, written publications or internet resources are present, and less than 3% of residents are literate (Central Statistical Agency 2004, ORC Macro 2006). The circulation of information is enhanced by geographically dispersed kinship networks, frequent mobility for labor and livestock, habits of greeting and storytelling at length, and increasing use of cellular telephones. Trust (*aammin*) in habasha biomedical authorities in the Somali Region was limited; instead, in the absence of foreign medical aid, most persons regularly obtained medical information and sought advice about medicine from other Somali laypersons – friends, family members, mullahs, and lay health providers. Medical decisions were frequently informed by "stories" (*sheeko*), "noise" (*maqaalid*), and "whispers" or "rumors" (*kutiri-kuteen*) exchanged among peers. An elder pastoralist said,

> There are so many myths and baseless information about medicine that gets passed along. One man, maybe he had a medicine, penicillin or something, and maybe he injects a sick animal himself if there is no doctor around. Then that animal might recover, and he would pass along this story to everyone: "I used this drug! It is the best drug to use for livestock!" Then everyone would follow him and do the same thing!

Augmenting the Somali grapevine, cellular phones are an emerging medium of oral communication urban Ethiopia. In general, women are the dominant purveyors of medical knowledge in the Somali Region, and more often then men, they are responsible for visiting clinics and purchasing medicines. Immense amounts of information are

passed efficiently via cell phone in the cities of Dire Dawa and Jijiga, especially between the numerous middle-class Somali women raising families there. Stories and information pertaining to healthcare are frequently then relayed to others from rural areas as persons travel around for work, trade, livestock grazing, or visiting. As of August 2009, the federally controlled cellular telephone network in Ethiopia did not extend far beyond the major cities in eastern Ethiopia, and did not provide coverage in most of the Somali Region. However, there was a more robust and reliable (privately owned and controlled) cellular network in Somaliland, just across the border. For those with cellular phones in the northern Somali Region of Ethiopia within 20 kilometers of the border with Somaliland, signals were stronger from towers in Somaliland than from Ethiopia. Most extended family groups in Aysha woreda who had purchased a cell phone, had also purchased removable subscriber identity module cards, or SIM cards, from both the Ethiopian and Somaliland networks, and used these interchangeably depending on their location.

Most health-seeking episodes I witnessed in Aysha woreda involved medical decision-making and medical information dissemination via both word of mouth and cellular phones. For example, someone described to me the following hypothetical, but typical, emergency health-seeking strategy: if someone became seriously ill in the small town of Elahelay, and if herbal remedies, Qur'anic healing, other common non-biomedical practices, and locally available biomedical treatments were all proved or perceived ineffective, the person's closest male sub-clan member would likely rise early on the first clear morning, climb the steep hill outside town (a hill called *buurta dheeri,* in

this case) with a cell phone and SIM card from Somaliland, and raise it high into the air to get reception (see Figure 1). He would make an international phone call to relatives in Dire Dawa or Jijiga (87 and nearly 190 miles away, respectively) from the Somaliland network, engaging the larger sub-clan care network there, and those kin would organize and pay for a vehicle to Elahelay to take the ill person to the nearest hospital. The patient would then stay in the home of the sub-clan relative until better, at which point they would probably either slaughter a goat or sheep from their own herd in thanks or repay the family with donated food aid.[90] Mobile phones were thus crucial to rural Somalis' health-seeking despite the expense and network coverage gaps.

[90] More detailed descriptions of Elahelay village, common health-seeking strategies, and the role of kinship and clan in health-seeking are discussed in Chapters 1, 3, and 5, respectively.

Figure 7. Emergency healthcare-seeking in Elahelay: Abdirahman, a resident of Elahelay, attempts to get cell phone reception from atop *buurta dheeri* ("tall mountain")

Radio Stories

Due to the paucity of written or television forms of information, many people in the northern Somali Region of Ethiopia also relied on radio stories for both news and health advice. Sometimes though, radios were imperfect conduits of important medical information. Here I provide two consequential examples: the misinterpretation of avian

flu risk during the global outbreak and the common mistranslation of "cholera" into the Somali term, "*shuban biyoot*" which means, literally, "watery diarrhea."

Avian Flu Scare in Degago

As the sun sets in Degago, and men gather to chew khat together and women gather to prepare bread for the next day, one can hear the sound of small, battery-operated radios clicking on. Every evening at six o'clock, many residents of Degago listen to the British Broadcasting Corporation's radio news program in Somali language, broadcast from a station in Djibouti City. Degago is a remote desert village, and was the site of a refugee camp from 1988 until 2005. A few mango trees and watermelon vines produce fruit a few times per year, tomato and onion plants struggle to survive the hot sun and lack of rainfall, and the meager livestock herds kept by a few households have depleted every bit of greenery nearby. Most residents of Degago also receive a ration of wheat, corn-soy blended grain, and vegetable oil[91] from the UN World Food Program. But few sources of protein exist. Why then, my husband and I wondered once, do people not raise chickens?

We found out from several people that four years prior to our arrival, a nongovernmental development organization had funded the purchase of chickens from Haramaya University for several displaced households in Degago. Haramaya University is the premier agricultural university in Ethiopia, and is located approximately one

[91] At the time of this research, residents of Degago were not receiving split peas as a part of the ration. As mentioned in other chapters, residents in Elahelay *did* receive split peas during the same period.

hundred and fifty miles southwest of Degago, at over 7000 feet in elevation. Haramaya is cool, shady, and relatively damp most of the year. Annually, several flocks of chickens are raised in Haramaya by the students there, and in 2004, some of these chickens were donated as a part of a food security project to the Degago refugee camp. Degago is located at an elevation of 1200 feet, in a depleted, arid climate with very little rain or shade cover. From the start, the chickens didn't do very well. In the first week or two after their arrival, several died of unknown causes.

At the same time chickens were struggling to survive in Degago, the BBC was reporting on the global outbreak of Avian Influenza (*hargabka shinbiraha*). Consequently, the vulnerability of chickens to illness and death became the subject of even more local discussion. As more and more chickens inexplicably became ill and died, residents suspected that their chickens, too, had the flu. Many persons in Degago, like many Somalis, are quite experienced with larger livestock such as camels, cattle, sheep, and goats, but entirely unaccustomed to raising chickens. Plus, there were no veterinary services in town at the time. Scared of creating an outbreak of disease among other livestock, or even among the local human population, the families who had received chickens promptly culled all the remaining survivors and burned them in a bonfire on the edge of town. Since then, no one has been willing to buy or raise chickens because they fear bringing the disease back to their community.[92]

[92] Although tests or surveys were never performed to assess the prevalence of avian influenza in the Somali Region, according to the WHO, there were zero suspected cases in eastern Ethiopia.

"Shuban Biyoot"*: Acute Watery Diarrhea Versus Cholera*

While radio sources of medical information are crucial to people's working knowledge about healthcare and medicine and crucial to their acquisition of important health news, I also witnessed one case of an important mistranslation from the English to Somali language. Cholera has a long history in Ethiopia and throughout the Horn of Africa (Pankhurst 1968). After a successful eradication of *Vibrio cholerae* 01 strains in Ethiopia in the 1980s, it re-emerged in Ethiopia in 1994. Then in 1998, an epidemic of multi-drug resistant *V. cholerae* in Ethiopia sickened thousands of persons, and killed several individuals in the Somali Region (Scrascia 2009). Since 1998, there have been only a few reports of "cholera" in Ethiopia, yet at least once every year, reports emerge from NGOs or the news media about an outbreak of "acute watery diarrhea" or "AWD," especially in refugee camps or encampments of internally displaced persons.

Acute watery diarrhea is the general clinical classification for severe watery diarrhea caused by *E. coli*, rotavirus, or *V. cholerae* infection. The exact diagnosis of *V. cholerae,* or any of the other causes of AWD, requires the laboratory analysis of a stool sample or rectal swab. Unfortunately, these tests are frequently either not available or not performed in Ethiopia. Instead, public health officials and the media simply warn of an epidemic of "AWD." In fact, the Ministry of Health in Ethiopia defines "cholera" in two different ways, one for "lower capacity" settings, where there are no diagnostic tests, and one for "higher capacity" settings, where the virus may be specifically identified. In "lower capacity" settings, cholera is defined as, "In a patient age 5 years or more, severe

dehydration or death from acute watery diarrhea" and "If there is [a] cholera epidemic[,] a suspected case is any person age 5 years or more with acute watery diarrhea, with or without vomiting." By contrast, in "higher capacity" settings, cholera is defined as when, "vibrio cholera 01 or 0139 has been isolated in the stool" (Federal Ethiopian Ministry of Health 2008:28).

In general, to avoid public and media outcry, governments often attempt to minimize the severity of epidemic disease or hide ineffective public health strategies (Briggs and Martini-Briggs 2003, Ghosh and Coutinho 2000, Farmer 1995). Governments around the world have attempted to suppress word of disease outbreaks or to label diseases in a way that pacifies public anxieties (Nichter 2008).[93] Like York (2009), my research suggests that cases of cholera in Ethiopia are frequently reported by government officials in the Ministry of Health as "acute watery diarrhea" not just because most clinical facilities lack diagnostic technologies, but rather, because the government does not want to be seen as still struggling with the management of cholera. Here is a sample news report from the online source, *Abbay Media*:

> 31 August 2009
>
> Health officials in Ethiopia's capital, Addis Ababa are battling a severe outbreak of Acute Watery Diarrhea.
> …
> Dr. Daddi Jima, deputy director general of the Ethiopian Health and Nutrition Research Institute says the outbreak has been diagnosed as AWD, not cholera.
>
> "We usually report it as Acute Watery Diarrhea. We have never fully confirmed for any etiologic agents," said Dr. Daddi Jima. "Because we more focus on

[93] For example, in India, clinical presentations of cholera were reported as "gastroenteritis" and other non-specific forms of severe diarrhea by the government there (Ghosh and Coutinho 2000).

> managing the cases, because the management of Acute Watery Diarrhea is similar. So we are focusing on managing the cases we have rather than going into the details of the specific causative agents. [Heinlein 2009:1]

Online media outlets have explicitly accused the Ethiopian government of hiding outbreaks of cholera from the public by euphemistically terming the disease "AWD" rather than reporting its more specific etiology or causative agents (York 2009). My research documents another way in which "AWD" is articulated, mistranslated, and thus trivialized by news media. Beginning in July 2009, reports of AWD were published in online and radio media outlets not controlled by the Ethiopian state, such as the BBC.[94] In interviews and informal conversations, aid workers for nongovernmental humanitarian agencies in Jijiga openly discussed the appearance of AWD in refugee camps along the Kenya-Ethiopia border and in various locations throughout the Somali Region. The staff I spoke with, although unwilling to go on the record, assumed that the reports of AWD meant there were "most likely" cholera cases, and that these outbreaks thus constituted a potential epidemic of cholera, even though there had been no official (or publicly available) diagnostic tests. For example, I asked one staff member at the NGO Samaritan's Purse "Have there been any reports of cholera in the Somali Region?" He did not say 'no,' but rather, "There have been reports of AWD." According to several staff of aid agencies in the Somali Region, there were neither plans to culture bacteria from affected persons, nor plans to conduct a representative population health survey. Yet, despite the lack of information about the seriousness of the problem or the actual

[94] To my knowledge, in the year I lived in Ethiopia, the Ethiopian state-controlled radio and television reports did not report any cases of acute watery diarrhea or cholera in the country.

diagnosis of the diarrhea outbreak, several aid groups, including Samaritan's Purse, and policymakers at the Somali Regional Health Bureau, completely reformed and rerouted their emergency relief operations from some of the southern areas of the Somali Region that were at the time experiencing conflict and higher rates of acute and chronic malnutrition to areas further north where AWD reports had surfaced.

The BBC Somali language station broadcast from Djibouti reported on these emergent AWD cases, translating reports of "AWD" into "*shuban biyoot,*" which literally means "watery diarrhea" in Somali. Shuban biyoot has long been a common phrase in Somali to describe diarrhea that is, in general, watery, and according to some, could potentially develop into a more serious illness. Lay persons and Somali health providers I spoke with described shuban biyoot as brown or green in color, and caused by anything from drinking raw camel milk to drinking from contaminated water sources. By contrast, *daacuun* (and more rarely, the word, *kalooraa*) is a more accurate translation of cholera into Somali language. Daacuun was described as a severe, fast developing, and infectious diarrhea that is white in color, like the water left in a cooking pot after pasta has been boiled. Further, while various forms of diarrhea including shuban biyoot were seen as common yet potentially dangerous for young children, daacuun was seen to mortally threaten all persons, even healthy adults. Reports of shuban biyoot on Somali-language radio carried less weight and generated far less local collective anxiety than if the word "daacuun" had been used. The Somali laypersons I spoke with assumed the reported cases of shuban biyoot were only "*yaryar*" (simple or small), in other words, not

serious. By contrast, concurrent rumors of measles in the area, or "*jadeeco*,"[95] were of much more concern to local residents. Because aid and governmental agencies resisted publicly defining AWD as "cholera" or even suggesting a connection between the two, the translation of AWD into shuban biyoot elided the potential urgency of a cholera epidemic among the local populations involved, and left unexplained to them the rationale behind such dramatic media attention and dramatic changes in humanitarian programming.[96]

Thus the radio news was crucial to local analyses and interpretations of medical information as well as popular rumors. Beyond these two examples, radio news also more generally shaped patient subjectivities and health behaviors. Accordingly, Briggs (2005: 275) looks beyond the content of media messages to include "how the ideological construction of their production, circulation, and reception shapes identities and social "groups" and orders them hierarchically." In my research, "Somalis," as an group, were interpolated into these Somali-language BBC news stories about disease epidemics and humanitarian interventions on a regular basis, and these stories were then re-articulated, reinterpreted and retold in successive informal conversations both between Somali lay persons and between health and humanitarian aid providers. Around the world, sensational portrayals of Somalis as shysters, tribal warlords, pirates, and famine victims

[95] In fact, there was an epidemic outbreak of measles in the northern Somali Region beginning in late 2008, until March 2009. WHO and the regional government in Ethiopia mounted a Vitamin A vaccination campaign in response.

[96] Reports of AWD outbreaks were not confirmed to be *V. cholerae* by NGOs prior to my departure from Ethiopia in August 2009; further, no additional reports of AWD surfaced in media outlets or press releases by relief agencies after August 2009. According to sources in Ethiopia, by November 2009, the emergency relief efforts that had been diverted to respond to a presumed outbreak of AWD in the northern Somali Region, ceased their operations there and began serving populations in the southern part of the Somali Region, where rates of acute malnutrition and political insecurity remained serious problems.

continue to fill the radio waves and news headlines (Gettleman 2011, IRIN 2008, IRIN 2009, Menkhaus 2011, Voice of America 2011, Voice of America 2008). The communication of all these images and types of information – including medical information – through news media was ideological: it produced and shaped social groups such as "Somalis," and entire regions, such as "the Somali Region," as poor and dangerous and thus more vulnerable to outbreaks of infectious disease and less amenable to intervention;[97] and it produced salient categories of healthcare providers, such as foreign aid workers or government public health officials, with differential capacities for providing trusted information.

Aid Stories: the Biocommunicability of Humanitarian Crisis

Stories and stereotypes of Somalis circulated not just amongst laypersons and healthcare providers, but also shaped policymaking at the national and international levels. Similar to radio news stories, UNICEF and other NGOs active in the northern Somali Region of Ethiopia authored their own narratives, of sorts, in policy briefs, planning documents, and stories for media outlets. These stories primarily narrated "disaster," "need," and their interventions in the language of body counts: statistics describing death rates, malnutrition rates, the epidemiology of infectious diseases, numbers of clinics built and clinicians trained (IRIN 2008, IRIN 2009, UNICEF 2010). In longer reports or summaries to media outlets, vignettes were provided to personalize

[97] This theme in particular will be revisited in Chapter 6.

the barrage of numbers, but these stories rarely adequately addressed social issues--dysfunctional political institutions, historical economic inequalities, racialized forms of violence, or even the lingering effects of repeated humanitarian interventions (e.g. Save the Children 2002, UNICEF 2006). Statistics can be compelling and informative. But Young and Jaspars, two astute nutritionists working amid disasters admit, "we have been seduced by anthropometry" (1995:133).[98] Statistical research and reporting are essential to understand some aspects of emergencies and poverty, but by frequently limiting the scope of inquiry and types of questioned posed, these can also reproduce donor expectations of pitiable subjects of salvation, stereotypes of poverty and hunger, and iatrogenic or inappropriate interventions (Briggs 2003, de Waal 1997, Kleinman and Kleinman 1997). These can also narrowly portray the so-called "beneficiaries" of humanitarianism as "bare life" (Agamben 1998), devoid of the broader social, historical, and systemic realities of crisis, and therein substantiate narrow biomedical and technical approaches to humanitarian response.[99]

Statistical numbers have what Briggs and Nichter (2009) call "biocommunicability," or the ability of flows of knowledge about biomedicine or healthcare to variably circulate and stick and morph, depending on how information at hand is used and represented. Several different stories were simultaneously being

[98] An example is in the mismatch between epidemiological analyses of humanitarian crisis and the donor appeals these data inform. Basic mortality surveys are conducted by relief agencies in crises to monitor daily death rates within the geographic parameters of a camp, hospital, or feeding center. In contrast to resulting donor appeals and media images, these larger surveys demonstrate that the highest *proportional* increases in mortality in crises are almost always experienced by teenage men. In almost all cases, women survive famines, refugee settings, and wars at a higher rate than their civilian male counterparts (Dyson & O'Grada 2002, Toole & Waldman 1993).

[99] I take up this argument again, in more depth, in Chapter 6.

communicated about Somalis, the Somali Region, Ethiopia, and concepts like hunger (malnutrition), illness (morbidity), death (mortality), and disaster primarily using numbers and statistical relationships. Statistics were required to describe to donors the success of improvements in health services and livelihoods, and these usually were presented as nation-wide counts: number of clinics built, number of health extension workers trained, numbers of megatons of food and doses of essential medications distributed and so on (Ministry of Health 2008, UNICEF 2009a, UN OCHA 2009). Measured in this way, the Ethiopian government and nongovernmental aid agencies have made substantial improvements in the health and lives of millions of Ethiopians, including, presumably, Somali Ethiopians (The Ethiopian News Agency 2011).

At the same time, negative numbers and pessimistic stories were also required to appeal for additional donations of food and medicine and cash to meet the needs of drought- and conflict-affected Ethiopians, including those in the Somali Region. These included numbers of severely acutely malnourished children under five years old, numbers of cases of acute watery diarrhea, and rainfall totals (UN OCHA 2008a, 2008b, 2008c, and 2009, UNICEF 2008c and 2009a, USAID 2008 and 2009). If possible, these numbers were given geographic and – because of Ethiopia's ethnic federal political system – ethnic attribution: ethnic regions were listed as having specific levels or rates of malnutrition or diarrheal diseases or lack of potable water. Somalis were simultaneously interposed into these contradictory stories: on the one hand they were included to represent success in numbers of clinics opened and vaccinations given, but on the other hand, they were portrayed as consistently lagging behind the rest of the country with

regards to health and other measures, and were shown to have made little progress in being able to withstand droughts, price inflations, and other shocks. Lautze et al. (2009:7) write that the Government of Ethiopia objects to the narrow framing of these stories:

> "there is a remarkable lack of variance in the media discourse about crises in Ethiopia, discourses that the government suspects are if not fuelled by then at least served by the fundraising needs of international humanitarian organisations. Time and again, the country is characterised as dependent on foreign aid, its people lazy, and its government obstructionist."

To further develop these themes, below I present a series of emblematic narratives or stories in which various ideologies and ideas about biomedicine, Somalis, and non-Somali health providers are communicated between individuals in the northern Somali Region. Some of the stories were articulated within the context of formal ethnographic interviews, while others emerged from informal conversations.

Stories of Malpractice in Aysha Medical Center

Almost every Somali resident of Aysha I spoke to for this research told me a story about frustrating experiences at the Aysha Medical Center. Most described the facility as inadequately equipped, and the staff inadequately trained and hostile to the local Somali population. Accordingly, a few women in Aysha told me variations on the following story: three Somali women from Aysha each had a sick young child – one with diarrhea, one coughing, and one with a high fever. After waiting a couple of days and feeding the children well, but not seeing any improvement in their health, each of the mothers,

independently, took their babies to Aysha Medical Center. After being seen in the Medical Center by one of the habasha male nurses, they were each given a small bag of red and black capsules and told to take one three times per day. They all received the same pills, the same abbreviated advice, no diagnostic tests nor any clearly articulated diagnosis. Upon hearing of the other women's experiences, they were each quite angry. They talked about this experience all over town. One of my interviewees, a friend of one of the mothers, shook her head in disapproval, laughed without smiling, and asked me rhetorically, "Did anyone even look at those babies? Or did they just give out pills?"

Aysha Medical Center is the only health facility in Aysha town, and is the largest clinic between the border of Djibouti, Somaliland, and Dire Dawa city. The Medical Center was originally designed to fill local gaps in healthcare left when the clinical facility in the Degago refugee camp closed in 2005. Prior to the construction of the Center, there was a two-room clinic in Aysha, built in the 1930s by the Italian government during the heyday of railroad commerce, and intermittently stocked with medical supplies by nongovernmental humanitarian organizations. From the late 1980s until 2005, most Somalis did not visit the tiny Aysha facility at all, but sought medical care in Degago, only 25 kilometers away. Today Aysha is a regional referral center, designed to augment the supplies and care in heath posts scattered throughout the northern Somali Region. Yet in my time observing and living at the Medical Center, there were very few Somali patients. And it was no wonder.

Although built only two years prior to my research, the Aysha Medical Center was already crumbling and filthy. Cheap metal screens had rusted and been halfway

ripped out, and many of the windows in the facility were broken and never replaced. The wind in Aysha is constant much of the year, blowing between 30 to 40mph, and it slams metal doors into loose aluminum siding, window parts into metal sills, and gutters into piping all day and all night long. Blowing electrical wires strung above the Center also provide an eerie, high-pitched hum that adds to all the clatter. No one was hired to regularly clean the wards, and the grounds were littered with rotting cardboard boxes, broken tables and chairs, rusty sinks, rotting food scraps, tires, used sharps, new sharps, piles of half-burned trash, goat droppings, and several petrified human feces. The staff at the Center were mostly young and male and on their first assignment after professional training; most did not choose to live in Aysha but had been assigned to live there; and most previously lived in major cities in the western part of the country, had not spent time with Somali populations or in the Somali Region of Ethiopia, and could not speak the Somali language.[100]

The year I spent in and out of the Medical Center there were 16 total employees: seven nurses, variably trained, one health officer (a higher ranking public health expert who is also a nurse), one midwife, one health extension worker, two druggists, two laboratory technicians, two environmental health experts, and two elderly Somali guards who sometimes provided translation services.[101] There was one Somali nurse hired in July 2009, but we never met him because he was in Jijiga for an unspecified training program; the midwife was also Somali, hired in July 2009, but was staying in Dire Dawa

[100] The difficultly training rural Somalis in healthcare and still retaining them for work in rural areas is one found elsewhere in the world, and mentioned in Somalia, for one, by Helander 1990.
[101] There were two Somalis hired during the year of my research: one female health extension worker and one female nurse. However, the first woman was only hired two months prior to my departure and was still residing in Dire Dawa for training activities in August 2009.

for another training program. Finally, one other Somali nurse was still on the payroll at the Medical Center, but no longer spent any time there at all.[102] Due to the large number of training opportunities and national holidays in Ethiopia, health staff may travel and stay in other places frequently. In fact, most of the days I spent in Aysha, there were only a handful of people staying there.

For instance, while I stayed in Aysha Medical Center for two weeks in late April and early May 2009, there were five total nurses, one health extension worker, one druggist, zero lab technicians, and two Somali guards; none of these staff, except the guards, spoke any Somali. The following selection from my field notes describes a typical weekend:

> Friday May 1, 2009
>
> Last night at 7:00pm a car horn blew from outside the gate. Then silence. A moment later the horn blew outside several more times, until finally, a woman from inside the vehicle got out, let herself into the compound, and opened the gate. Seeing this, I knocked on closed doors in the compound until two staff were located, fast asleep after the previous late-night chewing khat.
>
> They roused quickly and stumbled to find their white coats underneath piles of clothes.
>
> "An emergency!" one sleepy health extension worker yelled out to the dark, empty compound. "Where's Idrias?" [the highest-ranking nurse in town at the time]
>
> No one knew. The two healthcare staff glanced at each other and shrugged.
>
> An older Somali man jumped out of the back of the vehicle, threw out two full plastic bags, a yellowed water bottle, and a gourd. Then he hopped out. Another woman [his wife, I found out], slowly crawled out of the back of the vehicle, helped on one side by the Somali woman that had ridden along, and by

[102] This female Somali nurse collected a government salary to work at the Aysha Medical Center, but instead actually worked for another international NGO in Aysha town (this was another source of tension, as other staff at the Aysha Medical Center resented her taking two salaries but not apparently fulfilling her duties).

me. She could hardly stand, and could definitely not walk, so we had to hoist her up into the intake room.

She lay down as her husband produced a letter from the kebele [neighborhood] chairman in Elahelay saying she was sick and needed to be seen in the Aysha medical center. The letter was on a crisp paper, stamped, in neat handwriting and a flourished signature. However, besides us, no was in the health center that night was literate in Somali, so no one with authority could even read the letter. And of course, there was still no one to translate the Somali words into Amharic for the two present medical staff. We did some translating into English until finally, after a half hour or so, one of the guards, sleepy and tousled, showed up to provide some translation into Amharic for the three habasha staff on hand.

…

Coming back to the Medical Center later that night, all was quiet, but brightly lit. The woman was asleep in the "Male Ward" by herself. There were no sheets or blankets, the mattress she was on was torn, and the dirty stuffing was falling down around her. She had no extra water for drinking (the one functional faucet in the compound remains dry, and water in the large underground cistern in the back is too dirty for consumption), and there was no way to turn out the bright florescent lights above.

…

Saturday May 2, 2009

The next morning after I had gotten up, the female patient seemed to be the only other person awake. Again, no was has been out of their room all morning. She was lying down blinking, still a bit shaky, but seemed to be more with it than last night. … I went back to her room and asked if she's hungry and would like biscuits or borash [porridge]. Yes, she said, so I make an extra batch of oatmeal. I also brought her a bucket of water from the now slowly dripping faucet outside the latrine. By this time her husband had returned to the Medical Center, and he greeted me. We make basic introductions; his name is Abdul and her name is Maryan – they live outside Elahelay, and had travelled here because Maryan's heart is very weak, and she needs to get to a hospital.

…

[Later that day, after spending time with Nimo and other women in town]

Nimo and I headed up to the medical center where the Abdul and Maryan were resting, and still waiting on a referral to a bigger facility. Abdul had bought her three oranges in town, and she had partially eaten one, leaving the peeling and white wasted parts lying scattered around the bed. Nimo tells her about the project, then asks some basic questions about what happened. Maryan reports that she has been sick for a while, and even went to the mobile team[103] in

[103] Mobile Health & Nutrition Teams (otherwise called in the literature "mobile health units" but throughout this dissertation abbreviated as mobile teams) are a popular contemporary form of medical aid

Elahelay several weeks before. She collapsed on the floor there, and they revived her and tested her around the arm (blood pressure, most likely). Abdul, one of the mobile team nurses visiting Elahelay, told her to go to the hospital in Dire Dawa or the Ali Sabe Hospital in Djibouti if she could, but they didn't have the money to travel at the time. So they waited. Finally, she began feeling worse, and they have now decided they have to go to Ali Sabe Hospital. They are only in Aysha to get a referral and some medicine. Someone fetched a car from Biyoqooboobe 18km away, and drove her from Elahelay to Aysha yesterday. The car ride was particularly difficult, Abdul said, because the road was so rutted and rough; by the time Maryan arrived here, she felt, as she said, very seriously sick.

She said that once Hamsa, the Somali guard, arrived and helped translate her problems, the nurses "tested her"—meaning took her blood pressure and pulse. They gave her some pills too, which had already migrated to the very bottom of one of Maryan's tired plastic bags. She pulled out the foil package that had one pill missing and repeated the instructions they had given her the night before. She had no idea what was wrong with her though, no idea what the test was about, or what the pills were for. No information at all. They did not even know what they should do here; they expected someone to come and give them a referral to another hospital but no one had come back to check on what they needed. They were just waiting, alone, for something else to happen. Today is the Muslim holiday anyway, a Friday, so said they will wait until tomorrow to go to Djibouti.

…

As we leave their room, I note that it is noon already, and Idrias has not been seen anywhere. So, I knocked on his door only to find him still asleep. I let him know that Nimo was here and can provide a translation if he needs her to, and then ask him if everything was okay with the patient. "Well," he said wearily, "everything is okay," she had been given a "hypertensive" drug and told she could stay here because she had nowhere to sleep in the town. I told him that she had mentioned to us she had the same problem months ago when she was seen by the mobile team. He said hypertension seems to him to be "chronic," adding, "it's probably the low quality of the food she eats." Somalis' food is "so spicy."

…

Sunday May 3, 2009

Idrias yells in Amharic at Haile [another nurse] as Haile heads across the compound with his dirty shirt in his hand, bare chest, wrinkled pants, and

---

in the Somali Region of Ethiopia. Typically, they provide primary care and screening for pregnant and lactating women and children under five years of age, train community health workers, train community volunteers in health awareness, provide primary community healthcare, provide ambulance services, bridge linguistic and cultural gaps between providers and community members, and educate communities on public health concepts. Most mobile teams are administered by the Somali regional government, although most of their funding derives from nongovernmental organizations like UNICEF.

> sleepiness still evident. Haile stumbled into the intake room and a few minutes later, emerged with a sheet of paper – finally, the referral to another hospital.
>
> …
>
> Maryan and Abdul left town without another word to the staff at the Center. Idrias slept for the rest of the day. There were no more patients.

Like the mothers with the three sick babies and Maryan and Abdul, numerous Somali residents wryly questioned: 'Do those guys just hand out pills? Do they have any idea what they are doing? Do they care what happens to us?' This narrative is on the one hand instrumental: it is a cautionary tale to other mothers with sick children and an opportunity for patients to vent personal frustrations. More importantly, once contextualized, I find that sardonic jokes about malpractice and incompetence at the Aysha Medical Center articulate more general anxieties within the resident community about the quality of healthcare in Aysha and the probity of habasha individuals.

Stories of Body Theft and Experimentation in Dil Chorra Public Hospital

During four separate interviews with women, and in additional informal conversations with several Somali lay adults, a story was repeatedly told about clinicians at Dil Chorra public hospital in Dire Dawa city stealing internal organs, fetuses, stillborn babies, and cadavers in order to "experiment" or "practice" (*shaqaysatay*) on them. In the dialogue that follows, Asha, a Somali traditional birth attendant from Degago, relays variations on these stories to me during an ethnographic interview:

> Asha: So many problems can arise when women have a serious complication during childbirth. Here in Degago we don't have a doctor, and we don't have

injections [to stop uterine hemorrhaging] either. So that is why, sometimes, we have to go to the government hospital in Dire Dawa. … One time, I accompanied a woman [from Degago] in labor [to Dil Chorra Hospital] when she had a serious complication. She died there in Dil Chorra, and the habashas refused to let us take her body home with us after she died. They said that we must pay them money in order to take the body! ... They tugged on the dead body on one side, and we pulled it on the other side. … The man who lives in that house in front of us [she nods and points with her head] was her husband. They said to the two of us that we had to pay money to take the body and we said [we don't have that money]. I have never seen anything worse than that dead body for as long as I've lived. And so they kept the dead body. We accepted this. They [the clinical staff in the hospital] told us we would have to pay 300 birr [approximately US$25] to take the body with us. But we did not have that much money with us. Then they said if you don't have any money, the other hospital workers will operate on the corpse. The workers in the hospital said that the nurses will take the body and they practice (*shaqaysatay*) on it. …

Me: How did she know the nurse used the body for practice?

A: That is what the people who worked there said. Another woman [from Degago] who gave birth was taken [to Dil Chorra] from Shinile town [also in the northern Somali Region]. She gave birth to a living baby, but no one knows where the workers took the baby after that. Oh God.

M: Did that woman die?

Asha: No, and the baby was alive when he was finally taken out of her [vaginally] there in Dil Chorra. But oh God, … when she gave birth, actually the baby was unconscious [but alive] … and a lady said to her, "your baby has died. Now leave." That baby, he did die, I suppose, but then they said that she had to leave. And they never showed her the baby. There were other women who were referred [to Dil Chorra] from Degago and treated the same way. Another woman in our family, after she had an operation [to get the baby out, maybe a cesarean section] and then after that the baby went missing. … Oh God, we don't know what happened. …

M: So now are people afraid to go to Dil Chorra?

A: Yes. The people they have fear [of going to Dil Chorra] unless you have a strong person to accompany you. Someone who is a translator [from Somali to Amharic] and well connected in the town, someone who can follow you after every step.

Dil Chorra Hospital is the largest public health facility in Dire Dawa. On the bustling street outside the main gate, in the part of town called Kazeira, between ten and thirty people are usually seated on the sidewalk, begging for money as blue motorized rickshaws screech to a halt inches in front of them, dropping off new patients and visitors. Many of the men were missing limbs, most of the women were seated with infants and young children. At night, many of Dire Dawa's homeless and disabled male residents slept in a long chain of human bodies stretching from the front gates of the hospital, around the corner, one hundred meters down the street.

Dil Chorra employed numerous physicians, nurses, and medical assistants; nearly all were either habasha or Oromi[104] and few spoke any Somali language. The government salaries for these clinicians are far lower than what the same clinicians can potentially make in private practice, where they could charge higher individual fees per service. Consequently, clinicians referred many patients who presented at Dil Chorra to their private practices elsewhere.[105] Those too poor to pay the fees associated with private care sometimes languished in the wards, unable to receive basic care, either until they became sicker and died or until they recovered on their own enough to leave the facility.[106]

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[104] Oromo is the largest ethnic group in Ethiopia.

[105] This phenomena has been noted around the world; relationships between public and private health sectors has been a popular topic in the medical anthropological literature (Conteh and Hanson 2003; Birungi et al. 2001; van der Geest and Whyte 1996; van der Geest and Whyte 2005, Helander 1990).

[106] If Somalis near Dire Dawa can afford it, they most often visit Bilal Hospital for healthcare. Bilal is the largest private hospital in eastern Ethiopia. Unlike Dil Chorra, most clinicians there speak Somali, and the director of the hospital is a Somali-American physician. However, Bilal caters to wealthier Somalis vacationing in Ethiopia from Djibouti as well as wealthy Ethiopians, so their prices for services and medications are relatively high.

Patients were not turned away from Dil Chorra due to their lack of financial resources, yet often, medical specialists, diagnostic equipment, and other materials were lacking. Furthermore, either patients or their caregivers had to provide patients' meals and most medical supplies, including wound dressings, splints, pharmaceutical products, syringes, latex gloves, and IV bags, and these were for sale either in the hospital pharmacy or in one of the several private pharmacies nearby.[107]

The structural and material deficiencies of Dil Chorra contributed to Somalis' expectations of calamity and maltreatment there. In Asha's case, there was a sensible hospital policy that, for hygienic and safety reasons, persons cannot leave the facility with a corpse. But this policy was not effectively communicated to Asha, if mentioned at all. Instead, frantic stories of "practicing on" dead bodies have become scurrilous tales about habashas, ignorant of Somali language, blind to Somalis' suffering, and both incapable and unwilling to provide adequate care. Stories of malpractice at Dil Chorra were often held up in comparison to healthcare provided in the former Degago refugee camp and with the two Somali mobile team nurses.[108]

Stories about Medicine "From Abroad"

Many persons in the northern Somali Region expressed suspicions that the quality of medicine on the black market in the Horn of Africa was inferior to the quality of

[107] Although this paper documents the experiences of northern Somalis seeking care at Dil Chorra Hospital, experiences like these also befell persons of Amhara, Oromo, and other ethnic groups.
[108] This also compared detrimentally to Bilal Hospital in Dire Dawa.

medicine available in licensed pharmacies and private hospitals.[109] Medications available in unlicensed pharmacies, small shops, and government clinics were frequently compared, detrimentally, to those available from foreign relief clinics and expensive private facilities. At the same time, many Somalis assumed that medications produced by Ethiopia's burgeoning generic pharmaceutical industry were of substandard quality and strength. Sara, a young mother of five in Degago said,

> Sara: It's true that the people [here in Degago] believe that the pills in the [private, unlicensed] pharmacy are from abroad, and thus more original (*originaal*) than the ones made in this country [Ethiopia]. And they like that. The pills in the pharmacy are also more expensive than the ones in the [government] clinic. I believe (*aamminaa*) in the ones [medications] from abroad, that they are appropriate and are the highest quality...
>
> Me: I ask for clarification about what she means by "*originaal*"
>
> S: I mean the medicine of pharmacy from abroad – but [by contrast] the medicine found in the clinic is from Ethiopia so the medicine of Ethiopia is a copy but the medicine of pharmacy is original. Most people they believe in the medicine from abroad.
>
> M: [I want to clarify again and ask,] From every place abroad? Is it all places from abroad or just some places?
>
> S: There was an organization [an international NGO] here before [during the refugee camp time]. That organization, they used the medicine from abroad, that is why we now believe in the medicine from abroad. They [the people here] only believe in what is from abroad.

Hassan, a young Somali father and a social and political leader in Aysha, stated the same theme:

[109] See Chapter 1 for a summary of various flows of medicines and supply chains.

> Hassan: All the people here, all of our society, they agree the quality of the drugs here produced in Ethiopia is very poor and we believe that one tablet from abroad is equal to twenty tablets from [Ethiopia]. … If you tell somebody that this drug is from this country and that one is from abroad, even if that pill [from abroad] is more expensive, he will take the one from abroad.
>
> ... There is also a difference between the pills from abroad. People believe the drugs from France are better, for example, and many of the doctors in Djibouti are white people from France and can give medicines from France. … Every woman from here, when they are going to deliver a baby, they say, 'Oh don't take me to Dire Dawa, please take me to Djibouti!' because they know the quality is much better. Even my wife, I took her to Djibouti. The first child was born in Dire Dawa, but the others in Djibouti. She refused to give birth in Dire Dawa because of the quality, and now I take her to Djibouti. It is no problem to cross the border because there is a relationship between Somalis in Aysha and Djibouti – they recognize we do not have good medical services, so they know we always go to Djibouti for treatments. In this kind of case they accept us [to cross the border without a visa] because we are from one society, one people, especially the Issa clan.
>
> …You [referring to the author], as a white person or a foreigner woman, if you give somebody a drug, even if it is from Ethiopia, she will believe it is a drug from abroad and she will believe it is better than any other.

Persons did not express a simplistic preference for any medication "from abroad;" instead people specifically worried about the expiration date, quality, and safety of all medicines. Brand-name products from Europe and the United States were typically sold in recognizable colorful packaging materials and with expiration dates clearly printed on the box. By contrast, in shops and unlicensed pharmacies, pharmaceuticals were frequently sold individually or a few at a time, sometimes without their original boxes or blister packets. Similarly, in health posts, humanitarian relief operations, and governmental medical centers, generic pharmaceuticals produced in Ethiopia were often either provided in tiny nondescript zippered plastic bags, or distributed with no packaging materials at all. For example, most generic pills for sale in the Aysha Medical Center

were scooped from one-quart white buckets with the name of the drug name and basic indications abbreviated with markers on the side. As Hassan mentions, narratives of anxiety about the quality of Ethiopian medications mirror and may even compound common worries about perceived quality of care available from Ethiopian health providers and in Ethiopian public health facilities.

Nearly every layperson I spoke with throughout Ethiopia – informally and in the context of ethnographic interviews – described a similar hierarchy of quality in medications derived from different countries. For example, drugs from Germany and France were always considered the highest quality; after that, medications from elsewhere in Europe and the United States; after that, medications from China; after that, medications from India, Pakistan, and Yemen; and finally, the perceived lowest quality pharmaceuticals were those produced in Ethiopia. One Somali woman joked, "Nothing Ethiopians make is good quality! We are too poor." Thus, although Ethiopian generic pharmaceuticals were often the most affordable pills available, and were produced and procured via legal and sound methods, many Somalis preferred purchasing pills they knew were contraband. As Hassan states, many persons in the Somali Region assumed, often incorrectly, that the pills provided from expatriate clinicians or the UNICEF-funded mobile team also came "from abroad," and were therefore of higher quality, safer, and more powerful.[110] In the Somali Region of Ethiopia, when foreign relief workers or mobile team nurses ceased providing medicines, individuals were left to choose between

[110] Ironically, many of the pharmaceutical products distributed by international nongovernmental agencies were generic brands, produced in Ethiopia, India, or China. These generics met international standards for quality and formulation.

purchasing medications on the black market and obtaining generic drugs from government health facilities – and each of these, many Somalis felt, were inferior sources. Rampant concerns about the paucity of medications were often joked about as representative or emblematic of Somalis' marginality vis-à-vis the Ethiopian state and global supplies of medicine. To quote Hassan again,

> The mobile team provided *kiniini* (pills), mostly, to the people here. People loved the mobile team. And [the people] believed in those pills, during the six months they were serving here. The people all of them they focused on the mobile team, they liked them personally, they took the [medical] services from them and they believed that their medicine was quality medicine. The people even said that these pills were not sent by Ethiopia, they were surely sent by Allah!

Several studies in developing countries demonstrate how rumors of substandard or dangerous medicine have material bases – for one, the proliferation of counterfeit and fake drugs in West Africa has been a topic of much research and public speculation (Alubo 1994, Feldman-Savelsberg 1999, Obadare 2005, Samba et al. 2004). Narratives of distrust in pharmaceuticals are critical because they can potentially affect subsequent health-seeking strategies and people's future reactions to vaccination and other public health campaigns. There is no peer-reviewed research to indicate that counterfeit medicines or other harmful contraband medical products exist in eastern Ethiopia. But this research suggests that increasing numbers of people in the northern Somali Region fear that contraband pharmaceuticals originating in India, Pakistan, China, Yemen and elsewhere may either be substandard or harmful.

Stories of Racism and Resentment in the Aysha Medical Center

Habasha healthcare providers at the Aysha Medical Center were demonized and criticized, repeatedly, by Somalis living in Aysha town. But animosity and frustration flowed in both directions. Interviews and informal conversations with the habasha staff of the Center revealed several interpersonal, communication, and bureaucratic challenges they faced in providing care to the local Somali population, and the resentment such challenges engendered. The most common complaint voiced by healthcare providers was that, as one male nurse put it, "The Somali people have an adherence problem." In other words, they would not "do what we tell them to do. … They don't believe in what we give them." Idrias, a young habasha nurse I introduced earlier in this chapter, described his difficulties more specifically:

> People here love amoxicillin pills more than any others – they are red and black and so any other red and black capsules would be very popular here. The Somali people think that amoxicillin will cure anything! … People here also really love injections. Sometimes we give [sic] saline injections to people who are demanding. [Laughing, in frustration] … People prefer injections to pills, but even more than this they like the big IV bags – they think that the bags are full of some kind of medicine – they don't realize it's just glucose! … These are general beliefs of the Somali people.

Signaling the prevalence of communication barriers and cultural misunderstandings at the Aysha Medical Center, a newly hired health worker said sadly, "the Somali people here are hard to understand." None of the habashas employed in the Center spoke Somali, but as state, instead either depended on the elderly Somali guards manning the Medical Center gate or volunteers recruited from town to provide ad-hoc

translation services. Hassan spoke Amharic and frequently served as one such volunteer. He said:

> There is a language barrier here. The people who are civil servants, they don't know the local language, the Somali language, and our people they don't know Amharic or English, especially the rural people [pastoralists who live outside Aysha town]. There is a gap in communication, and for example, some patients were prescribed drugs that were not appropriate for their disease due to the lack of understanding [between Somali patients and habasha providers]. … There were some newly trained Somali people who were selected from the kebeles around Aysha. They were trained six months – I had assumed these people would get maybe one or two years of training to cover this problem, you know, but then they were trained only six months and they were deployed to the [rural] kebeles rather than the [Aysha] Medical Center.

Further, several clinicians in Aysha Medical Center also berated Somalis for their supposed ignorance of biomedicine and their frequent use of "traditional medicine." One druggist said: "there is not much education here – they need more. We need [to give them] more education on the rational use of drugs." For example, he complained that several Somalis had presented to the Center with infected burns on their skin from traditional healing rituals presumably gone awry.[111] Other staff expressed resentment that "Somalis have no respect" for their medical training or knowledge, and would instead prefer to seek advice from "traditional" healers or another Somali person, even one with less education. "Popularity is everything for the Somali people–not diplomas," Idrias said. "Somalis are very racist. They are a very racist people. … We are foreigners to them."

[111] The nurses in this exchange refer to the popular (although likely declining) use of burning or branding (*gub*) of the skin with smoldering wooden sticks at the site of disease or discomfort.

Despite the expense and hassle, most Somalis preferred to travel to healthcare facilities in Djibouti or Dire Dawa rather than seek care from the staff at Aysha in cases of a medical emergency. One Somali mother told me, "we go to them [the Aysha Medical Center staff] for simple pills (*kiniini yaryar*), simple diseases, (*xanuuna yaryar*) or vaccinations, but not for serious things. Then we must go to another place." Another woman who had visited the Medical Center recently reported being dismissively told her problems were only "allergies" (*xasaasiyad*) – all the staff of the Center know how to treat, she said, are allergies, colds, and uncomplicated malaria. Nurses in the Aysha Medical Center were acutely aware of such perceptions; several expressed regret that they did not have a better reputation within the Somali community. Idrias added,

> They [local Somalis] will not come here first, they will do everything else first, and then at the last stage they will come here. Then, they'll blame the medical center workers when the people die. For example, there was a child brought here with severe diarrhea. The child was only two years old, and had diarrhea for one full month. He died in the dispensary, and so the mother blamed the staff here.

Mistrust of the Medical Center staff extended beyond the local Somali community to include Somali-led healthcare bureaucracies at the woreda and regional levels. Idrias elaborated,

> Rumors spread very fast in the Somali Region. The side effects of a drug, the smallest mistakes we at the health center make, everything. The people in the government [at the Somali Regional Health Bureau] say that we have no health services here – and they just want to mention the bad things that happen here, never the good things. For example, there was one time when a patient died after a terrible car accident. All the people, they said that we killed him. But he arrived with his stomach the wrong side out, coming out of his body! The insides of his stomach were on the floor of our clinic – what could we do? But when the

> next meeting [at the local Health Bureau office in Aysha] happened, they became very angry, blaming us for his death. … it is like they want us to fail.

By contrast, the mobile team made frequent referrals for patients in remote areas of the woreda to the Aysha Medical Center, and Idrias was appreciative of the support this conveyed. When the mobile team left in March 2009, he expressed fear that, without those crucial personal referrals from the trusted Somali mobile team nurses, he would no longer see any Somali patients at all.

The Behavioral Effects of Stories and Idioms of Distrust

Such narratives have observable effects on specific medical behaviors. First, many Somalis' mistrust in certain pharmaceutical products – both generic pills produced in Ethiopia and contraband pills purchased on the black market – moderates their willingness to consume full, recommended courses, especially in the case of antibiotic and antimalarial medications. Some fear the consumption of counterfeit medications might have deleterious consequences for their health; others fear wasting their money on substandard treatments. For many, if the mistrusted medicine doesn't prove effective after one or two doses (measured, typically, by the person feeling better), alternative treatments are sought or the regimen is ceased.[112] Shortened or otherwise inadequate

[112] Additionally, clinicians I spoke with at Aysha Medical Center and in two health posts near Aysha reported instances in which patients would arrive at their clinic admitting to having consumed contraband medications purchased from local shops. These patients presented with complaints that were interpreted by clinicians as "adverse effects," such as vomiting or dizziness. Sometimes, clinicians assumed these adverse effects were consequences of the patients' consumption of multiple pills at once; other times, they worried the adverse effects were due to the consumption of inappropriate or counterfeit medications. For many

doses of antimicrobial medications may have important ramifications for local epidemiology, by creating an ideal environment for the development of resistant strains of infectious disease.

Second, as previously alluded to, there has been a recent rise in local preferences for medications as well as healthcare providers "from abroad," especially from Europe and the United States. Mohammad's story provides a case in point. Mohammad is a young Somali man who for years has suffered from chronic diarrhea, acid reflux, and an inability to gain weight. He was born in Mogadishu but fled as a child with his family to the Degago refugee camp during the civil war in Somalia. Before the Degago camp closed, many of his family members received medical care from the clinic there. After relief organizations pulled out of Degago in 2005, his family decided to remain. Mohammad is fluent in English. Consequently, unlike the other men in his family who keep livestock and run small shops, Mohammad has managed to get a few temporary jobs with humanitarian organizations conducting surveys, providing translation services, and monitoring food distributions. But most years, he doesn't make over US$100 (far below the national average). Mohammad has long been desperate to feel better, and had exhausted several local treatment options: camel milk consumption, ritual burnings, and Qur'anic healing. He had also tried generic antacids purchased from the health post and Aysha Medical Center, but these never stopped his stomach pain. In March 2009, frustrated at his continuing ill health, he spent over US$50 in order to travel to Dire

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reasons, several ill persons I spoke with only took a few antibiotics at a time for the treatment of common infectious disease, like acute diarrhea or respiratory infection. Only two persons I interviewed spoke of taking multiple doses of pharmaceutical medications at once, and this practice was generally regarded by Somalis as dangerous.

Dawa, visit Bilal Hospital, receive multiple diagnostic tests, and purchase brand-name German antibiotic and anti-parasitic medications. But by the time I left Ethiopia several months later, his health had still not improved. He was also increasingly discouraged about his lack of options. Even though he knew it was unrealistic and nostalgic, he once said sadly, "If MSF [Médecins Sans Frontières] was still here, I would be a healthy man I think." Still, neither Mohammad nor his family wanted him to purchase any medications from the unlicensed private pharmacy in town. He once said,

> Ali [the owner] says he has many medicines that would treat my stomach problems. But [his] medicine is not of good quality. He buys his medicines from Somalia, and I hear from other people that sometimes they are not good. I cannot know where they have been before now and how well they have survived.

Like Mohammad, many who had received care from humanitarian operations said they would not settle for what they perceived to be substandard or risky treatments. They were less likely to prefer or purchase contraband and generic medications and less likely to visit small health posts or the ill-reputed Aysha Medical Center. Instead they made extraordinary sacrifices to access medications from more trusted medical authorities elsewhere.

Third, when patients do finally seek medical care in larger and distant facilities they often receive a litany of diagnostic screenings; these forms of biotechnology have become both litmus tests and symbols of high-quality biomedical healthcare. For many women, abdominal ultrasounds have become emblematic of excellent care—most of their hospital health care seeking involves a pregnancy, childbirth, or concern about infertility. For many men, the collection and analysis of stool, blood, and sputum samples, plus x-

rays or other imaging technologies, are indications of sound practice. When persons have negative experiences with health providers in one place, like Aysha or Dil Chorra, and face travelling to other facilities, they frequently cite a desire for additional or better diagnostic tests. Stories about a positive clinical encounter typically involve the recounting of multiple diagnostic screenings, and, in the end, both a trustworthy diagnosis and a high-quality treatment. Unfortunately, Aysha Medical Center lacks much of the diagnostic equipment many Somalis increasingly demand. And despite its size, Dil Chorra frequently lacks the equipment or specialists to perform basic procedures as well. Adding to the awful reputations of these two facilities, the growth in demand for new biotechnologies adds to local preferences for distant and expensive private facilities.

Conclusions

Cheryl Mattingly writes, "Attention to human suffering means attention to stories, for the ill and their healers have many stories to tell" (1998:1). In sum, stories about medicine and malpractice in the Somali Region are instrumental in that they help people manage a range of medical insecurities. More crucially, the discourses I outline are also ideological, provocative, and highly consequential. They articulate the precarious contours of medical trust in the margins of the Ethiopian state, while more broadly evoking Somalis' frustrations over lack of access to trustworthy biomedical healthcare and the histories of violence and discrimination against Somalis by habashas and the Ethiopian government. Many Somalis perceived the habasha staff in Aysha Medical

Center and Dil Chorra Hospital as the latest in a long line of ignorant, racist, and discriminatory government representatives. When faced with a health crisis, they preferred to seek care from other Somalis, foreign aid clinics, private hospital facilities, and brand-name foreign pharmaceutical products. At the same time, habasha healthcare providers at the Aysha Medical Center repeatedly expressed frustration with the perceived recalcitrance of their Somali patients. They bemoaned Somalis' pushy "non-compliance," their mistrust of biomedical authority, and their reliance on "harmful traditional practices." Moreover, habasha staff expressed resentment at the lack of support they received from Somali governmental bureaucracies who were, as one nurse said, "only loyal to other Somalis and to their clan."

In reality, Somalis had a diversity of experiences in Ethiopian health care facilities – mostly negative, but some positive and helpful – and likewise, several habashas – for one, the regional World Health Organization representative for eastern Ethiopia – were admired and respected by residential Somalis. However, the narratives I outline magnify historical hostilities, worsen stereotypes, and reify racialized categories of "Somalis" as well as "habashas." Discourses of Somalis as inscrutable, ignorant and irrational fit neatly into logics that blame Somalis' character and culture for the continuing failures of health interventions.[113] This research demonstrates that health outcomes and Somali patients' "compliance" with recommended courses of action related more to the *lack of trust* between providers and patients and to the *low quality of care* at facilities like Aysha Medicine Center and Dil Chorra hospital rather than to Somalis'

[113] This argument draws on Briggs and Martini-Briggs (2005) and Farmer (2003).

ideas about disease and biomedicine. At the same time, narratives that typecast habasha providers as racist, careless and incompetent undermine the potential for future improvements in healthcare. They undermine the good intentions and capabilities of habasha clinicians and policymakers. Crucially, idioms of medical distrust reveal cracks and elisions in the official peace agreements and alliances between Somalis and the Ethiopian government in the northern Somali Region. They highlight what is inarticulable and too dangerous to say—namely that Somalis and habashas alike fear the rekindling of ethnic-based violence.

Finally, although efforts have been made to parlay humanitarian emergency funding into sustainable development of rural health systems in Ethiopia, as with the dispatch of Somali mobile teams, these efforts have largely failed in the Somali Region because such programs do not last and do not address profound bureaucratic and societal frictions. In stark contrast to Somalis' positive experiences with occasional foreign relief workers and Somali mobile team nurses, negative experiences with habasha clinicians generate patient subjectivities reluctant to trust emerging sources of biomedicine in rural Ethiopia, including the newly trained legions of community health providers, the newly affordable supplies of Ethiopian generic medications, and newly built rural government health posts. Accordingly, upon their departure, temporary medical humanitarian operations inadvertently worsen local racialized tensions and disparities that, down the road, may feed future conflicts and violence. Future attempts to improve the quality of care in Aysha Medical Center or Dil Chorra Hospital will undoubtedly be challenged by the palpable ethnic tensions manifested and worked out within the walls of these

institutions. If not recognized by health policy planners and local leaders, such subjectivities, and the associated health behaviors I describe, may cripple efforts in the Somali Region to improve clinical care, improve adherence to prescribed regimens of prescription medications, and promote timely and appropriate uses of healthcare facilities.

CHAPTER 5.

FLOWS OF PEOPLE:
KINSHIP AND MIGRATION IN CHRONIC STATES OF EMERGENCY

> Don't say the man was closer in blood relation to me, but say that he was good to me – they will not forget that. [Osman, a resident of Elahelay, reciting a Somali proverb]

In this chapter, I add nuance to contemporary considerations of Somali kinship and clan by taking healthcare practices, international interventions, and new migration patterns as points of departure. Family (*reer*) is vital to Somalis' personal and social identity. In addition, mobility and migration have historically been, and still are, central to social relationships and articulations of Somali life ways and kinship structures. This research finds that kinship and patterns of migration are also both profoundly shaped by repeated temporary humanitarian interventions and shifting demands for biomedicine. Thus, although humanitarian programs often target individual biological bodies (Agamben 1998, Fassin 2007, Redfield 2008, Ticktin 2011), sickness, health-care seeking, and healing are in fact experienced and managed by families rather than lone individuals.

In the northern Somali Region of Ethiopia, historically viable forms of nomadic pastoralism face continual challenges due to successive droughts, lowered water tables, restrictive international livestock trade policies, declining prices for livestock, and regional warfare (Markakis 2004). Faced with such conditions, new patterns of nomadism and cooperation have emerged. The strategies I document enable temporary

living for interim work with relief agencies, access to provisional food and medical aid distributions, and importantly, occasional access to distant and expensive healthcare facilities in the nadir of medical humanitarian relief. In essence, new configurations of kinship, mobility, and migration have all emerged in the northern Somali Region of Ethiopia, in part to deal with recurrent entries and exits of humanitarian agencies, and in part to take advantage of newly popular healthcare resources and technologies. Aid is deeply embedded and active within larger social, economic, and political structures.

Clan alliances are often cited as fundamental to, if not the cause of, incessant political instability and recurrent humanitarian crises in the Horn of Africa.[114] Considerations of Somali kinship in the news media have long focused on the ignoble and competitive relationships between clans for scarce resources, as well as violence perpetrated in the name of clan loyalty (e.g. Adow 2006). Few studies consider how kinship and clan are also shaped by foreign humanitarian and development programs, personal experiences of illness and disability, dynamic popular health cultures, and the humanitarian regimes assembled and re-assembled amid recurrent crises. In the northern Somali Region of Ethiopia, I find that kinship networks are central to post-conflict reconstruction efforts, everyday survival strategies, and responses to drought and food insecurity. Further, family ties are central to Somali's evolving care-giving strategies and healthcare seeking ventures during and after crises. Networks linking individuals within extended families facilitate flows of medical advice and information, travel and lodging for healthcare, travel and lodging for work and training with relief agencies, and cash

[114] The notion and history of Somali "clans" as well as the relationships between Somali "clans," state powers, and violence will be discussed in greater detail in Chapter 6.

payment for increasingly expensive diagnostic tests, medications, and private clinical facilities in urban centers. These kinship structures are flexible, contingent, and diverse – they have long provided a system of social solidarity and resource distribution in the absence of representative nation-state governments or reliable federal safety nets. Accordingly, I argue that Somali "clans" – while not without gaps and weaknesses – are not solely divisive or detrimental to Somali sociality or political stability, but are both constructive and necessary to meet dynamic local demands for aid and employment. Novel configurations of sub-clan units and sub-sets of siblings or cousins within extended families now form what are essentially kinship-based "therapy management groups" (Nichter 2002:81-82). In this chapter I focus on healthcare seeking as a lens through which to view these larger processes.

Constructions and deconstructions of the Somali "clan"

> Everyone's agenda comes down to clan in the end. [BBC's Somali Affairs Analyst, Daud Aweis, April 26, 2007]

Loyalty to family (*reer*) or clan (*reer* or *qabiil*) is frequently cited as characteristic of Somalis and central to their personal and social identities (Abbink 2003, Lewis 2004, Hagmann 2005). Somali societies in the Horn of Africa are, in many ways, structured by familial ties between individuals (*tol*) and a patrilineal, patriarchal, segmentary kinship system (Abbink 2003, Lewis 1961, Lewis 1994, Unruh 2006). Clan affiliation for most Somalis is based on the idea of a reconstructed and variably imagined lineage that traces individual family lines agnatically, through male descendants, back to founding fathers of

each clan, as well as the Prophet Mohammad or the Prophet's contemporaneous disciples (Lewis 1961). Lineages are central to individual identity and often shape political affiliations and persuasions (Abbink 2003). I.M. Lewis, the most prolific ethnographer of Somali peoples, has said, "Patrilineal descent (*tol*) indeed is all pervasive: most corporate activities are contingent upon it; in the veneration of local lineage saints Islam is interpreted to some extent according to it; and politics stem from it" (1994:19). Laitin and Samatar say further, "genealogy constitutes the heart of the Somali social system and is the basis of Somali collective predilection to internal fissions…a unity that borders on xenophobia" (1987:29).

Mid-twentieth century ethnographies by Lewis have long been the most influential texts about Somalis. His manuscripts typically situate political relations – as well as the roots of violence and political instability – within the segmented lineage system (Besteman 1996). In his ironically titled ethnography of Somalis in the Horn of Africa, *A Pastoral Democracy,* Lewis states that,

> The northern Somali are essentially a warlike people who readily engage in battle or raiding to redress wrongs and injuries, to release pent-up enmities, to acquire or maintain honor, and to gain access to natural resources or to conserve their rights over them. The aim of aggression is not so much to subjugate enemies completely as to establish political ascendancy. … In a society such as this, where fighting potential very largely determines political status, feud and war are instruments of power politics; they are the chief means by which the relations between groups are regulated. … [R]esort to violence…has to be viewed in the ecological context of acute competition for sparse resources, and in the abrogation of individual responsibility through group loyalties. (Lewis 1961[1999]:242)

Further, although Lewis made an argument for conflict and disunity among Somalis arising from competition for scarce resources, he says, "The real struggle is between the

elusive goal of nationhood and the day-to-day reality of sectional interests in lineage politics" (Lewis 1961[1999]:267). In a later publication, as further evidence, Lewis (1965[2002]) cites the geographical segregation and separation of pastoralist, agro-pastoralist and farming groups primarily by lineage rather than livelihood group. Thus he locates the roots of competition between Somalis for land and resources in a divisive and ultimately deterministic clan-based kinship structure. Clan structure, in these early and highly influential publications begets larger struggles for resources rather than scarcity itself driving social divisions and conflict.

Lewis (1994:221-222) later argues that Somalis in the Horn of Africa, "spoke the same language, shared the same…culture, and were all adherents of Sunni Islam," making them an "ethnic group" or "nation" but not a "unified polity." He says further, "Before and after independence, nationalist politicians [in Somalia] naturally sought to politicize their cultural legacy and transform it into effective national, political cohesion." In his analysis of the causes of Somalia's collapse in the early 1990s, Lewis (1994:232-233) essentially makes the following argument: first, he asserts that violence amongst Somalis is a result of inherently and historically divided and oppositional groups based on clan lineage; second, even when clans united to defeat other groups, they quickly re-divided to fight among themselves. Consequently, he goes on, "Everything that has happened in recent Somali political history is…an eloquent testimony to the accuracy of anthropological analysis [about the dominance of clan systems] – but at appalling cost in humanitarian terms." He then asks,

> is [clanship] in the 1990s basically the same phenomenon that it was in the 1890s? Linguistically the answer must be "yes," since the same terminology has been employed throughout the recorded history of the Somalis. Sociologically, the evidence also supports this view. Indeed, the argument of this book is that clanship is and was essentially a multipurpose, culturally constructed resource of compelling power because of its ostensibly inherent character "bred in the bone" and running "in the blood" as Somalis conceptualize it.

In a more recent text, Lewis (2004) expands on the "invisible" and "ontological" power of clanship by saying:

> the kinship groups or lineages that are, as we shall see, the basic building blocks of Somali society, have a biological form, although they are entirely cultural products, the results, over a long time-span, of Somali 'social engineering'. The sociologically significant point about this form of social division is that it produces what appear to be axiomatic, 'natural' distinctions, with the same ontological status as botanical species or zoological breeds. Despite its lack of any significant visible markers, this is, consequently, a very powerful cultural construction of socio-political identity since, by definition, it flows in the blood and must be taken for granted. In this respect, as a number of Somalis now recognise, it is similar to scientific understanding of the biological concept 'race'. In popular thought, of course, 'races' are assumed to be observably distinct and so treated as what are properly 'ethnic groups'. …
>
> Whether conserved orally or in writing, the genealogies embodying the invisible force of clanship are, therefore, in effect genetic guidelines for the social and political interactions of those whose descent they record. The genetic assumptions implied here are further exemplified in the case of lineages of holy men, whose hereditary mystical power is conceived to be a direct consequence of their shared descent from a famous saint. Religious blessing here is assumed to be a genetic endowment (see Lewis 1998b).
>
> Casting this demon in the atavistic role of out-of-date loyalties, unfitting for the modern age and hostile to progress, Somali nationalists gravely underestimated the catastrophically disintegrative forces that could be evoked in its name. Beating the drum of ethnic unity, modern Somali nationalists thus seriously miscalculated the divisive power of their traditional political heritage--as was so cruelly brought home to them by the collapse of the Somali state in 1990.

Thus in Lewis's formulations, clan-based kinship structures are fundamental – indeed "axiomatic" and "natural" – to what it means to be Somali, and the resultant clan-based Somali political systems have ossified historically salient and violent societal divisions despite nationalist projects. Through such an analysis of the deterministic and stubborn power of kinship, Lewis sidelines possibilities for significant temporal change and heterogeneity within Somali kinship systems, and, I believe, fails to adequately consider the more divisive effects of international interventions or market forces on violence and insecurity in the Horn. Reified characterizations of "Somalis," "Somali clans," and "Somali clanship" drive sensational media narratives that search for the causes of war, Islamic fundamentalism, and even pirating within the apparent culture of Somalis as a group. Furthermore, such analyses of kinship elide its positive supportive capacities and its flexible, contingent, and dynamic qualities.

More recent ethnographic scholarship similarly critiques anthropological constructions of a primordial, literal, and static notion of Somali segmentary clanship, arguing instead that Somalis' genealogy is more complex than bloodlines and is continually re-imagined and re-constructed by individuals over time (Barnes 2006, Besteman 1996, Luling 2006, Abdalla Omar 1995). Luling (2006), for one, argues that constructions of individual lineages are highly subjective and lack consensus. Besteman (1996, 1999) and Barnes (2006) both find that some ethnographic accounts of Somali peoples – again, in particular, Lewis's – myopically focus on lineage as the central social category and site of rupture, and ignore the more productive and dynamic effects of class,

race, gender, and regional warfare.[115] Besteman, in ethnographic research among agro-pastoralist and farming Bantu groups in southern Somalia, demonstrates that Somalis often switched their clan affiliations without negative consequence. Somalis from different clan groups intermarry, form political alliances, and settle in villages together, drawing on inter-clan relations to provide conflict resolution and other cooperative functions (Besteman 2005).[116]

Northern pastoralist Somalis' use of the word "*reer"* is also more indistinct and layered than literal, linear, or deterministic.[117] Most use the term broadly and variably, to refer to a clan group, one collection of lineages and alliances within a clan, a family, a (ethnicity-based) tribe, or a herding group.[118] Everyone I spoke with about their heritage could recite their personal lineages (*abtirso*) and found pride in the character and heroism of particular ancestors. As Lewis (1961:102) admittedly demonstrates, these memorized

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[115] Additionally, as a related argument, a peaceful and clan-based Somali polity can exist and does. The self-declared independent nation-state of Somaliland, which officially seceded from Somalia in 1991, presents what Nordstrom (2004:171) calls, "a curious inversion" where "spontaneous stability" rather than state collapse or war emerged in the midst of and because of international political chaos. The existence of an autonomous and relatively peaceful Somaliland demonstrates the possibility for peaceful and stable, "state"-less (Gledhill 2002) Somali societies elsewhere. Nevertheless, Somaliland remains one of the poorest nations in the world. For better or worse, the lack of diplomatic recognition facilitated its marginalization from systems of foreign aid and investment; and its cessation from internationally recognized nation-states may have facilitated its erasure as a subject of academic inquiry as well (Bradbury 1997, Little et al. 2001, Little 2003).

[116] Likewise, Besteman finds that Somalis have historically united beyond clan lines, such as in their opposition to the dictatorship of Siyaad Barre throughout the 1980s and 1990s: "oppositional movements contained people from diverse backgrounds, but as the struggle intensified, politicized clan identities emerged as the most salient groups on the national level. During chaotic times of intense state violence or collapse, clan affiliations can help people identify networks of support and alliance. The clan structure also provided a way to channel and define the lines of conflict, but it did not produce the conflict. Civil war in Somalia was simply not caused by ancient clan hatreds…made unbearable by resource scarcity resulting from population pressure. Rather, Somalia's civil war resulted from a rebellion against a brutal United States-backed dictator whose policies militarized the country, dispossessed rural people of their land, and diminished local forms of authority and mediation." (Besteman 2005:97)

[117] The term "*qabiil*" was used rarely, only to refer to large clan families outside the speaker's, like Darood, and only to reference descendency back to Samaale forefathers discussed in greater detail in Chapter 6.

[118] By contrast, the word "*qoys*" refers to the immediate or nuclear family living together in one house or homestead.

lineages are fluid and skewed to focus on one particular lineage: in other words, "foreshortened or telescoped in keeping with uneven [numerical] development [of some lineages]." Farah Mussa, my research assistant who is a member of the Issa clan, pointed out that, in English, the word "clan" connotes what he called, "blood kinship" or "generational kinship" going back in time to a common "ancestor." Yet not all "clans"[119] are, in his words, "sons of Issa – they are *like* brothers," he said, "in that they are [what you would consider to be] close friends" and "*walaalo.*"[120] Several Somali clans, such as the Hawiye and Issa, he continued, are of the same "ethnic group,"[121] and women often marry men from different clans. For example, he explained that as refugees from Mogadishu fled into the Aysha area in the 1990s, many Hawiye women married Issa men, and thus became members of the Issa clan. Additionally, besides alliances between male descendents, important alliances are also formed across clan lines through intermarriage, seasonal travel, local and transnational migrations, between a son and his mother's clan (what Lewis 1961 calls "uterine alliances"), and even more crucially, between an individual and his or her mother's brother (*abti*).

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[119] During once discussion, Farah Mussa said the word "tribe" more closely translates to "*reer"* because a tribe does not necessarily entail blood relations, but does denote close affiliation and solidarity. Despite Farah's objection, for the purposes of this dissertation, in line with other scholars, I refer to the various groups as "clans" such as the Issa clan.

[120] Helander (1991) provides a thorough exegesis of the various tactics and meanings of the Somali term "*walaal.*"

[121] An analysis of Farah's purposeful appropriations of these terms – "clan," "tribe," and "ethnic group" – is beyond the scope of this paper, but would be an interesting topic for further investigation. A few Somali groups – are what he called "other ethnic groups" that speak Somali, including Bantus and other Africans living in southern Somalia and Kenya and "speaking Somali language" (although these groups have distinctive dialects). These groups are sometimes – but less often over time – labeled or colloquially referenced as, "*beel*" or "*beeshay*"[121] meaning "lost community" or "left-out community." *Beel* in Somali literally translates as "a small community" and in the verb form, *beeshay,* as "lost" or "to suffer loss" (Abdirahman 1995). Women are also sometimes considered "*beel*;" they do not formally belong to any clan or political group in parliament, but rather form a *beel* group with the "other" ethnicities because of their marriagability to those outside their native *reer*. In recent years Somali parliaments have changed their practice of representation and designation of *beel* groups.

In many ways, the notion of "clan" itself is complicated by the contradictory ways in which clan is defined, constructed, and acted upon by different individuals. For example, Farah Mussa reported that some claim that members of the Issa clan are bound together by their "blood relations." However, he finds this belies oral histories he was told by his mother and father about the clan's male ancestor. According to Farah's family, the clan father named Issa had three sons, but when he died, none of the three knew how to bury their father or perform a proper burial ceremony. A few men living nearby helped the brothers prepare and inter his body. After that, the three brothers, in Farah's English words, "adopted" them into their family. Some Issas say that the descendants of these men are not "true blood Issas," but others like Farah have accepted them as "true family." Similarly, he noted, the Hawiye clan, in particular, maintains strong internal solidarity and cohesion even though they are not all of "true blood" relations.

Kinship-based Therapy Management Groups

> Me and my clan against the world
> Me and my brother against the clan
> Me against my brother.
> [A popular Somali proverb, quoted by two informants]

Within the segmented clan system, the second largest lineage unit after the clan family is usually called the "sub-clan." Lewis (1961:100) defines "sub-clans" as "congeries of [multiple] lineages" within a large clan group such as the Dir or according to others, the Issa clan (*Reer Ciise*). In different circumstances and historical moments,

different segments or sizes of larger lineage groups are more important for individuals seeking support or alliance (Lewis 1961, Cassanelli 1982). As the Somali population rises, and as more people abandon nomadic pastoralism and migrate to urban centers for commerce and wage labor (Laitin and Samitar 1987, Little et al. 2001, Little 2003, Markakis 1998, Markakis 2004), sub-clan relatives have become the primary unit of political cohesion, affiliation, and day-to-day support. As clans get too large for day-to-day responsibilities, the focal unit becomes the "*mag*" or literally "blood" group[122] of usually between 200 and 2000 nuclear families (Laitin and Samatar 1987).

Farah Mussa similarly stated: "the sense of connection to others decreases over generations as the population gets larger. …When [the group] is too large, you loose the ability to share responsibilities, like healthcare and contributions to ceremonies." While populations in the Horn of Africa are, in general, increasingly dense, Somali sub-clan cognates are also increasingly geographically dispersed. For wage labor and educational opportunities, many families have moved to larger cities in the Horn such as Djibouti City, Dire Dawa, Jijiga, Addis Ababa, and Nairobi. Others have migrated for work to Yemen, South Africa, and the Middle East; and a few northern Somalis have obtained refugee status in Europe and North America. Typically, persons who have migrated

[122] Within the sub-clan exist more rigid and small groupings called *"mag"* (literally, the "blood" group, elsewhere called the *diya*). Individuals of a *mag* are bound by *xeer* and agnatic ties. One informant described the various roles of the *mag* as follows: Mag has 4 categories: (1) "*magdhiig*" blood – you must share blood for a serious injury or murder, (2) *"magdhawaq"* word – compensation for an insult; (3) *"magmici"* theft – you have to take something, like food or livestock (4) "*magmogon*" rape – or unlawful sexual intercourse. The puntitive roles of the *mag* remained only theoretical during my fieldwork, as there were no murders or interclan conflicts of any consequence; people spoke about the role of the *mag* in historical conflicts and the potential for its future role if conflicts were to reignite. Instead, during multiple informal conversations and interviews people reiterated their responsibilities to kin who were "of my sub-clan" – not just Issa, and not necessarily within the more narrow *mag*. These relations were mutable and highly contingent upon the circumstances.

abroad to join the largely undocumented labor force in the Middle East and North Africa do not regularly contribute to their family or sub-clan's healthcare and other cash expenditures. By contrast, the few families who have obtained asylum in Europe and North America take regular part in the distribution of wealth through various types of remittances, individual sponsorships, and gift giving.

For example, Abdirahman, a young civic leader in Elahelay, had a close cousin (*ilma adeer*) who gained refugee asylum status in Canada several years prior. This cousin had made annual contributions to Abdirahman's family for the last several years. However, sizable portions of these annual gifts have always been redistributed to his sub-clan relatives and extended family living in the northern Somali Region of Ethiopia, especially if a relative was ill or in need, or used to repay local cash and material debts accrued over the previous months. Abdirahman reported that regular gifts of cash from relatives abroad were rarely spent on either day-to-day expenditures or saved in case of emergency. He did, however, use additional contributions three years ago to pay for a trip to several private hospitals and clinics in Dire Dawa and Addis Ababa for his son, who was born physically disabled. News of the baby's medical needs quickly reached his relations abroad, who then sent a special donation of money for medical care. Abdirahman acknowledged he was fortunate to have such resources at his disposal; most persons in the Somali Region did not. The number of Somalis in the diaspora who are able to provide funding for relatives in the northern Somali Region of Ethiopia is quite low; instead, resource distribution more often occurs between individuals within sub-clan groups who all reside in the Horn.

Frequently in the northern Somali Region, sub-clan relatives who held jobs with international nongovernmental relief organizations or who took part in the lucrative *khat* trade paid sizeable portions of their sub-clan relatives' healthcare costs.[123] Just as vehicles, housing home construction, and educational expenses were paid through resource distributions within sub-clan and larger family groups, rising healthcare costs were as well. Beyond financial assistance, relatives with employment or experience with nongovernmental organizations were also perceived by their relatives to have superior knowledge about biomedicine and an ability to facilitate access to high-quality healthcare facilities. Young unmarried women, in particular, would wait to seek healthcare in faraway facilities until they could be accompanied by uncles or male cousins who were employed by relief agencies. The extended family member's financial support, advice, knowledge of the healthcare system, and personal connections to expatriate clinicians and staff were seen as crucial to making the most out of a hospital visit. They were viewed as the best persons to accompany patients and act on their behalf. Accordingly, for Somali staff in the humanitarian or nonprofit sectors – even lower-level and non-clinical staff – their responsibilities to sub-clan relatives entailed substantial material outlays during health crises as well as routine clinical visits.

These novel configurations of kinship were essentially "therapy management groups," as described by Nichter (2002, drawing also on Janzen 1987). Therapy management groups were involved in activities like, "the marshalling of material

[123] Also, of note, these same wealthier sub-clan relatives are also, increasingly, responsible for tuition payments of children who desire secondary and higher education. However, in this chapter I focus on these dynamic kinship relations with regard to healthcare expenditures.

resources, the management of emotions, the performative aspects of "being sick" and relating to the afflicted, participation in the co-construction of illness narratives, and the provision of space where healing or the management of sickness takes place (Nichter 2002:82). As described in Chapters 3 and 4, increasing numbers of northern Somalis were seeking expensive brand-name medications, diagnostic technologies, and distant private clinics in lieu of closer public hospitals in Dire Dawa and Jijiga. The financing and logistical facilitation of these new options required greater contributions and cooperation than ever before from family members. Additionally, misunderstandings were common as Somali laypersons sought biomedical care from *habasha*[124] biomedical professionals. Often, lay categories of illness and descriptions of symptoms were incongruous with biomedical providers' diagnostic criteria and understandings of pathology. Family members who spoke English or Amharic, or who had experience with aid agencies or healthcare programs, often accompanied sick relatives to seek care. They liaised with physicians, translated, helped pay fees, and comforted the afflicted. In one example, due to his fluency in English and Amharic, his experience with international NGOs and his work with me, my research assistant Farah Mussa frequently accompanied members of his sub-clan from Aysha woreda and other friends of his family to seek medical care in Bilal Hospital and smaller private clinics in Dire Dawa. This was expected of him, he said. In thanks for his help, men often bought him khat and invited him to chew at their house, while women often fixed him meals.

[124] "Habasha" (otherwise spelled "habesha" or ሐበሻ in Amharic) is today is colloquially defined as persons of Amhara or Tigrynia ethnicities residing in Ethiopia or Eritrea, or simply speaking the Amharic or Tigrynia as a first language. The term habasha for many rural Somalis in eastern Ethiopia indexed not just ethnicity and language group but political support of the current Ethiopian government, although many habashas would object to this usage and association.

The limitations of kinship networks

While material redistribution among relatives and remittances from abroad were both ubiquitous, not everyone has wealthier kin. Yonis's story provides a case in point. By late November 2008,[125] the mobile team operation in Elahelay was in full swing. One hundred or so women, children and infants – all wrapped in brightly colored scarves and hijabs and cotton dresses – swarmed the three-room concrete clinic on the windy hazy Sunday morning. Abdul and Hussein, the two Somali mobile team nurses, rapidly saw a succession of patients: two anemic young women, several coughing and moderately malnourished children, and a few pregnant women stopping in for check-ups. Hollered jokes between teenagers, ululations of proud grandmothers, screams of impatient infants, and the gregarious banter between men filled the small space with a steady clamor. Halfway through the morning, Yonis, an emaciated older man with thin white hair slowly climbed into crowded space of the Elahelay health post, coughing beneath his left hand. Everything about him was tired: his sagging and threadbare khaki vest, his ancient leather sandals, and his small and distant eyes. He was helped up the two steps into the facility and over to the mobile team's table by Roble, a proud but quiet town leader in his thirties. Roble quickly grabbed Yonis a rickety wooden chair, as the man's legs nearly gave way, and then walked directly over to Abdul at the far end of their table to recite Yonis' basic medical history. "He's had TB before," Roble explained matter-of-factly. He was

[125] Two weeks after the visit to Elahelay described in Chapter 3.

treated in the hospital in Dire Dawa, but was again coughing profusely. Abdul nodded and quietly led the old man into the adjoining room to hear his lungs and his story in peace. The older man squatted on the ground before Abdul, but could hardly breathe through the mess in his lungs. Abdul beckoned me over to listen and learn. Without a word, Abdul nodded again, and together we cleaned off the examination table in the room, and helped Yonis rise and rest there. Back in the main room, Roble and Abdul whispered to each other discreetly, "is it?" "Yes, probably." Roble said, "He is my sub-clan, but only distantly. He has no family left" – no one to care for him and no one to take him to a hospital. A few minutes later, with more quiet nods and blessings goodbye, Roble and Yonis slipped out of the clinic.

Abdul and I discussed Yonis' case later, during a quick break between patients near the end of the day. Given Yonis's condition, the TB was probably highly infectious, and it was "far too dangerous" to transport him anywhere. "No one [of us] will take this man to the hospital," where he needed to go for treatment or die comfortably. There were no masks for passengers and no way to quarantine him for the duration of the drive to Dire Dawa. Furthermore, Abdul went on, Yonis needed far more than a lift to town. "You must have someone with you when you go to the hospital, because they cannot provide food or [medical] supplies." "You, Elsa [my nickname during fieldwork] cannot take him – it is not safe, and he has no one." He ended the conversation unemotionally, saying, "this man will most likely remain at home because he wants to stay" in Elahelay, maybe even exposing others to tuberculosis, and at some point soon, he will die. "This is all there is to do – the mobile team cannot do anything more. He has no family."

While Somalis frequently rely on clan relatives afar for emergency help and their extended family for routine needs, health crises like Yonis's highlight the limitations of such a system. Yonis was probably seventy years old; most of his life was spent living and travelling with livestock outside Elahelay. His (likely) re-infection by tuberculosis occasioned his most powerful and well-known sub-clan relative, Roble, to accompany him to see the mobile team nurses and seek their advice. Diagnostics and treatment, although officially free of charge from the Government of Ethiopia and UN World Health Organization, were perceived to be impossible given the limitations of the local health system and Yonis's social network. Travel would have been exorbitantly expensive and difficult given his contagious cough; food and lodging in Dire Dawa would have been more difficult still because he had no living children in the Horn of Africa and no grandchildren at all. Roble's responsibilities to his own family, to safeguard their health and cash savings, were more important than such an expenditure at the end of Yonis's life. Yonis passed away before the end of the *jiilal* in March of the next year.

Migration patterns in the northern Somali Region

Migration is thus contingent upon strong and geographically dispersed networks of kin. Northern pastoralist Somalis are famous for their almost incessant movement in search of water, pasture, trade, social visiting and religious practice (Cassanelli 1982, Laitin and Samatar 1987, Samatar 2008). Kapteijns and Maryan (2001:36) translated a

popular song in Somali that expresses the social and economic reality of migration. The refrain goes:

> Only a fool does not acknowledge
> a problem that stares him in the face
> Even camels don't just stay put
> in their enclosure
> Nothing is static in this world.
> and one's luck will change
> Abundance and drought
> succeed each other

Cassanelli (1982) finds that prior to the 20th century Somali pastoralists frequently migrated far from their home settlements; responses to drought and food insecurity were absorbed regionally in regular and predictable patterns of mobility. Sub-clan and smaller extended family groups, depending on conditions, frequently pooled resources, expanded traditionally restrictive grazing rights and areas, redistributed money from trade, and shared dry season water resources. As early as 1900, migration to urban areas had risen in its importance and was a commonplace strategy of what Cassanelli (1982:72) calls "nomadic adaptation":

> We have noted how each of the old commercial towns along the Indian Ocean and Red Sea coasts served, among other things, as outlets for pastoral produce, suppliers of imported foodstuffs, and occasional refuges for drought-stricken nomads. Every pastoral clan was linked in some way to a major town. Even where such links appeared to be minimal, the evidence suggests that they were used in times of drought-induced crisis. In essence, the establishment of commercial, credit, and kinship ties with townsmen was one of the basic forms of pastoral adaptation to a given region of the country (1982:72-73).

Thus Somali migratory patterns have long extended past local communities or small geographically distinct areas. Cassanelli elaborates: "knowledge of conditions beyond one's own grazing lands has long been vital to their survival. The grazing cycles, kinship

networks, and exchange systems underpinning pastoral activity in the Horn extended over wide areas. … The Somalis' social universe was an expansive one." Transnational migrations in the latter half of the 20th century for employment led to community settlements of Somalis throughout the Middle East, Europe and North America (Samatar 2008). And on top of this, political upheavals and refugee crises in the last sixty years provide additional and striking testimony to the strong transnational ties of kinship in the face of colonial partition, nationalist projects, and sundry conflicts what Samatar (2008:10) identifies as "*qaxootin.*" He says further:

> This is the age of *qaxootin,* or desperate exodus, an epoch unprecedented in a number of features. First, the intensity of the internal institutional crises is of such magnitude that, a decade ago, I termed the condition a "catastrophe." Second, the rupture in the collective identity is so severe that Somalis have taken almost *any* road out of the country [of Somalia]. Third, the numbers are so large, perhaps in the millions. … (Samatar 2008:1)

In her work with Somali refugees in northeastern Kenya, Horst (2008:8) finds that "Migration [both abroad and within the Horn of Africa] has been a good investment for many, and it has improved life in the [refugee] camps substantially." Hundreds of thousands of Somali refugees from the Ethiopian side of the border into Somalia, and later thousands more moving from Ethiopia into Somalia and Somaliland were welcomed and absorbed beyond the boundaries of camps into new communities, many by families with long-standing ties of kinship and mutual assistance with the incoming populations.

Present-day narratives of mobility and migration in the northern Somali Region of Ethiopia reference drought, livestock loss, dissipating water tables, forced migration during clan- and interstate conflicts, and difficult international migrations for work. Travel across the tenuous, porous and inexact borders between Ethiopia, Somalia,

Somaliland, and Djibouti has for decades been an annual, if not more frequent, occurrence for many. In 2008 and 2009, despite ongoing interstate conflicts in southern Ethiopia, Somali staffers manning checkpoints and border crossings at the Ethiopia-Djibouti and Ethiopia-Somaliland boundaries normally allowed free movement of other Somalis regardless of citizenship or documentation – especially in the event of a health crisis, death in the family, or other personal emergency.

Frequent and distant travel and migration are not just practical, they hold great meaning. Receiving travelers hospitably is a central ethic and obligation of all northern Somalis. Travel abroad and within the Horn for pilgrimages to visit the shrines for ancestors and saints (*rihla*), for pilgrimages to Mecca (*xaj*), and for employment or education are dreams for most persons, including, increasingly, middle-class and weathly women (Lewis 1971, Horst 2008, Samatar 2005). Similarly, Rousseau and his colleagues (1998:386) find that, "In Northern Somalia, travel, regardless of its reason or purpose, is considered to be a learning process and a source of wisdom in itself. A man who has traveled, a *wayo' arag,* is one who knows a great deal, has seen things, has lived." Further, they find a generalized "absence of boundaries" among young Somalis awaiting migration or asylum abroad: "Traveling is so deeply ingrained in the Somali social fabric that geographical space is a continuum, and youths find it difficult to integrate the idea of boundaries" (Rousseau et al. 1998:406). As well, in the Dabaab refugee camp of mostly Ogaden Somalis in northeast Kenya, Horst (2008:199) describes what is commonly called "*buufis*" – the largely unrealistic but ecstatic dream of migrating or resettling abroad:

> it is a dream that brings hope in the camps, but it is also characterized as a disease that the refugees are suffering from. Resettlement may be a solution for the most vulnerable in the community, such as those without social networks, but at the same time, refugees with money or connections stand a far better chance of actually achieving it. *Buufis* is something that, once realized, may lead to increased socio-economic security both for the migrants and for those remaining behind. (Horst 2008:199)

Supplementing the well-documented dreams and realities of migration abroad for asylum or work, I find new migratory patterns within the Horn: migrations to access distributions of food and medicines, migrations to access work for humanitarian relief agencies, and migrations to access comparable healthcare once relief agencies depart.

Contemporary migrations to access humanitarian relief

One increasingly common reason for mobility and resettlement within the Somali Region of Ethiopia is to access humanitarian aid distributions. Relief food has long been one survival strategy (among many others) for pastoralist Somalis in the Horn, especially during droughts and conflicts (Horst 2008, Sadler and Catley 2009). But this does not represent a simplistic case of dependency created through the historically reliable availability of humanitarian relief commodities. Nor would thousands of Somalis immediately perish if international food aid were to cease (de Waal 1998). Livelihoods in the arid climate of the northern Somali Region are inherently precarious; archives and oral histories are replete with incidences of droughts, famines, and stress migrations (Cassanelli 1982, Farah et al. 2003). In the northern Somali Region of Ethiopia since approximately 1999, pastoralist livelihoods have been ravaged by recurrent rainfall shortages, political insecurity (affecting transnational movement), currency and price

fluctuations, and livestock trade restrictions (Farah et al. 2003, Lautze et al. 2003, Sadler and Catley 2009). Many families camped in remote pasturelands in Aysha woreda lost livestock and cash holdings during successive droughts in the late 1990s and then again in 2002-2003. At the same time, UNICEF, Save the Children, the Ethiopian Red Cross and other relief agencies in Ethiopia made an explicit effort to prevent people from travelling long distances and sleeping in crowded camps to receive aid; instead they decentralized the distribution of most relief commodities, trucking rations and medicine to numerous remote locations throughout affected locales (Lautze et al. 2003, de Waal et al. 2006). While previously families would have had to be destitute, or nearly so, in order to justify migrating to faraway therapeutic feeding centers or large cities, this newly decentralized system usually only required they travel to a nearby village where relief commodities were distributed.

The community of Elahelay was established for such a purpose. According to local leaders, Elahelay had grown in size every year since its founding the late 1990s; families settling there between 2005 and 2009 said they moved to Elahelay to access the UN World Food Programme distributions, the new primary school and the newly staffed and supplied governmental "health post."[126] Most families residing in Elahelay during this research had lost livestock during recent droughts; others I spoke with moved to Elahelay after the refugee camp in Degago closed. Thus although several pastoralist and semi-pastoralist families had lived in the area surrounding Elahelay for several generations, Elahelay was classed by the Ethiopian government and international relief

[126] Refer to Chapter 1 for a more detailed description of Elahelay and its clinical facilities.

agencies as a settlement of internally displaced persons, and consequently all registered residents qualified for regular rations from the UN World Food Program. Abdirahman, a local leader summarized this:

> All residents of Elahelay are supposed to get 50 kilograms of wheat grain, 1/3 kilogram of vegetable oil, 5 kilograms of CSB [corn-soy blended flour], and 5 kilograms of pulses [split peas] per family of five per month. We get this food because the permanent residents [of Elahelay are] considered IDPs [internally displaced persons] without any other food source.

A community health extension worker in the community of Biyogurgur, 10 miles from Elahelay, said:

> WFP [the UN World Food Program] only came here one time; the [Ethiopian] government didn't give us anything though. Now we are waiting on Allah. Unlike in other places, people [from Biyogurgur] are not moving out of town to find better pasture, instead they are staying here and trying to find [year-round delivery of] water [by Oxfam]. … People come from five or six kebeles [villages] around here or from outside the town to receive rations from the WFP. Everyone gets 8 kilograms of wheat regardless of where they are from.

According to UNICEF and other NGO staff with whom I spoke, aid agencies often assumed that no one – even pastoralists – would divest of valuable livestock herds to settle in a different place unless they were dispossessed, destitute, or desperate for food. Yet the structure of recently decentralized[127] humanitarian relief in the northern Somali Region has indirectly and inadvertently encouraged pastoralist and refugee families to settle in village centers while grazing their remaining livestock elsewhere with relatives. For example, some households divided, enabling livestock to be maintained by men (not

[127] Decentralization, as one priority of the Ethiopian government throughout the country, is discussed in Chapter 1 and again in Chapter 6.

otherwise employed) in seasonal grazing areas while women, children, employed men, and elders remained in settled communities like Elahelay or Degago. Furthermore, Abdirahman went on:

> Pastoralists living outside the settlement [of Elahelay] get only 25 kilograms of wheat and half of everything else. There are many settlers here who can make pulses for breakfast like *fuul basbaasleh* [a spicy bean porridge], but pastoralists [who live outside Elahelay] don't know how to prepare the pulses, so they sell them in the market here in addition to the wheat, which they also sell for cash. … They [pastoralists outside Elahelay] eat mainly sorghum and milk and tea and the like, having sold the rest. … Sometimes people must or want to change and come here [to live].

Thus there are several advantages to nuclear families dividing and settling more permanently – food rations increase plus other services like healthcare, primary education, and year-round water sources may become attainable. The health post in Elahelay was a draw because community health workers there sold an assortment of essential medications and provided basic preventative healthcare services; the health post was also the site where the mobile team of nurses visited in 2008 and 2009 and provided training to the local staff. Local women gathered regularly in the health post to learn basic health literacy and to learn about preventative healthcare and nutrition. Plus, the Ethiopian government and other nongovernmental health and humanitarian organizations sporadically supplied various medical materials to the health post. Thus the health post was at once a community center, a rudimentary clinical facility, and a site where biomedical expertise and materials might be provided or purchased.

Migrations for temporary work for aid agencies

Today, many young Somali men – and increasing numbers of unmarried women under thirty years of age – travel and migrate for temporary wage labor or salaried work with humanitarian relief agencies. Aid regimes require constant monitoring and evaluation not just of their programs but also of population health, food security, socioeconomic variables, migration flows, and climate patterns. Dozens of Somalis in the northern Somali Region of Ethiopia work for aid agencies on research projects, development schemes, and aid distributions as surveyors, drivers, translators, and sundry support staff. Farah Mussa, for one, had worked for various NGOs since he was a teenager living in the Degago refugee camp. He was literate in Somali, Amharic, and English as well as being well-connected or related to nearly every adult male in the area. He was invaluable to aid agencies. His wife and children resided in Dire Dawa, but he travelled incessantly back and forth from there to Aysha, Elahelay, Degago, Jijiga and other towns in Ethiopia, wherever he could find temporary work, sleeping on floors in the homes of his sub-clan relatives. Farah was not alone. In every place I traveled during the research period, I bumped into members of a burgeoning cohort of young, literate, educated Somalis traveling for work and staying with sub-clan relatives: nurses in the mobile team, various temporary government employees based in Aysha bureaus, community health workers, and local Somali staff on international NGOs. Their livelihoods were made possible by the continual state of humanitarian emergency in the Somali Region; yet these emergent livelihoods were also made difficult and unpredictable by the short and sporadic funding cycles and contractual arrangements inherent to relief work. For example, none of these young men said they had job

security, and all dreamed of the day when they would be able to live full-time with their wives and move their families to Jijiga or Addis Ababa for permanent bureaucratic work with international nongovernmental organizations.

In addition to the rising legions of young literate Somali *men* involved in the thriving aid industry in the northeastern Horn, increasing numbers of *women* are delaying marriage in order to complete high school, complete vocational training of some kind, and enter the work force. Trends in the humanitarian sector to prioritize women's health, safety, and economic security during and after emergencies have led to several job and training opportunities for women from the Somali Region of Ethiopia. Somali women were hired by nongovernmental relief and development agencies in Aysha woreda to provide gender-specific health education messages, midwifery services, and translation services for expatriate and non-Somali Ethiopian staff. For many, such actions – secondary education, vocational training, and employment – required migration to urban centers like Dire Dawa or Jijiga. They reported that, rather than endangering their prospects for marriage and children, new career opportunities introduced them to just as many if not more eligible men, many of whom also worked in the nonprofit or humanitarian sectors. These women were proud to contribute financially to their families, including payments for the education of younger siblings and repayments to parents for the costs of their own tuition and travel. Still, although several women I spoke to enjoyed their work, they looked forward to one day quitting their jobs to raise families in urban areas with good schools.

Medical Migrations in the Aftermath of Humanitarian Relief

Medical migrations are nothing new for Somalis in Ethiopia. To cite a few examples: numerous persons with chronic illnesses have, for generations if not centuries, traveled to the town of Erer near Dire Dawa to drink and bathe in the natural springs and pools there. Revered herbalists (*geedole*) in the more verdant riverine stretches of the northern and eastern Somali Region served clients from as far away as Djibouti City, Addis Ababa, Nairobi and the extensive Somali diaspora. Expert midwives (*ummuliso*) traveled by foot for ten miles or more to attend women in delivery, and if needed, traveled with women in distress as they sought medical attention in cities elsewhere. Accordingly, traveling for medical care was nothing new, and in fact was widely expected and advised during a health crisis. However, the destinations and objectives of medical migrations were changing for many residents of the remote Somali Region. Today persons who travel and migrate often do so in order to access newly popular biomedical treatments and expatriate clinicians in private facilities, newly popular diagnostic technologies, and brand-name pharmaceutical medications in the major cities of the Horn, most often Dire Dawa, Jijiga, Djibouti City, and Hargeisa in Somaliland.

Petryna (2008:167-168) finds that clinical trials, for one, increase local demands for the particular pharmaceutical therapies being tested. During clinical research projects in Brazil, people travel to the site of a trial in order to receive medical services they could not access elsewhere. As such, the Brazilian pharmaceutical industry has profited from shifts in demand engendered by clinical research. At the same time, when trials end,

many patients are left without other ways to access these therapies. She quotes one doctor lamenting conundrums of providing care to such patients:

> We have to deal with the problems that begin when the study ends, particularly the continuity of treatment and quality of care as patients return to their hometowns. Many patients return home where no health infrastructure is in place and no one is responsible for setting this up. These are practical and ethical problems and they are very difficult to solve. (2008:168)

Petryna argues that the "global cartography" of biomedicine shifts in relation to demands for patients in clinical trials (2008:167). The ethical standards of many clinical research organizations dictate that, ideally, pharmaceutical companies and hospitals hosting studies should continue to offer healthcare for patients enrolled in clinical trials. In this way, the pharmaceutical industry recognizes the ethical implications of providing a new effective therapy to underserved patients, and at least officially works to regulate patients' rights to subsequent care.

Analogous to Petryna's findings in the Brazilian pharmaceutical industry, my research finds shifts in the global cartography of biomedicine due to medical humanitarian interventions, most starkly in places like the northern Somali Region of Ethiopia, where people have historically had limited access to biomedical facilities and treatments. In contrast to the pharmaceutical industry, the humanitarian aid industry has no specific ethical guidelines regarding the future distribution of medical materials and services, even though relief agencies frequently provide medications and medical attention to previously underserved individuals and may even introduce new and superior

treatments.[128] Although humanitarian interventions often knowingly target underserved populations, emergency relief funding cycles and aid appeals make lasting improvements to local health systems extremely difficult.[129] Once persons have experienced excellent medical care in a refugee camp or from foreign relief workers, they are more likely to seek what they perceive to be similar care in the future. Thus in essence, I find two different medical migration patterns in the northern Somali Region: one to access extant medical relief operations (like the mobile team in Elahelay or the refugee camp clinic in Degago), and one to access what persons perceived to be comparable care elsewhere in the nadir of humanitarian aid. Both require generous and extensive networks of kin relations.

First, new medical migrations occur as people seek immediate medical attention, screening for malnutrition and malaria, and supplementary food from relief operations. During the period when the refugee camp clinic in Degago was open, from approximately 1989 until 2005, many persons residing in the northern Somali Region would travel there for medical care. Although smaller provisional clinics had already been established at the time by the Ethiopian government in the nearby towns of Aysha or Shinile, many Somalis with whom I spoke chose to travel to the Degago refugee camp instead in order to receive care from the *firingi* (expatriate) clinicians staffing the camp facility.

Second, as outlined in Chapters 1 and 3, a UNICEF-funded mobile team of Somali nurses provided primary care and referrals to qualifying persons once weekly in

[128] There are published ethical guidelines for humanitarian agencies regarding the standards for provision of material assistance, e.g. the Sphere Project (2011).
[129] This is a theme I expand on in Chapter 6 and the Conclusion.

six different villages in Aysha woreda for six months from October 2008 until March 2009. The existence of Somali healthcare experts (compared to Amharic Ethiopian clinicians) and distributions of free medications prompted many pastoralist households who camped with livestock several miles away to travel to sites on the mornings the mobile team was supposed to visit. In addition, I met two women who moved permanently to Elahelay, they reported, because of the mobile team's presence. Neither woman qualified, officially, for treatment from the mobile team – pharmaceuticals, therapeutic foods, and supplementary foods were reserved for malnourished or sick infants, children under five years of age, and their pregnant and lactating mothers. The women did not move to Elahelay, primarily, for material distributions.[130] Instead, both desired the expertise of the mobile team nurses, and looked to them for general medical advice, referrals to other facilities, and basic diagnostic screenings – checks of their weight, blood pressure, and pulse rate.

Such medical migrations parallel or augment stress migrations pastoralists in Aysha woreda have been making in the last ten years to access water sources, pasture, and food aid distributions. In other words, as drought conditions persist and the livestock markets exhibit continual price declines, pastoralist households in the Somali Region are increasingly likely to travel and settle elsewhere; the locations where medical aid is available are seen as good places to move, even if other livelihood opportunities in these locations are lacking. Accordingly, in a third example, I met an elderly woman named

[130] And additionally, they did not move in order to receive care from the newly trained and appointed community health workers. Both women referred to the community health workers in Elahelay as "boys," lacking experience and knowledge.

Ubah who moved to Elahelay for medical care with the mobile team and to live with her daughter. She said:

> We [my husband's family and I] were nomadic before, and we used to have livestock. The reason I came here [to Elahelay] was that the *fiix* [extrapulmonary tuberculosis lesion] came out of me [manifested], from here up to there [gesturing to her neck with her hands]. I became a patient and I was taken here [to Elahelay] with a *rahab* [a homemade stretcher made of wood]. So I was brought here and my house was also [packed up and] taken here. After I had been here a while, I was taken by vehicle to the Dil Chorra hospital [in Dire Dawa] and I was treated there. I stayed there for 12 months. After they removed it [the *fiix*], then I took medicine for two more months. Then after the medicine was finished I came back here [to Elahelay] and I never went back to the countryside. Our livestock had disappeared [while I was gone]. I stayed here, even though I used to live over there, [she gestures to the horizon] near Ellis Mountain.

Ubah expected to remain in Elahelay for the foreseeable future, close to her daughter, close to markets, and crucially, close to the health post where medications and occasional free medical care might be obtained. She deemed Elahelay a place near enough to her extended family and sub-clan relatives, as well as a place established enough to receive basic services and humanitarian aid distributions.

On the other hand, as discussed at length in subsequent chapters, many Somalis expressed reluctance to travel to other facilities in Ethiopia once humanitarian operations ceased, preferring instead to go to private facilities in Djibouti or Somaliland. For one, Hassan, the young father from Aysha quoted at length in Chapters 3 and 4, complained that the local governmental medical center in Aysha has inadequate diagnostic equipment for dealing with many common medical problems. After two years of coughing and weight loss, he said was finally referred from the Aysha facility to a private hospital in Djibouti specializing in tuberculosis, where he was correctly diagnosed and treated. Now

he recommends anyone who is ill – especially if they suspect tuberculosis – to visit Djibouti as soon as possible. In contrast to Ethiopian governmental facilities in Aysha, Jijiga, and Dire Dawa, he said the diagnostic equipment and patient care in Djibouti were far superior.

Summary

Many residents of the northern Somali Region lost a majority of their family's livestock holdings between five and twenty years ago, and today many continue to mourn the loss of their nomadic, fiercely independent life ways and identity. Generations of interstate wars, violence between Somali civilian populations and Ethiopian, Somalian and colonial government forces, and lack of reliably federal programs or safety nets have dissuaded many persons from depending on state governments for help during health or humanitarian emergencies. In the vacuums left as various state powers and international relief agencies recurrently recede from people's lives, strong kinship-based support networks have remained. Although most Somalis in the northern Somali Region have long lived in the precarious margins of the Ethiopian state, as will be discussed at length in Chapter 6, their livelihoods, incessant mobility, and healthcare are made possible by financial, logistical, and moral support from family members. Accordingly, I find that clanship has not caused the chronic state of emergency and continuing political insecurities in the Somali Region, but is rather a source of social capital and a coping mechanism in the absence of trusted or effective governments or permanent international

relief operations. Even when government services are enhanced or introduced (such as new clinics built or schools opened), clan leaders and family members are usually the persons who facilitate the popular use and understanding of these services. Clanship, for northern Somalis, is thus an antidote to their shared history of division and violence, even as it is obviously also fodder for nationalist and other political maneuverings.

Additionally, as new medical technologies gain in popularity, patterns of medical migrations shift in response. What Petryna calls the "global cartography of biomedicine" reveals stark health disparities between the Somalis who know about and can afford emerging biotechnologies and treatments, and the Somalis *unable* to migrate, lean on family, or pay for care. For instance, women, in particular, are increasingly likely to spend large sums of money and travel far in hopes of ending their infertility and saving their marriages. Elder pastoralists who have outlived their closest relatives, in particular, often lack the social networks and cash to access hospital care. The last ten years have seen enormous improvements in the ethical and professional standards articulated by actors in the global health and humanitarian sectors on myriad issues, yet the ramifications of temporary medical aid on subsequent healthcare options and health-seeking behaviors for beneficiaries, like many residents of the northern Somali Region, remain under-theorized.

As chronic states of emergency enable and rationalize ongoing nongovernmental humanitarian interventions in the Horn of Africa, Somalis will undoubtedly continue to mold their migration and livelihood strategies to take advantage of new opportunities for income and aid. Migration patterns and livelihood strategies prompted and sustained by

chronic states of emergency require substantial support from sub-clan relatives who are geographically dispersed in both crisis-affected locales and urban centers. Nevertheless, despite the dependability and comfort such alliances afford, they allow young educated Somalis to continue to take unpredictable, temporary jobs without benefits in (thin) hopes of one day being promoted. The humanitarian industry should thus also revisit the cost, in human and financial terms, of allowing such disparities between international and local staffs.

CHAPTER 6.

CITIZENSHIP AND HEALTHCARE IN THE NORTHERN SOMALI REGION

As discussed in Chapters 1 and 5, kinship and migration in the northern Somali Region of Ethiopia have long challenged and transgressed state formations and boundaries. Today northern Somalis[131] live in the margins of multiple "state" entities – the ethnic federal system of the Federal Democratic Republic of Ethiopia, the autonomous Somali Regional State within Ethiopia, and the transnational ethnic community of Somalis throughout the Horn of Africa and diaspora. In the absence of many reliable governmental services – public safety nets, police protections, transportation infrastructure, cellular telephone networks, school systems and the like – transnational kinship networks, *xeer* (Somali customary law), extra-legal[132] economies, and the international nongovernmental aid industry remain vital to life and livelihoods there. These non-state governance and social structures are also central to contemporary medical systems and medical discourses.

Even so, as Somalis in the periphery of the Ethiopian state progressively demand more services from governmental facilities (especially, as this research documents, in the healthcare sector), notions of citizenship and belonging vis-à-vis the Somali Regional State are also shifting. New expectations about the Somali Regional government's

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[131] When I use the term *northern Somalis*, I refer to persons who self identify as Somali and who resided during this research in the Shinile Zone, including Aysha, Shinile and Dembel woredas of the Somali Region of Ethiopia, and the city of Dire Dawa.

[132] I use the term *extra-legal* the way Nordstrom (2004, 2007) and Ferguson (2006) do, to denote activities that fall outside legality as it is defined by governments and law enforcement. This includes illegal and illicit economies of goods purposefully hidden from taxation and declaration, as well as informal exchanges of commodities such as interpersonal gifts and trades.

responsibility for its citizenry as well as new perceptions about the role and relative power of the Somali Regional State within Ethiopia have been shaped, in large part, by health and humanitarian programs – the new community health posts opened, the Mobile Health & Nutrition Teams, the fledgling Aysha Medical Center, and infamous public hospitals like Dil Chorra.[133] I argue that these trends have not emerged because of the relative sizes and influences of the Somali Regional Health Bureau[134] or the Somali Regional State per se, nor simply because of the relative dearth of other Ethiopian state services, but because of the intimate and profound nature of medical encounters themselves. As described in Chapters 3 and 4, personal experiences of infertility, pain, tuberculosis and even hunger were not divulged lightly or without reservations; trust was always key to positive experiences with healthcare providers no matter the healing modality. Theoretical concepts of "biological" and "therapeutic citizenship" (Nguyen 2005, Petryna 2002, Rabinow 2005, Rose 2006) hinge on people's dynamic feelings of belonging, entitlement and access to state services and resources. Accordingly, what it means to be a member of the transnational network of Somalis, a Somali Regional State citizen, an Ethiopian citizen, a "patient," and even a foreign aid "beneficiary" are all being forged within the walls of various clinical facilities and medical humanitarian operations.

Since 1991, the structure of the ethnic federalist state in Ethiopia has enabled the Somali Regional State to develop its own largely autonomous system of governance.

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[133] Each of these providers and facilities are described in Chapter 1 and discussed throughout the dissertation.
[134] The Somali regional branch of the Ethiopian Ministry of Health.

With only sporadic federal mechanisms of control active within the northern Somali Region,[135] regional bureaucratic institutions and economies have emerged that are remarkably detached from institutions in Addis Ababa. As previously alluded to, these structures draw primarily on the capabilities of Somali personnel, *xeer*, clan and sub-clan networks,[136] transnational population movements for wage labor, grazing and trade,[137] informal and illicit transnational economies of commercial goods and services,[138] and largely unregulated and pluralistic health systems. [139] In essence, as discussed throughout this dissertation, the Somali Region contains myriad structures of governance and social organization (both state-based and non-state) that are socially and culturally resonant, although not without heterogeneity. The Somali Regional State is distinctively Somali.

At the same time, disparities between the Somali Region and the rest of Ethiopia persist: infant, child and maternal mortality rates in the Somali Region are higher than anywhere else in the country; average access to regulated primary healthcare facilities is lower than in other regions; and political violence and human rights abuses continue (Amnesty International 2010, Human Rights Watch 2008, Human Rights Watch 2010, UNICEF 2009a, UNICEF 2009c). Although the Somali Region has been given the constitutional right to organize its own systems of governance, it garners less federal support to do so (International Crisis Group 2009). The Somali Region receives less per

[135] Federal mechanisms of control in the northern Somali Region included infrequent and unpredictable police- and military-led efforts to quell illegal trade between Somalia and Somalis in Ethiopia and to quell uprisings by separatist groups further south in the Somali Region, including the Ogaden National Liberation Front.
[136] Discussed at length in Chapter 5.
[137] Discussed at length in Chapter 5.
[138] Described in Chapter 1.
[139] Discussed at length in Chapter 3.

capita funding than other autonomous regions of Ethiopia for infrastructure development projects, public education, health system improvements, and enforcement of food and occupational safety among many other things. I argue that this marginalization has relegated the Somali Regional government to obtaining funding for many of its *basic* social services from humanitarian relief organizations – and these sources are beholden to emergency funding priorities and requirements. The budgets and architectures of the Somali regional government are consequently lopsided: bureaus that can argue for humanitarian assistance and can partner with disaster relief NGOs, such as the Somali Regional Health Bureau, have become disproportionately inflated, while other governmental offices, such as the Education Bureau, have atrophied. Additionally, sustainable development of the health system, for instance, is carried out with significant amounts of money earmarked for temporary relief operations – the mobile team of nurses in Aysha *woreda* (district) provides a case in point.

In such cases, state institutions take on the priorities and mentality of emergency relief – the precedence and triage of "bare life" (Comaroff 2007, Agamben 1998, Fassin 2007) – frequently without future promises or considerations of the longer-term effects on economies, social services or health systems. At the completion of one emergency funding cycle, a new case is made for humanitarian crisis; new statistics on acute child malnutrition and food insecurity are collected to prove the severity of the situation to donors; and a new disbursement of food aid, free essential medications, vaccinations and other materials is planned to save the lives of the "most vulnerable groups" – infants, children and their mothers. Often, the suffering and struggles of persons outside the

purview of relief operations are sidelined: too many teenagers go without educational opportunities, the elderly go without food supplements or arthritis medications, large public hospitals lack adequate equipment and trained staff, and so on. In the last few years a handful of nongovernmental organizations – UNICEF, Save the Children, and the Feinstein International Center among a few others – have been working with Somali Regional State entities to translate emergency funding into sustainable improvements in governmental services. However, these efforts are undermined by the enduring structures of foreign aid and ethnic federalism in Ethiopia.

Defining and Theorizing "the State"

Asha, a young mother from the small town of Biyogurgur in the rural Aysha *woreda* (district) said,

> People here are very poor. [We] are not Ethiopian and not Somalian – [we] are neither. In between. The Ethiopian government will not do anything to help the people here, and Somalia is not our country either. There is no communication between the people here and the Ethiopian government – our people are not heard.

Like Asha, many Somalis in the northern Somali Region of Ethiopia felt marginalized – geographically, politically and economically – from Ethiopian sources of power in Addis Ababa. During 2008 and 2009, further south in the Somali Region, Ogaden National Liberation Front (ONLF) rebels were engaged in skirmishes with Ethiopian police and military forces for control of roads, towns, and taxable commerce (Amnesty International 2010, Human Rights Watch 2008). Numerous Somali political parties and militias

further south in Somaliland and Somalia, including *al-shabaab*, were in active and often violent resistance to the Ethiopian military offensives and the Ethiopian-supported Transitional Federal Government of Somalia and the African Union peacekeeping efforts (Menkhaus 2010). The peaceful and remote northern Somali Region of Ethiopia, including the towns of Aysha, Degago and Elahelay, by contrast, existed in the margins of these regional conflicts and, more broadly, in the margins of Ethiopia's larger contestations over political control and resources in the Horn of Africa.

Further, one might ask upon visiting, where exactly are the lines demarcating Aysha woreda and the Somali Region within Ethiopia? Their precise locations seem to be of little importance to Somali residents, and signs of border patrols and checkpoints were absent along most of the northern boundary region. In fact there was no geographic map in existence that correctly traced all the boundaries of the Somali Regional State, Ethiopia, Somaliland or Somalia – primarily because each of these states is in ongoing and uneven processes of boundary making and enforcement. The Ethiopian Ministry of Maps in Addis Ababa has not updated its map of the northern Somali Region since the early 1990s. And since 1991, there have been numerous modifications to regional cartographies and bureaucratic architectures within the Somali Region (Hagmann 2005). The blurry, porous and disputed boundary between these different state powers points to the long history of incomplete and contested processes of state formation in the Horn of Africa.

Additionally, rather than being located at the geographic edge of the state or continent, Aysha woreda felt more like a place people passed through but never stayed:

The Road to Djibouti, described in Chapter 1, brought travelers and herders through roadside villages for a few minutes or hours but not longer; *khat* trucks blazed through communities to deliver fresh leaves throughout the Horn; new electrical power and fiberoptics lines were being laid parallel to The Road to Djibouti but only in order to provide services elsewhere; healthcare providers in the Aysha Medical Center worked there only for as long as it took to get a promotion or transfer; every few months caravans of eighteen-wheelers laden with UN World Food Program's rations were slowly hauled into the Ethiopian interior; various NGOs would visit for a morning to deliver donated materials, but never stayed more than a few hours; and even the mobile team nurses were constantly moving from village to village and only worked Aysha woreda for a few months. The near constant movement of people for work, commerce and visiting characterized the northern Somali Region, and further obscured its political and geographic borders.

Economists use the notion of a "national economy" and "national account system" to estimate economic activity with the boundaries of a country and to calculate the gross domestic product and the gross national product (albeit imperfectly). Yet in much of the Horn of Africa economies are what Jamal (2009:203) calls, 'unconventional,' "in the sense that a bulk of economic activities takes places outside the aegis of the national accounts." Few taxes were collected and scant industrial or agricultural development programs existed in the eastern lowlands to enrich an Ethiopian national economy. Instead, the arid northeastern corner of the Somali Region was a hub of contraband trade, and the numerous trade routes through Aysha woreda connected

ports in Puntland, Somalia, and Djibouti with large unregulated markets in Jijiga and Dire Dawa. Khat, electronics, household goods, fabrics, and pharmaceuticals could all be found circulating in these shadow markets. Residents of Aysha woreda frequently looked beyond what few public health facilities and licensed private providers were available, and instead many purchased medicine from unlicensed private clinics in Dire Dawa and Jijiga, small corner shops and unlicensed pharmacies in their hometowns, and unlicensed pharmacies in Somaliland. In addition, significant amounts of healthcare commodities and services were attributed to or provided by nongovernmental aid organizations. But for the most part, residents of the northern Somali Region said they felt passed over or invisible to many of these extra-legal and nongovernmental suppliers. In the case of contraband markets, most residents had too little purchasing power to demand broad-based and high-quality stocks of medications. In the case of international NGOs, laypersons had little influence on the materials or services they received due to organizational definitions of need and limited donor bequests.

In the last decade, the theoretical de-centering of nation-state power within the social sciences has frequently involved looking towards "the margins" of states, such as the northern Somali Region of Ethiopia, and how power operates in what are called "weak" or "failed" nation-states like Somalia. Asad (2004:279) describes the margins of states, in general, as "unstable" places "where state law and order continually have to be reestablished." As such, the so-called "margins" of states aren't really marginal at all, but rather indicative of the mechanisms and limitations of contemporary forms of government and power (Das and Poole 2004). Anthropologists have increasingly sought

out subjects of ethnographic analysis that defy the bounds of ethnic and territorial groupings – wars, disasters, diasporas, human rights, the global pharmaceutical industry, extra-legal economies, food systems, climate change and so on (Biehl et al. 2007, Fassin and Rechtman 2009, Ferguson 2006, Merry 2009, Nordstrom 2007, Petryna 2009, Tsing 2005). There has also been an erosion of attention to social categories and inequalities rooted in nation-states and territories, while individuals' identity are understood as more commonly generated through the reification of biological and bodily realities (Comaroff 2007, Epstein 2007, Rabinow 2005, Rose 2006).[140]

In the same vein, several anthropologists have taken on the project of rethinking "state" power and citizenship as it shapes everyday health practices and healthcare systems (Biehl 2004, Petryna 2002, Nguyen 2005, Ong 1996). Equating "states" with geographical territories, ethnic groups or bounded economies becomes problematic when viewing people's illness experiences and strategies to access healthcare resources. For example, Rose (2006:3) notes that in recent years, "a reorganization of the powers of the state, with the devolution of many responsibilities for the management of human health and reproduction that, across the twentieth century, had been the responsibility of the formal apparatus of government, [have been devolved] to quasi-autonomous regulatory bodies…to private corporations …and to professional groups." In developing countries,

[140] Underpinning many of these ideas is what Foucault (1980:139-140) called "biopower," or the control of populations that is dependent on both visible and discreet techniques of regulating individual bodies, such as the designation and enforcement of exclusive categories of citizenship, and thus rights to certain protections and services by state entities. For Foucault, biopower refers to control over life at the level of the human body as an object of discipline and medical intervention, and at the level of the population as an object of regulation, scientific research, and welfare. He argues that knowledge about the public's health (e.g. through the collection of demographic statistics, etc.) is produced to determine the focus and forms of "governmentality," Foucault 1991).

public health is increasingly provided by non-state and private entities, due in part to the poverty of many federal and local health systems, and in part to broader neoliberal processes in many parts of the world of state withdrawal from public services (Fidler 2003, Fidler 2007, Harvey 2005).

"Bottom-up" primary health care (WHO 1978) was originally based on the ideal of decentralizing authority and responsibility for healthcare to local communities (i.e. Jitta 2003). Ironically though, in Ethiopia and elsewhere, decentralization has instead involved the subcontracting out of healthcare services to international NGOs and multinational corporations. Several ethnographies shed light on the growing role of these global non-state healthcare assemblages in lower income countries, including nongovernmental aid and human rights organizations (Ong and Collier 2005, Redfield 2006, Sassen 1998), private hospitals and specialty clinics (Benson 2001, Hamdy In press), private pharmacies and local corner shops beyond the reach of state regulators (Brieger et al. 2004, Conteh and Hanson 2003, Kamat 2004, Kamat and Nichter 1998), and multinational pharmaceutical companies (Biehl 2006, Wendel and Hardy 2006, Whtye et al. 2005). The missions and priorities of international NGOs are often structured by organizational expertise, the politics and economies of donor countries, and organizational expectations and measures of need; the primary goals of private drug companies, private pharmacies, and private hospitals are to ensure profits and appease investors (Dukes 2002, Ferner 2005). By contrast, optimally, politicians and policymakers in representative democracies, especially at local levels, can be held accountable for the provision of public health and other human rights through elections,

the media, and other unofficial political processes (Holzer and Sorensen 2003, Sen 1999). In the end, targeted populations usually have little say in the design of health and humanitarian interventions that affect them.

Professionals involved in public health around the world have long acknowledged the growing roles of nongovernmental organizations, multinational pharmaceutical and research corporations and transnational movements of pathogens – and thus introduced the concept of "global health" – contra "international" health (Fassin 2009, King 2002, Nichter 2010). However, even though "global health" has become a buzzword, this does not mean that officially recognized nation-states are seen to have a lesser role in healthcare policymaking or health outcomes. In fact, there is heightened and novel relevance for the role of borders in the enforcement of exclusionary state power and in the emergence of health disparities between territorially and politically distinct catchment areas (Machledt 2007). Thus, protecting citizens from foreign threats of pathogenicity, contagion and bioterror are central concerns for nation-state governments (Fassin 2009, Lakoff and Collier 2009, Ticktin 2006). Whether physical, legal or socially constructed, boundaries demarcating citizens from non-citizens often also divide persons entitled to assistance and state services from those who are not. Contemporary anthropological studies of "citizenship" show how boundary-making activities in the humanitarian and healthcare sectors, such as the implementation of aid programs with limitations on who qualifies for medical care, are important methods of designating and deploying sovereign power today (Briggs and Martini-Briggs 2003, Castañeda 2008, Nguyen 2005, Nichter 2008, Petryna 2002).

In the wake of humanitarian disasters or political crises, federal regulatory agencies may be disbanded, leaders left unaccountable, and global nongovernmental actors suddenly more intimately involved in the everyday workings of local law, order and healthcare (de Waal 1997, Fassin 2005, Leaning et al. 1999, Nordstrom 2004). As mentioned in Chapter 5, the expansion of medical aid programs into previously underserved locations also entails increased local knowledge and expectations of pharmaceuticals, vaccinations and other forms of biomedicine—even though subsequent demands and expectations are often not met. At the same time, several studies demonstrate how failures of clinical trials and vaccination campaigns to produce noticeable local health improvements can severely damage the reputations of governments as well as international NGOs (Feldman-Savelsberg 1999, Kaler 2009, Obadare 2008, Renne 2010, Shah 2006). This research suggests that the same may be said about nongovernmental aid agencies and governments who provide temporary humanitarian relief without at the same time improving sustainable forms of primary healthcare and supplies of trusted medicines.

Ethnography provides a useful analytical tool with which to investigate processes of state formation and to understand how state structures, their boundaries and their responsibilities are all culturally and socially constructed and enforced. I view the Federal Democratic Republic of Ethiopia and the Somali Regional State, as "cultural artifacts" with important transnational dynamics (Sharma and Gupta 2006:5-6). In the case of this dissertation, ethnography made visible how trust in, and notions about, "the

Ethiopian state" and "the Somali Regional State" – as well as "*habashas*" [141] and "Somalis" as discussed in prior chapters – were constructed from within the walls of clinical facilities and humanitarian operations. As Sharma and Gupta phrase it, "What the state means to people…is profoundly shaped through the routine and repetitive procedures of bureaucracies" (2006:11). By analyzing the mundane processes in which the Ethiopian state and the Somali Region were instantiated and experienced by a variety of persons in the northern Somali Region, I highlight the contested and incomplete nature of state formation in the Ethiopian periphery beyond the mere lack of reliable maps and patrolled borders. More specifically, this dissertation focuses on relations of power and trust within medical practices and healthcare institutions – perhaps the most intimate interfaces between the state and individual bodies. I argue that *reer*-based alliances, notions of citizenship, racialized antagonisms, and relations of trust are each mutable, and moreover, are constantly reworked during medical encounters. But first in this chapter, I outline key political structures and historical moments in which enmities and relations of distrust between Ethiopians and Somalis have evolved.

Ethnic Federalism in Ethiopia

[141] "Habasha" (otherwise spelled "habesha" or ሐበሻ in Amharic) is colloquially defined as persons of Amhara or Tigrynia ethnicities residing in Ethiopia or Eritrea. The term habasha for many rural Somalis in eastern Ethiopia indexed not just ethnicity and language group but political support of the current Ethiopian government, although many habashas would object to this usage and association. The term "highlander" is also used to refer to persons of Amhara or Tigrynia ethnicities.

In 1991 the Tigray[142] People's Liberation Front (TPLF), with assistance from other ethnic-based militia groups in Ethiopia, led a coup that toppled Mengitsu's regime and deposed of its centralized dictatorial administration.[143] In the wake of the revolution, an alliance of ethnic groups from across the country formed the Ethiopian People's Revolutionary Democratic Front (EPRDF), led by Tigrayan military commander, Meles Zenawi.[144] The EPRDF under Meles Zenawi strategically sought to unite the disparate and oppositional ethnic groups in Ethiopia under one ethnic federalist state (Cohen 1995, International Crisis Group 2009, Mengisteab 1997).[145] In 1995 the Transitional Government of Ethiopia ratified a new constitution that established the Federal Democratic Republic of Ethiopia (FDRE) and divided the country into primarily ethnic-based regions. The ethnic autonomous regions included: Afar, Amhara, Benishangul-Gumuz, Gambella, Harar, Oromia, Somali, Southern Nations Nationalities and Peoples, and Tigray. In addition, two chartered urban regions were formed: Addis Ababa and Dire Dawa.

Ethnic autonomy was central to the new Ethiopian federalist system: Article 39 of the Ethiopian Constitution asserts that, "Every nation, nationality and people in Ethiopia has an unconditional right to self-determination, including the right to secession" (FDRE 1994). The Constitution also guaranteed democratic representation and equitable

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[142] Tigray is an ethnic group residing predominantly in northern Ethiopia along the border with Eritrea; along with persons of Amhara, Oromo, and a few other smaller ethnic groups, they are often referred to as "highlanders" by Somalis in Ethiopia.
[143] A detailed history is provided in Chapter 1.
[144] Meles Zenawi has held onto power since the 1991 coup; he was elected Prime Minister by the Ethiopian Parliament in 2005 and again in 2010.
[145] Girma Wolde-Giorgis, an Oromo man, was elected President of Ethiopia in 2001, then again in 2007, by the Ethiopian Parliament. The Ethiopian presidency is a symbolic office with little power; most of governmental power is vested in the hands of the Prime Minister.

resource allocation to all ethnic leaders, a term Abbay (2004) calls, "consociationalism" or power sharing between ethnic elites at the federal level. However, Abbay (2004:610) also finds that although the Constitution theoretically calls for fair representation, "the gap between society and state remains wide, [and] the current system is hardly democratic." A Human Rights Watch report published online in May 2010 specifies:

> In the nearly 20 years that the Ethiopian People's Revolutionary Democratic Front (EPRDF) has been in power, Ethiopia's government has taken steps to promote economic development and has introduced the technical framework of democracy. The 1995 constitution incorporates a wide range of human rights standards, and government officials frequently voice the state's commitment to meeting its human rights obligations. But these steps, while important, have not ensured that Ethiopia's citizens are able to enjoy their fundamental rights.
>
> … in practice, Ethiopia's citizens are unable to speak freely, organize political activities, and challenge their government's policies—through peaceful protest, voting, or publishing their views—without fear of reprisal. Democracy's technical framework will remain a deceptive and hollow façade so long as Ethiopia's institutions lack independence from the ruling party and there is no accountability for abuses by state officials. (Human Rights Watch 2010)

Moreover, despite the decentralization of some forms of bureaucratic power and local governance, control over budgets and disbursement of external development and humanitarian aid have remained highly centralized and have disproportionately favored projects and policies overseen by EPRDF party loyalists and located in the north and west of the country (Human Rights Watch 2010, International Crisis Group 2009).

Decentralized ethnic federalism in Ethiopia was originally conceived in order to end the ethnic domination of the Ethiopian state by the Amhara ethnic group, and to dissuade revolt and secession by allowing ethnic groups to manage their own economic and political affairs (International Crisis Group 2009, Samatar 2004). The embrace of ethnic diversity and national self-determination in Ethiopia by the EPRDF was, on the

surface, also an effort to provide an antidote to the history of absolutism, centralized governmental power, and violent assimilation favored by the Derg and Haile Selassie's Empire (Abbay 2004).

The Somali Regional State was included in the first national conference of representatives in Addis Ababa in 1991, and the Somali People's Democratic Party has officially represented the interests of Somalis and the Somali Region in the national parliament since 1998. Since the country's first national elections in 2000, the Somali People's Democratic Party (SPDP) has allied with the EPRDF and its elected Members of Parliament have supported the EPRDF and Prime Minister Meles Zenawi.[146] With the Somali Region's inclusion into the Ethiopian federal state system, the Somali-Ethiopians were integrated into multiple, fluid and often antagonistic political organizations: on the one hand, they were incorporated as one administrative unit within the Ethiopian state. On the other, residents of the Somali Region continued to interact, travel and trade with Somalis living in Djibouti, Somaliland, Puntland, Somalia, northern Kenya, and the swelling Somali diasporas abroad. Somalis' bifurcated practices of citizenship – at once officially belonging to the legal entity of the Ethiopian state and while also, more palpably, belonging to transnational communities of Somalis – challenge various projects of Ethiopian state formation and the federal provision of healthcare.

[146] Critiques of the legitimacy and constitutionality of recent elections in Ethiopia, EPRDF's political maneuverings vis-à-vis minority parties like the SPDP, and the Government of Ethiopia's politicization of foreign aid may be found in reports by Human Rights Watch (2010), Amnesty International (2010), and the International Crisis Group (2009).

Reerka Ciise[147] within and without the Ethiopian State

Despite disagreements about the nature and uniformity of Somali clanship in the Horn of Africa (described in greater detail in Chapter 5), several scholars argue that the authority of lineage-based clan affiliations, clan leaders, and other kinship structures in Somali societies have historically surpassed or superseded formal state, colonial, or international authorities (Abbink 2003, Lulling 1978, Laitin and Samatar 1987; Little 2003; Cassanelli 1982). Repeated colonial and post-colonial movements to centralize political power in the Horn of Africa have, time and again, proven incompatible with the decentralized and egalitarian systems of governance in most pastoralist Somali communities. Centralized political projects were, according to Lulling (1997:289), "suspended above a society which would never have produced and did not demand" such centralization. Likewise, Abbink (2003) argues that prior to colonization by British, Italian, French, and Ethiopian states,[148] Somali peoples in the Horn of Africa were not united by a "shared culture" or a particular nationalist project, but instead, remained largely isolated, only loosely associated through their common religion and language, and only infrequently connected through trade and intermarriage. Similarly, Laitin and Samatar describe modern Somali social organization as "egalitarian," "acephalous" and "anarchical," but neither isolated nor solely determined by clan structure (1987:42-43).[149]

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[147] The Issa clan or Issa family.
[148] Many Somalis include Ethiopia as another colonizing power, because of its occupation of the Ogaden and fight for control over *haud* pastureland and trade routes linking Djibouti to Dire Dawa.
[149] Yet by contrast, Cassanelli (1982:86, 103) finds oral histories in southern Somalia that speak of several instances of domination of one clan by another. He argues that the powerful Ajuraan clan dynasty during the 15th through 17th centuries produced a highly cohesive and long-lasting Somali polity replete with

Moreover, in the wake of failed nationalist projects, civil strife, and recurrent humanitarian crises in the latter half of the twentieth century, many Somalis profess a lingering distrust of state institutions as well as international interventions (Markakis 1994, Little 2003). In this way, Little (2003:167) finds what he calls a "radical localization" of politics that overshadows nation-state authority, and this is characterized by an array of residual customary social structures in contemporary Somalia, such as the hierarchical structures for clan leadership and Somali customary law.

Despite the SPDP's political alignment with the EPRDF in nearly all elections, many Somalis, to each other and in interviews, professed a lingering distrust of the government in Addis Ababa and apprehensions about the character and justness of habasha Ethiopians in general. These apprehensions manifested, for one, during clinical encounters between Somalis and non-Somali Ethiopians (see Chapter 4). In northern pastoralist communities in the Somali Region, local governmental bureaus and governance structures (such as police forces and the judiciary) remained largely detached and less active in everyday life than religious leadership, kinship support, and Somali customary law (*xeer*). Male elders (*oday*), including sheikhs and mullahs *(wadaaddo*) and chosen clan leaders (*ugaas*) organized most local conflict resolution, individual dispute resolution, and interpretation and enforcement of customary laws and contracts. Wadaaddo, in particular, maintained positions of community leadership outside their clan affiliation and apart from formal Ethiopian systems of governance, drawing instead upon

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administrative hierarchies, theocratic ideologies, suppression of local conflicts over water and grazing rights, and unified opposition to other ethnicities in the Horn such as the Oromo groups in southern Ethiopia. Thus, Cassanelli finds, pre-colonial Somalis were not "egalitarian" at all, as some scholars claim, but rather, have an early and marked aversions to centralized political institutions.

their religious scholarship, local religious roles, experiences with pilgrimages, and talents for Qur'anic healing, divination, and mentorship.

Separate from religious and customary social structures, *kebeles* are legal Ethiopian governmental entities. Kebeles (an Amharic term meaning "neighborhood") are territorially distinct administrative units throughout Ethiopia, one step more local than woredas. Small towns and clusters of homes, including those within the northern Somali Region, are divided into distinct kebeles. Typically, kebeles include only a few hundred households. For instance, Elahelay is its own kebele; Degago is its own kebele; Dire Dawa includes several numbered kebeles; and scattered settlements of pastoralist, semi-pastoralist and farming households throughout the rural Somali Region are conglomerated as distinct kebeles within larger woredas. A chairman plus a cabinet (in Somali, called *shir,* or literally, "committee") are elected to represent the residents of each kebele, and can pass local decisions and desires up to the woreda and then to the Region. The chairman and other cabinet members are elected by popular (male) vote in each community.

Kebeles are residues of historical "peasant associations," that were created during the socialist Derg regime in Ethiopia in the late 1970s and 1980s. As such, they were originally conceived to promote local development and manage the Derg's agricultural and proprietary reforms. Derg-era kebele administrations were also designed as local defense squads, and were frequently intimidating and violent; they enforced military control over irredentist groups in the remote and unstable corners of the Ethiopian state (Bahru 2009). In the last twenty years since Prime Minister Meles Zenawi has governed

Ethiopia through ethnic federalism, however, kebeles have relinquished their military functions, and are now primarily organizational units within the Ethiopian state through which governmental and aid agencies manage the distribution of food aid and other forms of material assistance, the planning of public works, and the provision of state educational and medical services.

Kebeles are the most local form of federal electoral power in Ethiopia, and are one of the few connections remote northern Somalis have to the Ethiopian state. The elected chairman (*guddoomiye beesha,* literally the community chairman) has authority to, as many Somalis expressed it, "write letters" and "talk to people" on behalf of residents in need. In the northern Somali Region, in the year of this research, kebele chairmen were all literate Somali males under the age of 50 with the ability to "write letters" in Somali language and forge positive relations with politicians elsewhere in the woreda—in particular, other members of the SPDP and EPRDF. Kebele leaders and cabinet members in the northern Somali Region rotate among different sub-clan groups so at least one representative of each group is sure to serve within the kebele administration at all times. In most kebeles in Aysha woreda, one or two extended family groups are dominant and form the majority of residents in a particular locale, so often these groups elect proportionally greater numbers of representatives to positions of power. Thus ideally, kebele administrations are conceived, in the Somali Region at least, to represent persons of various lineage groups, incomes, livelihoods, and interests. At the same time, the ways in which resources, services, and favors were meted out were constant sources of tension and public debate. Unlike Somali political structures

elsewhere in the Horn of Africa, Ethiopian Somali political structures (for better and worse) unite persons from different kinship groups into a coherent and secular organizational system that was (mostly) loyal to the ruling EPRDF; thus in some ways the kebele administrations undermined the power and influence of *xeer* (Somali customary law) and *tol* (kinship or genealogical ties). In other ways, kebele administrations were complementary. For example, kebele leaders typically make decisions about how a local development fund might be disbursed, but xeer and ugas were often called upon to resolve interpersonal disputes and grievances.

Clan and familial ties also typically crosscut and partially even out class divisions and income inequalities. Laitin and Samatar (1987:47) describe this phenomenon in Somalia by saying,

> …clan ties blur the cleavage of class. Although Somalis are keenly conscious of the power, prestige and social status that wealth confers, this does not translate into a consciousness of class difference…The rich and poor continue to be bound together by an ethos of kinship and religious interdependence and an ideology of individual equality.

Likewise, families in the northern Somali Region of Ethiopia often distributed monetary wealth within sub-clan and *mag* (otherwise known as *diya* or blood compensation group), especially when an individual needed to pay for medicine, bank loans, religious pilgrimage, specialized Qur'anic or other spiritual treatments, travel abroad for work, or education for a promising child. Wealthier individuals who worked for international aid agencies or were involved in the *khat* trade often participated disproportionately in distributions of their incomes. Furthermore, individuals often pooled resources within a small sub-unit of the mag – such as a group of cousins or siblings – in order to purchase

vehicles, start new businesses or pay for medical treatments abroad for sick individuals. Bank accounts were frequently shared between small groups of brothers or cousins, or alternatively, cash and generous amounts of khat were gifted to individuals within the mag or family following a payday.

Despite these various ways in which political and economic structures and practices undercut kinship divisiveness, the social construction of distinct clan groups has long shaped politics in the Somali Region and throughout the Horn. As such, this idiom is an excellent vessel for manipulation by elite groups" (Abbink 2003:335). This topic is taken up in greater detail in Chapter 1 and Chapter 5.

Conversely, recent Somali nationalist and secessionist social movements within Ethiopia have attempted to undermine divisions based on clan in order to unite all Somalis in Ethiopia through the invocation of remembered oppression during the colonial period (prior to 1960), the conscription of ethnic Somalis into wars with Somalia (described in Chapter 1), the continuing dispossession of nomadic pastoralists throughout the Horn, generalized economic and social inequality between ethnic Somalis and other ethnic groups in Ethiopia, and marginalization from the current Ethiopian democratic system (Hagmann 2005, Hagmann and Hoenhe 2009, Samataar 1992). One such organization, the Ogaden Human Rights Committee (OHRC) researches human rights violations and has connected recent crimes against Somalis to historical patterns of neglect and abuse of ethnic minorities (OHRC 2006). They state,

> Ethiopia since the beginning of this century and up to now has been characterized by one nation using the power of state to subjugate and exploit all the other nations within that artificial system." …"[The] EPRDF [has] planted the seeds of

> the next cycle of bloodshed and violence in the region. It started trying to divide the Ogaden Somali people and undermine the leader role of the ONLF [Ogaden National Liberation Front] by creating pseudo-organizations based on tribal lines... the EPRDF government master-minded the killing of several ONLF officials [OHRC 2006:1].

Hagmann (2005: 514), for one, acknowledged intermittent human rights abuses and economic disparities between Somalis and other Ethiopians, but also stated, "Ethiopia is far from exerting hegemonic control over its Somali borderlands." Additionally, while many individuals within Issa, Ogaden, Gadabuursi, Garre and other Somali clans share a general mistrust of habasha political elites, they are far from united on this and other political matters (Hagmann and Hoehne 2009). Hagmann (2005:524) says of the Somali Region in general: "Variegated political devices by the Somali Region's political groups illustrates plural, contradictory, and differentiated relationships between the centre and periphery, state and society." He calls governance in the Somali Region "hybrid political domination," where power is based simultaneously but variably on patrimonial kinship-based and legal state state-based forms of legitimacy. The inclusion of contested woredas in southern Ethiopia populated mostly be non-Somali, non-Oromi ethnic groups into either the Somali or the Oromo Regions belie the idea of a homogenous, stable and obvious ethnic division at the site of borders between different ethnic federal states (Hagmann and Hoenhe 2009). The politicization of kinship and ethnicity through the expansion of the Fedearal Democratic Republic of Ethiopia and the construction of a Somali Regional State, Hagmann argues further, has been a major engine of instability there (2005:519).

In April 2007 the ONLF attacked a Chinese oil installation in the southern Somali Region, killing more than 70 Chinese and Ethiopian civilians. The Ethiopian government, led by Prime Minister Meles Zenawi, responded by launching a systematic counter-insurgency campaign in predominantly Ogaden communities in the southern Somali Region. Thus after April 2007, relationships between Somalis – not just ONLF supporters or Ogaden-clan members, but many Somalis throughout the region – and the Ethiopian government deteriorated, and in the southern Somali woredas, turned violent. During the period of this research, from 2007 until 2009, Human Rights Watch (2008) accused Ethiopian police and military forces of numerous attacks on civilians and civilian livelihoods, "that amount to war crimes and crimes against humanity." They went on to say:

> For those who remain in the war-affected area, continuing abuses by both rebels and Ethiopian troops pose a direct threat to their survival and create a pervasive culture of fear. The Ethiopian military campaign of forced relocations and destruction of villages reduced in early 2008 compared to its peak in mid-2007, but other abuses-including arbitrary detentions, torture, and mistreatment in detention-are continuing. These are combining with severe restrictions on movement and commercial trade, minimal access to independent relief assistance, a worsening drought, and rising food prices to create a highly vulnerable population at risk of humanitarian disaster.

Issa Somali clan and political leaders have not in recent years participated in Somali secession movements and have never en masse aligned with the ONLF or other secessionist or rebel incursions in opposition to the Ethiopian government. Within the Somali Region, the Issa clan is a minority group;[150] by comparison, the Ogaden clan is the largest clan in Ethiopia. Issas were also described by several non-Somali Ethiopians

[150] In neighboring Djibouti, however, Issas have long been a more powerful political contingent.

as, in general, "closer" and more "cooperative" with the federal government Addis Ababa and Dire Dawa, although sometimes marginalized within the Somali Region as a whole. Issa Somali leaders and bureaucrats in Aysha said they were in fact glad to be marginal to tensions between the ONLF and Ethiopian government,[151] and yet they bemoaned their related marginalization from the humanitarian aid moneys directed at conflict-affected locales.[152] Reactions to governmental programs (such as clinics and schools opened) among residents of the northern Somali Region were thus ambivalent and diverse: on one hand, a majority of people have long been aligned with the EPRDF and supportive of Meles, yet on the other hand they variably distrust the Ethiopian government due to their continuing marginalization from many beneficial federal development programs and the Ethiopian's abusive politics vis-à-vis Somalis further south.

After 2007, following the aforementioned increases in violence and counter-insurgency efforts in the Somali Region, local apprehensions about the justness of the Ethiopian government and the reliability of political alliances with the EPRDF were on the rise. Reified clan divisions and hostilities (such as Issa versus Ogaden) in many respects were declining, while tensions between Somalis as a contingent and the Ethiopian government in Addis Ababa were increasing. In the midst of this, I argue that the mobile team intervention, for one, also shifted the ways in which Issa Somalis in Aysha woreda regard their historically antagonistic Ogadeni neighbors to the south, and

[151] Due to the sensitive and fear-driven political climate at the time, I did not ask any research participants about their political affiliations, alliances or opinions.

[152] I spoke with many of the woreda-level leaders in Aysha during field stays there. Other Somali Regional politicians, policymakers, and humanitarian staffers I met in Jijiga, in government offices, aid agencies and conferences held there. Additionally, I listened to accusations of hiring and firing at the Somali Regional Health Bureau based on clan, but given the limits of this project, I could not fully investigate these claims.

more broadly, has increased the saliency of a cohesive Somali Region in contrast to an unstable amalgamation of distinct clans or a unified Ethiopian nation.

Both mobile team nurses in Aysha woreda were Ogadeni: Hussein spent most of his life in the rural southern Somali Region while Abdul grew up in Jijiga, the regional capital. Yet when I spoke with Issa Somali individuals (and even in a few cases Hawiye and Gadabuursi Somalis) in Aysha woreda who had received care or advice from the mobile team, clan differences or affiliations were never volunteered or said to be important. Instead, nearly universally, persons receiving care from the mobile team lauded the nurses' respectfulness and knowledge of medicine. I found a similar trend within state and nongovernmental healthcare bureaucracies headquartered in Jijiga: Somalis employed there explicitly attempted to understand Somali people's needs as a whole and better serve their healthcare needs.[153] If anything, efforts were made to prioritize the needs of Somali pastoralists over any particular woreda or clan group per se, because they were seen to be hardest hit by the recent rainfall declines, and because many Somalis locate their cultural roots in these nomadic herders. In addition, although people were introduced in conversations as being from this or that clan, and related to this or that individual, processes of healthcare governance and policymaking seemed largely removed from antagonistic or competitive divisiveness based on clan. So I take Hagmann's argument (2005) a step further: the contested processes of regional state formation in the Somali Regional State have altered the parameters of what it means to be

[153] I heard stories about Somali bureaucrats to the contrary. I mean to indicate this as a general trend, and thus not without exceptions. I also do not mean to say there was no corruption – such claims are beyond the scope of this research. One characteristic of the Somali Regional Health Bureau in particular was that planned staff and leadership turnovers kept one person (and his cadres) from acquiring disproportionate amounts of funding for any one project or employee.

Somali and what it means to be Issa within the Somali Regional State. Since the toppling of the Derg and institution of ethnic federalism, clan divisions and even ethnic differences have been (unevenly) subsumed in efforts to create and maintain a cohesive Somali contingent.

Additionally, for the Somali Region as an autonomous polity, state formation has relied heavily upon foreign humanitarian aid and international backing in the forms of humanitarian assistance as well as human rights and political activism contra the Ethiopian federal state. Expatriate and diplomatic narratives[154] reinforced the amalgamation of Somali clans under a cohesive notion of a Somali Region by locating differences between groups and political contestations primarily at the sites of formal political boundaries, and between the supposedly stable nation-state of Ethiopia and minority rebel groups such as the ONLF. For many in diplomatic and foreign policy circles, markers of stability and "good governance" were defined within the framework of a Somali Region fully integrated into a democratic Ethiopian nation-state. These narratives referred to "The Somali Region" or "Region 5" rather than to particular clans such as the Issa or Ogaden within the region (World Bank 2005, World Bank 2006). Additionally, much of the time since the late 1980s, the entire Somali Region was uniformally labeled a "Phase 5" security zone by the United Nations. Other times only the roads to and from the capital city of Jijiga and international border areas were labeled "Phase 5," even though most of the surrounding countryside was safer. "Phase 5"

[154] These were represented during conversations with governmental and United Nations bureaucrats, during formal conferences of health and humanitarian policy stakeholders, and in the substantial NGO policy literature. My methodology and details about the research sample are provided in Chapter 2.

represents the highest level of security concern: most of Iraq and Afghanistan in 2008 and 2009 were also "Phase 5" zones. Consequently, during the drought and food crisis in 2002 and 2003, the Somali Regional State received less foreign and federal humanitarian and development aid than other regions because of "security concerns" and "lack of access" given to diplomatic and relief personnel (Carruth 2005, Carruth 2007, de Waal et al. 2006). Few UN or international NGO staffs were granted access to the Somali Region by their organization or by the Somali Regional administration. Not only did this impede and delay the distribution of relief commodities and medical assistance, but it also prevented data collection and monitoring by federal and international relief agencies (Lautze et al. 2003, UNICEF 2008c).

Moreover, the reification of political boundaries by the aid community glossed important contestations within and between different woredas and obscured novel ways in which clan differences were invoked by Somalis[155] to explain corruption, misappropriation of funds, and nepotism within regional bureaucracies. On the other hand, in speaking with habasha and expatriate relief workers in nongovernmental organizations, I found that fears about instability, clan divisiveness, corruption, and violence in a few areas or instances within the Somali Region were inappropriately applied to all Somali people. Several habashas I knew – both staff of NGOs and laypersons – expressed anxieties about upcoming travel or work in the Somali Region, citing stories they had heard of ethnic-based violence and intolerance there.[156]

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[155] During interpersonal conversations and interviews.

[156] Other habasha staff I met *were* highly devoted to investigating and solving healthcare and other policy problems in the Somali Region, in particular ones I met through Handicap International, the Feinstein

Additionally, many expatriate staff of nongovernmental organizations bemoaned the battery of security protocols necessary for work in the Somali Region, and instead expressed a preference for spending time in safer urban areas like Addis Ababa or Dire Dawa. Security concerns and the reluctance of many staff to spend time in the Somali Region of Ethiopia meant that, increasingly, Somalis were being trained and hired for work there (a boon to literate Somalis' livelihoods, as discussed in Chapter 5). However, this also meant that the ambits of health and humanitarian interventions were often limited to one-time donations of material goods. Branch offices of the Hararge Catholic Secretariat (the eastern Ethiopian arm of Catholic Relief Services) and Oxfam-Great Britain in Aysha woreda were routinely critiqued by residential Somalis for their propensity to drive up to a small village, leave off bags of pharmaceuticals or unassembled wheelbarrows, and drive away. The only Americans most Somalis there had ever seen had been either United States Army troops or NGO staffers accompanied by military escorts and habasha Ethiopians. A Somali man living near Aysha said to me once, laughing, "You are like a French person, not an American. Americans are always too afraid to sit here at our houses and enjoy the day." Indeed, days before, a habasha employee of the Hararge Catholic Secretariat had warned me about going to Aysha: "You don't want to stay there. It is dangerous for foreigners"—including, presumably, himself.[157] Similarly, Idrias, a habasha nurse at the Aysha Medical Center once said about the local Somali population: "Somalis are very racist. They are a very racist

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International Center at Tufts University, and Save the Children. Their work, unfortunately, in my experience, was the exception and not the rule.

[157] Notably, my research team – including a Christian Amharic-speaking Oromi male driver – never experienced any security problems or violence. These were common topics of cross-cultural conversation during our research stints together though.

people. … We are foreigners to them."[158] In addition to essentializing and reifying notions about the Somali Region of Ethiopia, each of these assumptions and fears complicated the prospects of sustainable and responsive (not just reactive) humanitarian interventions in the Somali Region.

Beyond Band-Aids and "Bare Life"

Humanitarian relief has long been critiqued for its shortsighted focus on relieving immediate bodily suffering at the expense of lasting political engagement and reform (Reiff 2003, Terry 2002). Most nongovernmental humanitarian agencies, such as the Ethiopian Red Cross and the emergency unit of UNICEF in Ethiopia frequently (but unevenly) portrayed themselves as neutral[159] or apolitical during conflicts around the world in order to preserve their access to populations in need (Duffield 2001, Macrae 2002). Other humanitarian organizations, most prominently Médecins Sans Frontières and Médecins du Monde, are explicitly counterposed to the apolitical mission of other aid

[158] Idrias is quoted and his perceptions are discussed in much greater length in Chapter 4,

[159] The principle of neutrality, as defined first by the International Federation of the Red Cross means "not taking sides in hostilities." Not taking sides and not appearing to take sides can be an attitude of objectivity and/or an operational necessity that enables humanitarian space, access, and trust from all sides of the conflict, all parties, and all stakeholders. Many NGOs and UN agencies have realized the benefits of maintaining neutrality in situations of conflict and competition for aid resources; the UN's '8 Common Humanitarian Principles' includes the principle of non-partisan action; also, the NGO Code of Conduct states that "aid will not be used to further a particular political or religious standpoint." By contrast, the principle of impartiality means humanitarian aid should be guided by need alone; therein aid must be both proportional to the severity and distribution of needs, and appropriate to the nature of needs. Impartiality is grounded in the Geneva Conventions', in human rights law, and in refugee law. It is a core principle for all agencies engaging in 'humanitarian' work; further, its primacy is reflected in the Sphere Projects' (2011) standard of "the right to life with dignity." Impartiality is a legal and moral principle on which humanitarian actors base all decisions. In contrast, since neutrality has a primarily operational purpose for many agencies (most of all for the ICRC), if it impedes the first principle of humanity, it can be abandoned (e.g. by organizations engaging with partisan actors to change the root causes of crisis and vulnerability, or even by the ICRC in the extreme case of genocide) (Duffield 2001, ICRC 2011).

institutions, and instead bring moral outrage, the principle of witnessing (*témoignage)*, and political opinions into their medical interventions (Fassin 2007, Redfield 2006). Despite differing stances on the principle of neutrality, however, most medical humanitarian organizations remain steadfastly focused on efficiently relieving immediate physical suffering – applying Band-Aids to those deemed in greatest medical need[160] (Redfield 2008). Politicians, the media and aid agencies, at times, wrongly medicalize humanitarian crises and the suffering of individuals involved (Ticktin 2011).

The biomedical encounters I witnessed in the northern Somali Region of Ethiopia were not designed to ameliorate the historical, political or economic marginalization Somalis felt contra habasha Ethiopians.[161] But they were not apolitical either; humanitarian relief always, in my experience, involved politically sensitive negotiations and cooperation with governmental bureaucracies.[162] Humanitarian aid was increasingly expressed as one part of larger strategies to improve the functioning and capacity of the Ethiopian government. And at least in the case of the mobile team of Somali nurses, health and humanitarian interventions indirectly bolstered the reputation of the Somali regional government, even through its association with (presumably superior) foreign relief agencies. Yet in other ways, such relief programs remain forms of disengagement: in policy documents and during interviews with bureaucratic staff of the Somali Regional

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[160] Of course, triaging and prioritizing the needs of persons who officially qualify for humanitarian emergency assistance – most often in the northern Somali Region, women and children – was at times contrary to this mission. Elderly men in particular were often in greatest need of medical attention. This created tensions, and will be discussed subsequently.

[161] See Chapters 3, 4 and 5 for detailed descriptions of the medical encounters during mobile team interventions.

[162] My argument here is different than Ticktin's (2011), when she shows how humanitarianism mostly maintains the status quo. Here I also acknowledge the more intimate, emotive, and interpersonal aspects of aid, compared to Ferguson (1994), de Waal (1997) and others studying international aid.

Health Bureau, the Ministry of Health and UNICEF, policymakers highlighted their predominant interests in expanding the *material* apparatus of a decentralized health system, rather than focusing on enhancing *expertise* and *efficacy* within existing healthcare facilities and bureaus.[163] Documents expounded upon the importance of improving the capacity of healthcare workers in the Somali Region, but such statements, in reality, were largely aspirational (e.g. Federal Ministry of Health 2005, Federal Ministry of Health 2008, UNICEF 2009b).

For example, every pastoralist health extension worker I spoke with in the Somali Region regretted there were not mechanisms by which they could significantly improve their training in biomedicine and pharmacology; also, the mobile health team nurses regretted they did not have adequate time to adequately train and supervise the health extension workers. Admittedly, there were regular conferences and workshops designed to improve the capacity of the health extension workers, yet participants said afterwards, these initiatives did not help them master concrete skills. Often, courses were taught in the English language and were thus mostly incomprehensible to Somalis, or the lessons were too broad and vague (e.g. literature and lectures were provided during workshops on topics like "harmful traditional practices" without specific details on what these entailed in particular locations or on how neophyte health workers might effectively pose critiques

[163] Most healthcare providers in Ethiopia – from United Nations employees down to pastoralist health extension workers – attended regular (semi-annual or in some cases monthly) training workshops and conferences. However, after attending several of these myself, I must confess they impart little valuable information and are more a way for staff to vacation in urban areas and network with other professionals in the healthcare sector. Real enhancement of human capacity would require a much different commitment on behalf of policymakers and providers.

of practices like female genital mutilation/circumcision to their elders and mothers[164]). Conferences and workshops for most government employees were chances to travel and visit with relatives in urban areas, and were not primarily seen as learning experiences. Furthermore, these educational initiatives did not confer specific professional degrees or licenses, nor did they significantly increase patients' subsequent respect for health extension workers' abilities or knowledge. Thus, it would seem that policymakers at times took for granted that both providers' authority and expertise as well as patients' trust were hard won, especially at the margins of the Ethiopian state, and would not automatically follow from the construction of facilities, the hiring of community health workers, and the provision of free medications.

In order to better understand the ways in which narrow conceptions and narratives of crisis and aid in the Somali Region of Ethiopia shaped subsequent processes of state formation and citizenship, I draw on theorizations about "bare life" – human life devoid of citizenship and sociality – during humanitarian emergencies. The Ethiopian and Somalian governments have repeatedly declared what political theorist Carl Schmitt (1985[1922]) might term "states of exception." States of exception are defined by the suspension of constitutional guarantees and citizens' rights during war or political insecurity. As such, states of exception instigate altered relationships between sovereigns and society, and between citizens and non-citizens. More specifically, this dissertation demonstrates how eastern Ethiopia has long existed in a "humanitarian state of exception" (Fassin 2005, 2007). Fassin (2005:390-391) defines this as the suspension of

[164] These kinds of conundrums, as articulated by pastoralist health extension workers and others, are discussed in greater detail in Chapters 1, 3 and 4.

the rule of law and constitutional guarantees "in the name of emotion generated by the cataclysm and its human repercussions." Fassin argues that it is not fear of danger or anomie that authorizes exceptional measures by leaders, but rather the threat of foreign intervention into a sovereign state, in apparent defense of the human lives of its populace, when the leadership is perceived to no longer capable of protecting or representing its people. Notions of humanitarianism, as such, are grounded not just in ideas of war or emergency but also in moral sentiment and transnational action – even at the expense of sovereignty – to relieve individual biological suffering (Fassin 2007, Redfield 2005, Ticktin 2006).

In his work *Homo Sacer: Sovereign Power and Bare Life* (1998), Giorgio Agamben draws on Aristotle and Foucault (among others) to trace a genealogy of biopolitics, arguing that its origins lie in a leader's power to suspend law and declare a state of exception, in the sense Schmitt describes. He uses the example of *homo sacer*, a sacrificial figure in ancient Rome whose rights were revoked and who could be killed without legal recourse. Agamben argues that Roman law distinguished bare life (*zoë*) – biological or physiological life but nothing more – from full life (*bios*) – a socially meaningful life with political rights and protections from the sovereign state. The ability of law to distinguish human bodies from citizens, he argues, remains fundamental to contemporary forms of political power.[165]

[165] This and other elements of Agamben's *Homo Sacer* are in some ways good to think with, but I find offer only metaphoric and vague supporting details and accounts of individual actors' agency (LaCapra 2004). Consequently, I draw primarily on the work of Didier Fassin who offers ethnographic and theoretical specificity as a way to complicate Agamben's ideas (Fassin 2005, 2007).

Fassin (2007:501) utilizes Agamben's idea of "bare life" in order to move past Foucaultian biopolitics, defined by the regulation of entire populations, to what he calls a "politics of life" which takes as its object the saving of individual bodies. Humanitarian regimes are paradigmatic. Therein, humanitarianism is now a central instrument of foreign policies: wars are fought for avowed humanitarian reasons, humanitarian space is provided even in warzones, and humanitarian relief is a crucial diplomatic tool of nation-state governments. But with limited resources and time, such politics necessarily make judgments and compromises: "not only risking others [lives] but also making a selection of which existences it is possible or legitimate to save… And humanitarian intervention is also a politics of life in that it takes as its object the defense of causes, which presupposes not only leaving other causes aside but also producing public representations of the human beings to be defended" (Fassin 2007:501). Humanitarian policymaking and clinical care are necessarily a moral and emotional as well as pragmatic practices. Agamben sees the specter of a modern *homo sacer* in the African refugee – a human relegated, in an age of humanitarian empathy, from state-administered protections and left to die from hunger and neglect (Agamben 1998: 130-134).[166] Indeed, displaced persons in the Horn of Africa are often excluded from full legal citizenship at their destination, even as their bodies are obsessively counted, measured and monitored – as Scott (1997) phrases it, made "legible" – by state and nongovernmental agencies.

In practical and financial senses, humanitarian regimes in Ethiopia were inseparable from regional and federal state formations – the Somali Regional Health

[166] For other similar uses of Agamben and the notion of "bare life," see Heins 2005, Robins 2009 and regarding Muslim populations, Razack 2008.

Bureau and other governmental offices obtained substantial funding, staff support and political backing from international nongovernmental organizations like the Emergency Unit at UNICEF, the NGO Hararge Catholic Secretariat, branches of Médecins Sans Frontières, and Samaritans Purse. Consequently, the priorities and programs of the Ethiopian government, to a great extent, echoed the missions of these relief organizations – foremost the provision of basic necessities to "vulnerable groups" as efficiently as possible. Of course this created gaps: rural Somali residents largely lacked the means to withstand future shocks and disasters, and many services not readily under the mandate of humanitarian agencies and not payable with funding from emergency relief coffers – medical education, well-appointed healthcare facilities, primary schools, teachers, roads, piped water and so on were underfunded. Additionally, vulnerable groups were mostly limited to women and children; therapeutic foods, vaccinations and essential medications were often the only products provided free of charge; and programs rarely lasted more than one year.

A majority of the relief programs during 2008 and 2009 – including the mobile teams, one-time donations of medications, and deliveries of potable water via tanker truck – were each also exorbitantly expensive. They were far too expensive for the Somali Regional Health Bureau to continue past the horizon of humanitarian relief funding. Continually proving the severity of the humanitarian emergency in the Somali Region through research and donor appeals enabled these programs to carry on, despite their unsustainability. One UNICEF staffer admitted that maintaining emergency funding in the Somali Region was the only viable way to get international aid, and

therein, possibly a few sustainable improvements in the capacity of local healthcare providers and facilities. More commonly though, humanitarian mandates and budgets were sporadic and provisional, and thus insufficient to meet the holistic and continual demands of all residents. Consequently, in the Somali Region at least, transnational extra-legal economies continued to thrive and fill local demands for commercial goods, medicines and other services—especially those economies with historical antecedents; sub-clan family members donated what they could for the welfare and healthcare of those left out of humanitarian programs; and Qur'anic healers at times provided both spiritual counsel as well as unregulated medications for the treatment of presumed infectious diseases.[167]

Still, the ways in which the objects of humanitarian intervention were portrayed in policy documents, news media stories, and donor appeals – not as citizens but as bodies – were paradoxically starting points from which Somalis were forging new relations to various state powers around them. New lines of trust in biomedical regimes and therapeutics were actively being forged through interactions between clinical providers and patients. Although in ethnographic interviews most people expressed desires for sophisticated diagnostics and medications from international NGOs and expatriate relief workers,[168] services and materials were increasingly delivered by Somali Ethiopians through institutions within the Ethiopian government.[169] Most humanitarian relief in the Somali Region of Ethiopia was coordinated and administered by staff of the Somali

[167] These ideas are expanded on in Chapter 3.
[168] Assumptions about and preferences for medical materials and services "from abroad" – and specifically those deriving from international relief efforts – are discussed in greater depth in Chapter 4.
[169] And by this I mean persons who are registered citizens of Ethiopia and self-identify as ethnically Somali.

Regional Health Bureau. Plus, the burgeoning Ethiopian generic pharmaceutical industry provided a majority of the essential medications and vaccinations UNICEF and other NGOs disbursed during relief operations. Nongovernmental organizations frequently subsidized or gifted these generic medicines as well as food aid, vehicles and staff salaries, but crucially, these donations were made through and in support of extant governmental initiatives (UNICEF 2008b, 2009b). Mobile team nurses – again officially Ethiopian government employees – actualized UNICEF's and other relief agencies' missions to improve the health and wellbeing of Somali children and their mothers; and newly trained pastoralist health extension workers classified basic infectious diseases, allocated medications, and dispensed vaccinations. As such, these NGO-funded humanitarian programs were profoundly altering – and in many cases, as I will detail in the following section, improving – levels of trust between Somali biomedical experts and the governmental institutions and Ethiopian industries with which they were affiliated.

Citizenship and Trust

Health is a vital resource for people – especially in contexts like the northern Somali Region, where recurrent epidemics of infectious disease and acute malnutrition threaten individuals' resilience and livelihood. Safeguarding health and taking advantage of local opportunities to obtain free medical advice and medicine were sometimes axiomatic matters of life and death. But clinical encounters were also intimate interactions. Trust was fundamental to medical practices, not a luxury – *especially* for

persons who had faced prior breeches in trust during clinical encounters or more generally had faced political marginalization, violence, discrimination, or displacement. Even during chaotic humanitarian relief operations like the mobile team intervention in Elahelay, ill persons were frequently confronted with the need to divulge details about potentially embarrassing or private symptoms and problems, discuss the personal effects of drought and poverty, admit to ignorance of public health and biomedical discourses, admit to consumption of counter-indicated or contraband medications, admit to use of so-called "traditional" forms of medicine, and admit to fears of possession by malevolent jinns.[170]

Many medical relief operations – both refugee camp clinics like in Degago and mobile teams in Elahelay – were staffed by unfamiliar male healthcare providers, even if they were Somali and were able to speak the language and understand local illness etiologies and conceptions.[171] Therefore, according to participants in this research, some medical encounters were awkward, especially during the first weeks of the given operation and in the midst of a chaotic and crowded clinical space. As mentioned in Chapters 4 and 5, in order to assuage interpersonal anxieties and set people at ease, mobile team nurses were careful in their use of sensitive terminology (e.g. "TB") and explicitly developed relations of trust with residents. They enjoyed building friendships within the patient population as a way to encourage people to participate in educational

[170] See Chapter 3.

[171] The mobile team's attempts to understand and negotiate with local residents regarding their understandings of disease, therapeutics, and vaccinations are discussed in greater detail in Chapter 3. There I also demonstrate that although the mobile team were far better at listening and responding to local needs, sometimes they were unsure about or unable to respond to certain clinical presentations, mostly in the cases of women. Women were often too shy or embarrassed to speak or ask about reproductive health problems with the male nurses, and clinical encounters with the mobile team lacked privacy.

initiatives, screenings for malnutrition, and checks for high blood pressure. In addition, to reach out to male leaders, the mobile team made overt efforts to understand local political dynamics and to dispense food and medicine to persons deemed by local leaders both desperately needy and unfairly excluded from aid. Such encounters and strategies were profound: they allowed providers and laypersons to co-construct how a Somali Regional State might provide for and respect its citizenry. At the local level, the rigid architecture of international aid policies was bent in response to realities, prospects, and social tensions on the ground.[172] In this way, medical aid shaped expectations of government as well as biomedicine.

Thus the protection of "bare life" during medical encounters in the northern Somali Region was never really "bare" at all. Medical encounters were instead always heavily laden with both sociality and emotion for those present – and because of this, I contend, medical humanitarian interventions have the potential to build responsive governance structures as well. Here I am not arguing that humanitarian relief begets meaningful gift exchanges or culturally resonant relationships of reciprocity. Instead, medical aid provided spaces in which relations of care-giving and trust can develop. This is, however, undoubtedly a double-edged sword. As the cases of Aysha Medical Center and Dil Chorra Hospital from Chapter 4 exemplify, perceived breeches in trust, injustices and malpractice inside government clinics tended to exacerbate racialized antagonisms between Somalis and habasha Ethiopians.

[172] These were exemplified best in the surreptitious material support for pastoralist health extension workers, described in Chapter 1, and in the mobile team intervention, described in Chapters 1 and 3.

Samatar says wisely, "Citizenship is not to be reduced to the mere acquisition of documents that validate resettlement" (2008:3). To be meaningful, people must trust that social services, elections, and civilian protection initiatives are legitimate and in their best interest (Samatar 2008). By contrast, during the period of this research, the most commonly discussed federally mandated policies in the Somali Region were those designed either to quell Somalis' rebelliousness or to undermine Somali-controlled transnational contraband trade networks. As mentioned, in 2008 and 2009 attacks and threats continued between ONLF rebels and Ethiopian defense forces; Ethiopian government representatives had been accused of human rights abuses in the Somali Region; and Ethiopian police had stepped up enforcement of international trade by occasionally stopping contraband vehicles, arresting drivers, and burning illegal or undeclared commodities along secondary roads throughout Aysha woreda. In many respects, during this research trust was severely lacking between residential Somalis and both Ethiopian government representatives and ethnic habashas. Perceived violence or discrimination by governmental and nongovernmental authorities has been shown elsewhere to cripple future health interventions (Feldman-Savelsberg 1999, Obadare 2005, Renne 2010). Likewise, as elaborated on in Chapter 4, histories of violence and discrimination for Somalis in Ethiopia cannot be divorced from Somalis' contemporary fears of malpractice and idioms of distrust. Relations of trust and solidarity were more frequently drawn along the contours of kinship and belonging to the transnational Somali ethnic community. Responsibilities to family, declarations of ethnic solidarity, and claims made on the government by residents of the northern Somali Region were being

increasingly directed at Somali Regional state formations rather than the Ethiopian federal government, even in the case of Issa Somalis in Aysha woreda. In ethnographic interviews and conversations, only a few individuals spoke highly of the Ethiopian government or the EPRDF – and then it was only in comparison to the dreadful years under the Derg's rule. Still, even as several Somalis I met were cautiously optimistic about the role of the Somali Regional government to provide beneficial social services like healthcare, they remained skeptical about the capacity of the Somali Region to garner equitable resources and power from the federal government in Addis Ababa.[173]

Summary

Although in recent decades Somalis obtained much of their healthcare from extra-legal economies, pooled resources and social capital within sub-clan groupings, or international nongovernmental humanitarian agencies, increasingly medical humanitarian aid was being channeled through regional governmental staffs and institutions. Between 2007 and 2009 the Somali Regional Health Bureau was growing in prominence and public awareness. Accordingly, this dissertation describes an important moment of change for northern Somalis: new health and humanitarian interventions were altering the frames within which people devised and revised concepts of citizenship and healthcare. Health and humanitarian interventions such as the mobile team of nurses served as both

[173] It should be noted that this finding cannot be applied to most Somalis residing further south in the Somali Region, where the Ethiopian government is more actively involved in violently subduing public dissent, and where most people identify with the Ogaden clan, which has for decades been in active (but uneven and contested) opposition to the Ethiopian government.

evidence and instruments of growing relations of trust between residential Somalis and their newly trained Somali healthcare providers, as well as between residential Somalis and a burgeoning Somali regional government. A reterritorialization of the Somali Region in eastern Ethiopia was underway in and around Aysha woreda based largely on evolving roles for government employees and governmental representatives in local healthcare and humanitarian response. When seen as a dynamic cultural artifact, "the Somali Regional State" manifests through kinship networks, awkward ethnic identifications over clan divisions, shared ambivalences about political processes in Addis Ababa, enduring informal and illicit healthcare economies, newly popular livelihood strategies and migrations described in Chapter 5, and sets of commonplace medical practices and idioms described in Chapters 3 and 4.

Even so, the development of an increasingly powerful and cohesive Somali regional government was at the same time stymied by Somalis' violent relationship to Ethiopia, as well as by reverberations of Somalis' past experiences of interclan conflict, impoverishment, and importantly, their circumstance of being "beneficiaries" subject to the whims of local NGOs and a global humanitarian industry. Instead of conceiving of themselves narrowly as recipients of the charity of foreigners or as citizens of Ethiopia, Somalis I knew discussed the diverse ways in which they were increasingly interpolated into Somali regional politics (for good and bad), and in the case of the mobile teams and pastoralist health extension workers at least, increasingly able to benefit from medical humanitarian aid even after the intervention ceased. Thus, humanitarian regimes in the northern Somali Region of Ethiopia were increasingly not only taking as their objects the

narrow preservation of “bare life,” but also the generation of novel but ambiguous forms of citizenship for historically marginalized northern Somalis.

CONCLUSIONS

Medical Humanitarianism and the Aftermath of Aid

"Medical humanitarianism" is a topic of rising interest within the field of anthropology, and this dissertation contributes to these conversations. Accordingly, I provide an ethnographic case study of medical humanitarianism as it unfolds in communities in the northern Somali Region of Ethiopia. More specifically, on one hand I designed this study to address practical and policy-relevant concerns – namely, how best to design, implement, and evaluate crisis responses. On the other hand, I also looked to theoretical debates and ethnographic innovations within medical anthropology and the anthropology of aid to help me decipher the significance of emergent health subjectivities, global health regimes, and humanitarian regimes (Biehl 2009, Biehl et al. 2007, Bornstein and Redfield 2011, de Waal 2010, Fassin 2011, Nichter 2008, Petryna 2009, Ticktin 2006, Whyte 2009).

Several scholars studying the effects or underpinnings of the global aid industry in the last decade tackle the writings of social theorist Giorgio Agamben (1998), who argued that ancient Roman law distinguished "bare life" (*zoë*) – biological life but nothing more – from "full life" (*bios*) – a socially meaningful life with political rights and protections from the state. The ability to distinguish human bodies from citizens, Agamben argues, remains fundamental to contemporary forms of political power as well. Fassin (2007:501), for one, uses this idea of "bare life" in order to move past Foucaultian

biopolitics, defined by the regulation of entire populations, to what he calls a "politics of life" which takes as its object the saving of individual bodies. Medical humanitarianism, as such, entails both ethical sentiment and transnational intervention (or foreign interventions inside the boundaries of sovereign states) in the defense of individual human lives or in order to "witness" bodily suffering (Fassin 2005, Fassin 2011, Redfield Redfield 2005, Redfield 2006, Ticktin 2011). Building on this, I show how medical encounters during relief operations are not "bare" at all but necessarily imbued with sociality, emotion, and politics. Practical efforts to save lives and end suffering during humanitarian crises[174] in Ethiopia are undermined by long histories of institutionalized health care disparities, ethnic-based violence, and even racism that make places like the Somali Region vulnerable to recurrent crises in the first place.

Medical Insecurity in the Aftermath of Aid

This dissertation also argues that temporary medical humanitarian interventions, despite good intentions and real advancements in healthcare provision during emergencies, have indirectly exacerbated *medical insecurity* in the northern Somali Region of Ethiopia. Within the field of humanitarian studies there has long been a focus

[174] For the purposes of this dissertation I define humanitarianism as efforts that are structured by International Humanitarian Law and designed to protect and care for persons during and in the aftermath of wars, disease epidemics, natural disasters, or sudden collapses in governance structures or assets (Bouchet-Saulnier et al. 2007, Walker and Maxwell 2009). In its strictest sense, as articulated by the founders of the International Committee of the Red Cross, humanitarian action includes efforts to make war itself more humane, but *not* to campaign for or foster human rights or economic development. More broadly, "humanitarianism" is a fashionable moniker and mission in the contemporary world of global aid. Its moral and sentimental associations make it a useful and compelling descriptor to which no one can object (Fassin 2011).

on "food insecurity." I build on this concept to provide an ethnographic case study of what I call "medical insecurity," or a lack of accessible, high quality, and trusted medicine and medical care. Medical insecurity in the northern Somali Region was defined by far more than an immediate lack of adequate medicine, doctors and hospitals; it also includes a lack of regulatory assurances, lack of medical education opportunities for local Somalis, fears of discrimination and malpractice at the hands of ethnic *habashas*,[175] and fears about future prospects of accessing adequate and trustworthy care.[176] In places where local primary health care has long been untrustworthy or inadequate, relief agencies have raised people's expectations of biomedicine without successfully contributing to the development of health systems both capable of providing adequate primary health care and managing future health crises. Northern Somalis' idiomatic and narrative expressions of medical insecurity have increased, paradoxically alongside steady (but meager) improvements in population-based health and nutrition indicators.[177]

Major Findings

[175] "Habasha" (otherwise spelled "habesha" or ሐበሻ in Amharic) is colloquially defined as persons of Amhara or Tigrynia ethnicities residing in Ethiopia or Eritrea. The term habasha for many rural Somalis in eastern Ethiopia indexed not just ethnicity and language group but political support of the current Ethiopian government, although many habashas would object to this usage and association.
[176] The relationship between *imagined futures* (as articulated by Andrew Lakoff, Anna Tsing, among others in relation to disaster and illness in particular) and the lived experiences of daily insecurity (e.g. Deborah Lupton) are topics I want to explore further as well.
[177] As measured by UNICEF 2009b and the Ministry of Finance and Economic Development 2010

In the body of this dissertation I describe several enduring effects of recurrent medical humanitarian aid, and I describe ways in which medical insecurity has transformed as aid recurrently recedes from and returns to communities in the northern Somali Region. First, and most intimately, medical humanitarian aid has altered subjective experiences and expectations of pathology, clinical care, biomedicine, and healing. For example, Abdul and Hussein, the two Somali Mobile Health & Nutrition Team nurses, did constant translational work between what were oftentimes incommensurate and vexing illness presentations and labels. Because of their attentiveness and access to well-regarded relief commodities, many residential Somalis sought them out for counsel and care—but after six months, the mobile team departed. Subsequently, habasha clinicians in the remaining governmental facilities were detrimentally compared to the mobile team nurses; they were perceived to lack empathy, the were perceived to lack adequate biomedical training, they lacked knowledge of Somalis' popular health cultures, and most concretely, they could not speak or understand the Somali language. Frequent misunderstandings during clinical interactions in Aysha woreda worsened existing racialized tensions between many Somalis and habashas residing there. More broadly, I find that after positive experiences with health care providers in the mobile team or in the Degago refugee camp, persons were more vocal and insistent about their desires for better-trained clinicians, more sophisticated diagnostic equipment, and brand-name prescription pharmaceuticals.

Second, I outline several the social mechanisms by which Somalis cope with crisis, aid, and then the absense of aid. Kinship and migration have long been

fundamental to the lives, livelihoods, and social identities of northern Somalis. New configurations of clan and sub-clan groupings, new roles for wealthier extended family members, and new migration patterns have emerged in the wake of recurrent emergencies and aid interventions. These kinship formations facilitated the emergence of new migration patterns: new medical migrations to access foreign relief commodities and clinicians; new labor relations to enable temporary work with international NGOs; new medical migrations to access comparable care at distant private hospitals once aid agencies departed; and transnational informal economies of medicine to fill local gaps in care.

Third, in the aftermath of aid, a set of racialized stories and medical rumors have proliferated that warn of malpractice and abuse by non-Somali Ethiopian clinicians. Such discourses echo Somalis' historical experiences of ethnic violence and conflict with Ethiopian groups as well as their contemporary marginalization from Ethiopian sources of power. The narratives I outline include stories about misdiagnoses and malpractice at Aysha Medical Center; stories about the theft of human remains and scientific experimentation on cadavers in a nearby public hospital; stories about preferences for medicine "from abroad" over contraband and generic formulations; and stories about incidents of discrimination between Somali patients and non-Somali habasha healthcare providers. These narratives were consequential because they both generated and reinforced racial stereotypes and animosities: Somalis, on the whole, were portrayed as obtuse, ungovernable and noncompliant, and habasha healthcare providers were portrayed as careless, incompetent and racist. Thus, harm is done when medical aid

programs depart, both because medical aid typically leaves untouched entrenched health disparities and social frictions, and because the departure of medical aid programs can leave populations with higher expectations of biomedical treatments, yet no way of subsequently accessing comparable or trusted care. Stories, apprehensions and ideas have lingered, even as the materials of humanitarianism repeatedly disappear.

Stories and stereotypes circulated not just among laypersons and healthcare providers, but also shaped policymaking at the national and international levels. UNICEF and other NGOs active in the Somali Region of Ethiopia primarily described their work to the public, news outlets, and potential donors in the language of body counts: statistics describing death rates, malnutrition rates, and the epidemiology of infectious diseases. In longer reports or summaries, emotionally wrenching vignettes were frequently added to personalize the barrage of numbers, but these stories rarely adequately addressed social and historical issues—dysfunctional political institutions, historical economic inequalities, racialized forms of violence, or the lasting effects of repeated humanitarian interventions. Such narratives de-socialize and de-politicize subsequent humanitarian interventions as well as the biographies of persons involved.

Finally, medical humanitarian interventions have altered local expectations of citizenship. Northern Somalis live in the margins of multiple "state" entities–the Federal Democratic Republic of Ethiopia, the autonomous Somali Regional State within Ethiopia, and the transnational ethnic community of Somalis throughout the Horn of Africa and diaspora. In the last ten years, as Ethiopia has decentralized its health care delivery system, humanitarian aid has been progressively channeled through Somali Regional

State institutions and staffs. Somalis now feel they have a greater stake in the provision of community health care and local healthcare governance. Numerous inter-clan and intra-regional differences and grievances have been increasingly (but unevenly) subsumed as a more united Somali Regional State government takes responsibility for the wellbeing of its citizenry. Northern Somalis increasingly discussed the diverse ways in which they are interpolated into regional politics–often in opposition to the Ethiopian government. Medical aid has shaped expectations of government as well as biomedicine.

I argue that these new forms of so-called "therapeutic citizenship" (Nguyen 2005) have emerged not because of the relative size or power or the Somali Regional State per se, but because of the intimate and profound nature of medical encounters themselves. The narrow humanitarian mission to minister to the "bare life" (Agamben 1998, Comaroff 2007, Fassin 2007) of victims during relief operations, in actuality, is neither dispassionate nor removed from sociality and politics. Clinical care during emergencies provides spaces in which relations of care-giving, trust, and therefore also responsive governance structures can potentially develop. Conversely, breeches in trust and rumors of malpractice that are born or fester in the insterstices of aid may severely undercut the potential for political as well as bodily health and healing. Paradoxically, temporary medical humanitarian aid itself can worsen Somalis' perceived vulnerabilities to racialized experiences of violence, discrimination, and illness. Humanitarian aid is a popular diplomatic tool, but this dissertation highlights the potentials for lasting and unexpectedly harmful effects.

Trust and Preferential Care

In humanitarian emergencies, most relief agencies prioritize the provision of materials as efficiently as possible (Leaning et al. 1999, Redfield 2008). But this research demonstrates that without first building *trust* between recipients and long-term healthcare providers, health and healing are not possible. Likewise, humanitarian programs and budget structures, as they manifested in the northern Somali Region of Ethiopia, have hitherto been focused on providing the *stuff* of medicine and clinics more than ensuring the *integrity* and *excellence* of care. Pastoralist health extension workers were provided pharmaceuticals and clinical spaces, but far too little training and supervision to meet local expectations and demand. Aysha Medical Center was designed to be a preeminent healthcare facility for the chronically underserved northern Somali Region. Its pharmacy was stocked with medications and therapeutic food aid, but its wards sat empty. By contrast, the mobile team was always met with more demand than they could provide given their limited mission, time, and materials. Comparison of the mobile team intervention to healthcare provision in Aysha Medical Center demonstrates that trust is fundamental to the amelioration of medical insecurity as well as to bodily and political healing.

The issue of clinical trust also relates to stereotypical perceptions of Somalis' "non-compliance" voiced by nurses in the Aysha Medical Center. To repeat a quote from Chapter 4, a young habasha nurse working there stated: "The Somali people have an

adherence problem. [They will not] do what we tell them to do. … They don't believe in what we give them." Indeed, Somalis often did not trust the habasha nurses in Aysha – they perceived them as careless and discriminatory. Additionally, Somali patients were often perceived by their habasha providers to be irrationally reliant on "traditional" forms of medicine, and ignorant of public health messages and the principles of biomedicine. Another nurse, complaining about having to treat the wounds of a man who had injured himself presumably during a "traditional medicine" therapy said, "there is not much education here – they need more. We need [to give them] more education on the rational use of drugs." However, this research reveals that health outcomes and Somali patients' "compliance" with recommended courses of action related more to the *lack of trust* between providers and patients and to the *low quality of care* at facilities like Aysha Medicine Center than to Somalis' ideas about disease and biomedicine.

Indeed, Somalis "complied" with medical advice at other times. Positive clinical encounters with the mobile team provide a stark contrast to encounters in the Aysha facility. Hussein and Abdul, the two Somali mobile teams nurses, stated that many "rural people" (*qof baaddiye*) did not have an "understanding" of the action of biomedicines in their bodies or a "familiarity" with biomedical treatments. As shown in the beginning pages of Chapter 3, sometimes people indeed "feared" painful medical technologies like vaccine injections, especially for babies and children. Like the nurses in Aysha, Hussein and Abdul also championed local education initiatives to increase "acceptance" of vaccines and "the rational use of drugs" – but crucially, they did so both with an appreciation of how such anxieties resulted from popular fears, rumors of malpractice,

and histories of discrimination at Ethiopian healthcare facilities, and with an appreciation of how injections and intravenous therapies were scary for many, regardless of ethnicity of familiarity with biomedicine.

In his book, *Pathologies of Power,* Farmer calls for medical practice that takes a lesson from liberation theology – providing a "a preferential option for the poor" rather than "whatever happens to be deemed 'cost-effective'" (2003:158). He makes an ethical case for providing the poorest people in the world the highest level of medical technology and care available, rather than simply calculating how much can be squeezed into international aid budgets. Poor people, he argues, need the best care the most. In addition to what he says would entail "sharing the fruits of science and technology," I would add that medical practices should include efforts to provide *trusted* medical encounters and ensure the *sustainability* of services long after emergency aid dissipates. This research shows that the fruits of science and technology are maximally beneficial only when provided within the context of a trustworthy clinical encounter. If suddenly the Aysha nurses gained the best possible diagnostic technology and treatments for tuberculosis or HIV/AIDS, many Somalis residing in Aysha would still be reluctant to visit; work would be required to heal the wounds of past injustices and counter local fears of discrimination and malpractice.

In emergency situations or in chronically underserved locales where demands are enormous, building trust may be challenging and time consuming—the very antithesis of rapid response. Prior breaches in trust, histories of violence, or histories of institutionalized health disparities (as in the case of the Somali Region of Ethiopia), may

make trust within clinical encounters even more difficult. However, fostering clinical trust beyond the timeframe of the relief mission cannot come at the end or as a hopeful result of a medical humanitarianism. It is not a luxury. Instead, if a real effort to improve healthcare is to be made, trust must be a primary mission – an integral aspect of post-conflict reconstruction, post-conflict reconciliation, and medical treatment. This research additionally demonstrates that clinical trust is *not* something that necessarily must be built over a long period of time; the mobile team, for instance, was quickly trusted because they were Somali and immediately concerned with fostering lasting relationships within targeted communities. Thus, I argue, it is possible to foster clinical trust within the parameters of other emergency programs.

For example, I suggest that Somalis or persons fluent in Somali language, especially women, should be trained as *patient advocates* who provide language translation for non-Somali relief workers, and more broadly, help relief workers understand the multifaceted nature and context of clinical presentations and encounters. Such advocates would be able to help relief workers understand local or ethnic tensions, women's shame and shyness, and even non-biomedical illness categories and etiologies. These liaisons would also be able to help Somali patients understand what to expect during clinical visits, help them to better articulate their concerns and symptoms, and perhaps most crucially, help them negotiate the Ethiopian public health system once aid agencies depart. Such employment should be a permanent staff position at the Ministry of Health in Addis Ababa as well as throughout the Somali Region and in individual

woredas, and paid for through nongovernmental relief funds. As relief agencies and relief missions come and go, these patient advocates would remain.

Applications to Global Health Policy and Clinical Care in Emergencies

This dissertation points to the primacy of social, discursive and otherwise intangible manifestations of medical insecurity in reproducing the conditions under which northern Somalis are disproportionately vulnerable to calamity and illness – and these cannot be rectified with technical fixes. However, ethnographic examination of the lasting social and health system effects of medical humanitarian operations highlights several issues of practical importance for the design of global health policy and clinical care in emergencies. First, in the aftermath of aid, many people's ideas about and expectations of biomedicine changed: former aid recipients demanded from local medical facilities the level of care and technology they received from relief organizations. For myriad reasons I delve into in Chapters 3 and 4, many Somalis preferred medications as well as healthcare providers "from abroad," especially providers and brand-name products from Europe or the United States. Many assumed, in fact incorrectly, that the pills provided from expatriate clinicians, NGOs, or the UNICEF-funded mobile team also came "from abroad," and were therefore of higher quality, safer, and more powerful. Some persons reported compensating for the perceived lower amount of active ingredients in generic or contraband medications by consuming more pills at once or

opting instead for injections or intravenous therapy, even when these were contraindicated.

Second, when persons distrusted local healthcare facilities or local providers, they frequently delayed seeking medical attention, and only much later made distant and expensive treks in search of better care. In Chapter 5, I describe how emergent configurations of kinship and therapy management groups helped make these extensive and expensive trips and migrations possible. But I also document limits to these social networks: elderly and internationally displaced persons were more likely than others to lack the support they needed.

Third, Somalis' growing skepticism about the quality and safety of certain pharmaceutical products – both generic pills produced in Ethiopia and contraband pills purchased on the black market – moderated their willingness to consume full, recommended courses, even in the case of antibiotic and anti-malarial medications. Some feared the consumption of counterfeit medications might be dangerous; others feared wasting their money on substandard treatments. For many, if a medicine did not confer healing after two or three doses, alternative treatments were sought or the regimen was ceased altogether. Shortened or otherwise inadequate doses of antimicrobial medications may have important ramifications for local epidemiology, by creating an ideal environment for the development of resistant strains of infectious disease. Additionally, persons who expressed skepticism about the conditions of pharmaceutical supplies or the ethics of federally mandated public health programs, may also decline to

participate in vaccination campaigns and other important health interventions (Kaler 2009, Obadare 2005, Renne 2010).

Fourth, future multidisciplinary research might investigate in greater detail the effects of recurrent medical interventions in underserved locations on transnational healthcare commodity markets. Although many laypersons in the Somali Region fretted over the quality and safety of contraband medications for sale in eastern Ethiopia and Somaliland, sometimes they had little recourse or few alternatives. Unregulated supplies of pharmaceutical products were largely unmonitored by either the Government of Ethiopia or international regulatory agencies such as the World Trade Organization. For years, Ethiopian police and governmental regulators have sporadically targeted small, unlicensed pharmacies and shops in order to stem the sale of counterfeit medicines. But these efforts have not quelled the rampant use and trade in non-prescribed, unregulated, and contraband medical commodities in the Ethiopia-Somaliland-Djibouti borderlands. Surveys and quality testing of products derived from samples of vendors and traders along regional commodity chains would be an important step toward understanding the distribution and functioning of local emerging markets in biomedical commodities, and understanding the relationship between humanitarian interventions and subsequent healthcare economies. Testing and monitoring local pharmaceutical products may also be important for resident populations, as a way to build their trust in licensed sources of medicine. It is undoubtedly difficult to design interventions to study, alter, or stem transnational pharmaceutical economies and health systems—but I argue, it is a necessary challenge.

Future Directions for Anthropological Research

Also, there are several directions in which this ethnographic research might expand. This dissertation suggests that for many northern Somalis, the interpretation of biomedical treatments and vaccinations draws on culturally resonant metaphors and understandings of the human body (this issue is discussed in greater detail in Chapter 3). For example, Malayka, a young mother from Degago, compared the action of camel milk to intravenous glucose (she called it, *nafaqo ahaan dee ruuxii* or "nutrition that is inserted into the body") because of its ability to both treat disease and provide nourishment. More broadly, injections, IV drips, pills, and even oral rehydration therapy may at times be evaluated in terms of their abilities to trigger diarrhea or vomiting, or resume other humoral flows. Medications prescribed to Somali patients may have different perceived modes of action or efficacy – namely, the medications' ability to complement humoral flows, restore humoral balance, or purge the body of disease. Somalis' reactions to medical advice may be filtered through or shaped by their uses of the metaphor of camel milk or their other understandings of pathology – especially, this research suggests, in cases of digestive illnesses.

More research is also needed to better understand how women's experiences of uterine pain, over-exertion, infertility and spirit possession (Boddy 1994, Fadlalla 2005) interrelate, as well as how these are (re)interpreted with metaphors and uses of ultrasound and other imaging technologies. Increasing numbers of women are seeking biomedical

treatment for childbirth fistulas, complications from infibulation,[178] infertility, sexually transmitted infections, and varicose veins from a private nongovernmental clinic in the town of Harar in eastern Ethiopia. This clinic has apparently become a Mecca for Somali women (among others) seeking respectful and private consultations plus sophisticated technologies such as sonograms and in vitro fertilization. In addition to research on acute reproductive pain and illnesses, more in-depth research on women's embodiment of stress and exertion over the life course (Bledsoe 2002) might be centered in this clinical facility, and might investigate the illness experiences and treatment trajectories for women seeking care there.

Finally, formative ethnographic research might center on health science training initiatives at Jijiga University. In Appendix B, I make recommendations for changes in the way biomedicine and public health are taught at the graduate and post-graduate levels in Ethiopia, particularly in the Somali Region. A modified curriculum designed for students from the Somali Region of Ethiopia would be cognizant of Somali popular health cultures; changing expectations of biomedical providers and facilities, the need for added recruitment and retention of Somali students, especially women; the need to teach courses in Somali instead of English; and the need for courses to teach the English language for use by health care professionals. Fostering clinical trust, ameliorating medical insecurity, redressing health disparities, and improving the design of humanitarian interventions all require in-depth and historical knowledge of local health

[178] Type III female genital circumcision/mutilation (WHO 2009)

systems and health cultures. These must be one part of a concerted investment in improving educational opportunities for historically marginalized Somalis.

APPENDIX A.

GLOSSARY OF SOMALI HEALTH AND DISEASE TERMS

Few comprehensive dictionaries or advanced language tutorials have been written in or for the Somali language. And typically, few terms regarding diseases, health, symptoms, treatments, or bodily states are recorded in the few published volumes (e.g. Abdirahman and Awil 1995, Awil and Abdirahman 2005, Orwin 1995). As I was learning to speak and write Somali, few written sources were very helpful. Furthermore, consistency and precision were often lacking in the vocabulary used by laypersons and health professionals in the Somali Region, and miscommunications and misunderstandings abounded between individuals (see Chapters 3 and 4 for specific examples). In order to provide a cursory introduction to key concepts I learned in the northern Somali Region, below I list and define several commonly used terms.

Still, no two persons I interviewed would define or translate many of these terms in exactly the same way. Several factors influenced people's word usage and choice. These included, variably, their age, education level, experience with health care and care-giving, place of residence, and knowledge and training in so-called traditional medicine (*dawo daqmeedka*), herbal remedies (*geedo*) and spiritual healing using the Holy Qur'an and other related texts. These are discussed in greater detail in Chapter 3. Very generally and not without many exceptions, younger persons or persons who had worked for governmental agencies or NGOs were more likely to use English language or

English-derived words. Older persons and persons who had little experience with biomedicine would often use terminology that referenced symptoms and treatments.

Somali terms are grouped into the following categories, based on (Lewis 1998 and Senger 2002) and discussed in greater detail in Chapter 3:

(1) Medical and bodily terms, symptoms and descriptors,

(2) Functional illnesses caused by imbalances in bodily fluids or humors, including illnesses and weaknesses associated with nutritional deficiencies,

(3) Structural illnesses or disorders of bodily organs,

(4) Psychological illnesses of the mind and brain (*maskax)*, outside the realm of spiritual disorders, such as those classed in biomedical terms as paranoid schizophrenia and epilepsy, and

(5) Spiritual illnesses or disorders caused by the actions of an invisible spiritual being (*jin*) or, more rarely, satan (*shayddaan*).

Confusion and disagreement about a particular diagnosis or etiology was important to people when the differing possibilities existed in two or more of these categories, such as for example, disagreement about whether someone suffered from epilepsy (a disease of the brain and often treatable with biomedicine) or an attack of a jinn (a spiritual disorder treatable with a religious ceremony of some kind). The ubiquity of confusion about definitions and etiologies often compounded peoples' distrust and skepticism about the quality and appropriateness of available treatments (a topic

discussed at length in Chapters 3, 4, and 5). Consequently, most persons experimented with multiple avenues of therapy at once or in close succession: for example drinking raw camel milk, at the same time taking antibiotic medications, and as soon as possible also visiting Qur'anic healers.

Additionally, the following organizational structure and listed definitions do not represent an indigenous, universal, or static Somali nosology. I have constructed and filled in these categories artificially based on literature in Islamic medicine as well as data collected through semi-structured ethnographic interviews, unstructured conversations and clinical experiences, as well as structured "card-sort" interviews with various Somali healthcare professionals. As described in greater detail in Chapter 2, these latter structured interviews prompted informants to group a series of named illnesses according to their relative severity, etiology, general treatment strategy, common co-morbidities, and the age and gender of most commonly afflicted persons. Although these tables reflect a general pattern of classification, there are several instances in which terms and categorizations overlap, are inconsistent, or are incomplete. Socially constructed nomenclature is necessarily flexible, contingent, and continually shifting due to changing available healthcare options and popular trends. These tables are are only starting points for understanding the ways northern Somalis used language to talk about their bodies, illnesses, and suffering.

Table 5. Important medical terms, body terms, and symptoms

Somali Term/ Alternate Spelling	**Definition, Related Terms and Usage**
Adayno	(n.) rash from over exposure to the sun, often seen in women who have recently bleached or exfoliated their skin to achieve a lighter tone.
Arrima	(n.) advice or consultation
Baasalin	(n.) penicillin, mostly in injection form, mostly used for treatment of infected wounds. The liquid injectable form is called *baasalin irbad* or "broken penicillin."
Bogsasho	(v.) to heal or convalesce
Bukaan/Buktan	1. (adj.) sickly or prone to sickness and weakness. 2. (n.) A person who is repeatedly sick, chronically weak, unable to resist infection. Synonyms: *Ricin, hagaas, daciif*
Buulee	(v.) to change the diet or to provide a feast for a victim of either wrongful violence or disease. In the first case, the victim's sub-clan or *mag* (or "blood group" – a small segment of the lineage group, elsewhere called the *diya*-paying group) will demand a *buulo* (a meal or feast) from the perpetrator. Ideally, the perpetrator's extended family will provide shelter for the victim, slaughter a large animal, and give the meat to the victim's family to eat. So for example if Ahmed hits Ali, Ahmed's extended family takes Ali in, gives him shelter, and feeds him. In the event of a serious illness, the family of the victim will often provide a smaller-scale *buulo*, drinking the fat of a sheep for example. Many persons said that the most important thing for the treatment of injury or disease it to change the diet and to provide a delicious high-fat and high-protein communal meal. *Isbuulee*: (v.) to change the diet or feast.

Buulo	(n.) the change in diet or the feast provided a sick person or victim of violence. *Isbuulee*: (v.) to change the diet or feast.
Caado	(n.) menstrual blood
Calaxirir dawo samay	(n.) pharmaceutical medication Synonym: *kiniin*
Cudur la isqaadsiin	(n.) Contagious disease. *Isqaadsiin:* (n.) Contagion
Culays badan	(n.) Over-exertion or over-work, especially exertion that causes disability or disease.
Cune xanuun	(n.) sore throat
Daay	1. (n.) fresh, unprocessed camel milk, drunk often in order to induce diarrhea and thus manage or reduce bodily levels of *dacar*. 2. (v.) to release or set free
Dacar	1. (n.) bile 2. (n.) aloe plant 3. (adj.) bitter 4. (n.) a disease of excess bile in the body. Allowing *dacar* to get out of control, some argue, can lead to *joonis* (hepatitis).
Daciif/Diciif	(Adj.) Literally, weak, but also used to describe a malnourished or stunted child.
Daryeel	(v.) to care for or to conserve. *Daryeelay:* (v.) he cared for [a sick person]
Dawo dhaqmeedka	(n.) traditional medicine *Qofka sameeya dawo dhaqmeedka:* traditional medical practitioner or healer
Deegaanka nolosha	1. (n.) hygiene (a new usage of the term) 2. (n.) residence, compound or physical environment
Dhaawac	(n.) wound

Dhac	1. (v.) to fall or fail generally 2. (v.) to have a disease or affliction befall someone. E.g. *Duray baa igu dhacay* means literally a cold fell on me (or befell me or afflicts me). A jinn can also afflict or attack, *dhacay*, a person. *Ku dhac*: to afflict, or literally to collide with something, including a disease or illness
Dhaktar	(n.) doctor – in a very general sense. A person who is working in a clinical setting or someone with expertise in health, healing, or medicine.
Dhibaato naqas	(n.) difficulty breathing
Dhicis	1. (n.) premature baby (this definition not used in the northern Somali Region) 2. (n.) miscarriage *Dhicisoob:* (v.) to miscarry or to become infertile. *Way dhicisowday:* she had a miscarriage or she became infertile.
Dhiig kac	(n.) high blood pressure
Durid	(n.) injection
Duris	(v.) to inject
Duugid	(n.) a therapeutic abdominal massage given usually by older women to other women for the treatment of menstrual pain, infertility, varicose veins, back pain, and other non-specific reproductive disorders. Sometimes legs are also massaged for varicose veins and other whole-body aches and pains. (v.) *duug:* to massage
Fayow	(adj.) healthy Synonym: *Ladan* *Fayoobaan*: (n.) the state of being healthy
Fiitamiin	(n.) vitamin

Fircooni	(adj.) Pharaonic. (n.) Pharaonic circumcision. Refers to a type of female circumcision procedure, also known as infibulation or Type III female genital circumcision (mutilation or cutting). Some women in the northern Somali Region (inappropriately) used this term to indicate *excision*, or removal of clitoris and other genitalia without stitching together or closure of the vulva.
Gaajo	(n.) famine or extraordinary period of hunger
Gargariir	1. (v.) to shake or tremble 2. (n.) (likely) Parkinson's disease, described as a disease mostly in older persons and characterized by physical shaking and difficulty walking.
Geedole	(n.) herbalist or expert on trees and other plants
Geermis	(pl. n.) germs Synonym: *caabuq*
Gub	(v.) to burn. (v.) Also used to indicate burning or branding of the skin of an ill person in the approximately location of the pathology (for a persistent cough or pulmonary tuberculosis, burns are applied to the chest and mid-back). Most experts thought that burning would trigger the resumption of bodily flows (such as blood or stools or bile). One wooden stick is spun or rubbed onto another to generate heat, fire and smoke, then the hot ends of the stick are applied to the skin until a blister forms. The blister usually then scabs and heals, leaving a permanent scar. These treatments are often performed by family members, traditional healers, or herbalists, and are frequently disparaged for being ineffectual. Despite this, they are very common; most Somalis have scars from prior burnings.

Gurguurato	(n.) A painful abdominal or uterine infectious disease that affects women, usually after giving birth. Some women believe *gurguurato* is contagious, and so will stay away a safe distance away from a woman who has just given birth. It is said to be caused by blood that remains in the uterus after the delivery, and becomes diseased. This word derives from *gurguurad* which means crawling like an infant.
Hagaas	(n.) A child who is frequently sick and stunted. Synonyms: *Ricin, Buktar, Daciif*
Hormar	(n.) Advice
Ilaali	1. (v.) to care for or look after a person (often one who is sick) 2. (v.) to protect or guard
Imbi oofeed/ Imbi caloole	(n.) co-trimoxizole, or other capsules commonly prescribed as a broad-spectrum antibiotics, usually for either lung infections or recalcitrant gastrointestinal problems. These literally mean "lung pill" and "stomach pill" respectively.
Isbadalka cimilada	(n.) Bad air or a rapidly changing weather pattern, both causes of heightened risk of infection or other disease, especially among children.
Jacjacle	(n.) headache
Jin/jinni	(n.) Jinn (Arabic: singular جني; other English spellings include djinn and genie). Jinns are supernatural creatures in many Islamic cosmologies; they are mentioned in the Qur'an and described there as living in a parallel world to the world of humans. They are not necessarily malevolent, although they are frequently mischievous or can easily be angered. Their actions, spirit possession, and spiritual disorders are discussed in Chapter 3.
Karuur	(n.) soured camel milk, consumed mostly as a food source
Kiniin	(n.) pill, tablet, capsule or pharmaceutical medication. Derived from "quinine."

Kitab	(n.) book. Often refers to Holy Books or hadiths used in Qur'anic healing
Ladan	(adj.) healthy Synonym: *Fayow*
Ladnaan	(n.) health
Lahan	(n.) pain or suffering Synonym: *Xanuun* Usage*: Lahansantahay?:* Are you in pain?
Lahaan	(n.) possession, as by a spirit or jinn
Ma dhalays	(n.) infertility, or literally, "without a pregnancy"
Mawlaxo	(n.) the moment or the ceremony or change (e.g. *buulo*) that brings a person back into his community, and during which he is pronounced healed by his clan and family.
Muxug	(n.) This is a less common word for "uterus;" some women will say, "*muxuggaa ixanuunaya*" which means, "I have a pain in my uterus" to indicate a non-specific abdominal pain or muscle strain. Synonyms: *Makaan, Ilma-gateen*
Makaan	(n.) uterus Synonyms: *Muxug, Ilma-gateen*
Maskax	(n.) brain
Nafaqo	1. (n.) nutrition, nourishment or nutritious food 2. (n.) glucose or other nutritional supplement in an intravenous drip
Naqas	1. (n.) breath 2. (n.) unhealthy air or wind
Oday	(n.) elder or expert, often indicates either a leader or an expert in traditional medical practices
Qalbi/Qaalbi	(n.) soul or metaphysical heart (not used for the heart organ)
Qardhaas	(n.) paper on which verses or spell from the Qur'an or hadiths are written

Qoon	(n.) a particular jinn often attributed to women's infertility or miscarriage.
Qorcase	(n.) tetracycline capsule, or literally, "red necks" because they are typically red and yellow in color. Laypersons commonly consume between one and ten for various stomach problems, including stomach aches and dysentery and chronic diarrhea. Tetracycline in such a form has been sold in the northern Somali Region for at least four decades; tetracycline-resistent infections were epidemic in Dire Dawa between twenty and ten years ago.
Qormadobe	(n.) ampicillin capsule, literally means "black neck" because ampicillin capsules typically have black halves
Quruumo	(n.) illness When women want good food or an excuse to slaughter an animal. Synonym: *Wadaado*
Ricin	(Adj.) Stunted or malnourished. Derived from *ricir* (n.) vertebra, as in the vertebra is protruded and/or stunted. Synonyms: *Daciif, ruus*
Ruus	(n.) a pejorative and insulting term for a baby that does not grow (*ma korays*) Synonyms: *Ricin, Daciif*
Saar	(n.) illness or possession by an evil spirit or jinn
Sareeye/ Sarreeye	1. (n.) a child weakened by chronic diarrhea or *geed sare*.
Sixir	(n.) sorcery
Tahaliil/ Taxaliil	(n.) holy water used during Qur'anic healing
Ummul	1. (n.) a new mother who has just delivered baby 2. (n.) the 40 day period after birth
Ummuliso	(n.) traditional birth attendant or mid-wife

Wadaado	1. (pl. n.) Plural of sheik, mullah or spiritual healer 2.(pl. n.) Unseen spirits causing any type of disease in the body. Jinns affect people's mind (*qaldi*) mostly, while *wadaado* affects the physical body, and manifests as a physical disease. Apparently, one must go to a mullah for this kind of disease. 3. (n.) Also refers to one type of spiritual disease or disorder that is treated by mullahs or sheikhs by several means, including prayer, recitation of the Qur'an, writing the Qur'an and placing the paper in a necklace around the person's neck, etc. Synonym for 3. *Quruumo*
Warwareer	(v.) to feel dizzy
Xagga jidhka	(n.) literally, "body direction" or posture
Xanuun	1. (n.) a pain or illness 2. (v.) to be in pain
Xanuun khatar	(n.) Serious or dangerous disease or illness.
Xanuun yar	(n.) Simple, curable, uncomplicated, literally "small" disease or illness.
Xidh	1. (v.) to close, shut or imprison 2. (v.) to circumcise (a girl or woman)
Xidhayn	(adj.) closed or circumcised
Xoog	1. (n.) bodily strength and stamina 2. (n.) a force 3. (n.) army 4. (n.) rape
Xumow	(v.) to worsen or become worse

Table 6. Functional illnesses caused by imbalances in bodily fluids

Somali Term/ Alternate Spelling	**Definition and Usage**
Alaato	(n.) diarrhea. Not a widespread term in the the northern Somali Region, but used sometimes by Somalis further south and in the regional capital Jijiga.
Barar	(n.) kwashiorkor, or edemic severe acute malnutrition. Literally means, "swollen." Some persons were unsure of its definition and etiology, but thought it might be one type of diarrheal disease or general state of malnourishment. There was little consistency or consensus around a definition despite the term's popularity.
Beer/ Beer yar	1. (n.) "Liver" or "small liver." 2. (n.) a disease often diagnosed in children by the existence of a distended belly and thin limbs (as seen in marasmic children). Its definition and etiology lack consistency and consensus between laypersons and between healthcare providers, but it was mostly seen as a problem of undernourished children. Treatment commonly included burns or brands (*gub*) to the stomach and lower back.
Calool istaag	(n.) Constipation; literally "stopped stomach." People often describe this as having a stone in their stomach that won't move.
Curuuq/Uruuq/ Ubuuq	1. (n.) a stomach problem, some said due to menstrual cycles or the build-up of menstrual fluid in circumcised or infibulated women prior to sexual intercourse or a surgery to enlarge the vaginal opening. 2. (n.) stiffness and build-up of menstrual blood if a woman sits all day during her period. Symptoms of uruuq include, variably, tiredness, joint pain, and muscle weakness, and sometimes, pain in the back. Usually it is treated by "*duugid*" – which is massaging performed mostly by older women. Synonyms: *hindo hindhuro, sorati*
Dhiig la'aan	(n.) Iron-deficiency anemia, or literally, "blood-less." This mostly affects young women during childbearing, especially if their diet is compromised.

Dulmar	(n.) diarrhea Synonyms: *Shuban, laan, geed sare,* etc.
Geed sare	(n.) literally translates as, "tree top," but refers to common, "soft," (compared to watery) and darker colored diarrheal disease in children. It is often treated with teas made from the leaves harvested from the tops of trees. The most common treatment is to put cook and/or mashed leaves from the top of the *qood* tree on the child's fontanel or the top of their head. Synonyms: *shuban, laan, dulmar*, etc.
Gooryaan	(n.) intestinal worms or parasites
Hindo hundhuro	(n.) women's nonspecific illness and abdominal pain around the time of menstruation. In its severest form, this indicates a build-up and possible infection of menstrual blood following infibulation or when the vaginal opening is too small to allow easy menstrual flows. Synonyms: *Sorati, ubuuq, cubuq, uruuq*
Joonis/Jaandis	(n.) hepatitis
Kaadi sonkor	(n.) literally translates as "sugar urine," but refers to diabetes. Synonyms: *Macaan or kaadi macaan* ("sweet urine")
Kaadidhiig/ Kaadida	(n.) blood in the urine or another non-specific urinary tract problem or incontinence
Kelyo xanuun	(n.) kidney disease; often informally diagnosed in cases when chronic back pain has not been caused by an injury, or in urban areas when city water sources are suspected to be contaminated with heavy metals, salt, or other minerals.
Laabjeex/ laabdoox	(n.) acid reflux or heart burn; often seen as a result of *dacar* rising up out of the stomach, or too much *dacar* in the body, and more fundamentally, an effect of a bad diet. Literally translates as "torn chest" or "stabbed chest."
Laan	(n.) diarrhea in children that is dark in color. The most common treatment is either to give the child fresh camel milk or to feed them camel milk plus cook and/or mashed leaves from the *qood* tree on the child's fontanel or the top of their head. Synonym: *Shuban,* etc.

Macaan/ Kaadi macaan	(n.) literally translates as "sweet" or "sweet urine" but refers to diabetes. Synonym: *Kaadi sonkor*
Moxog	(n.) menstrual cramps
Nafaqo daro/ nafaqodarro	(n.) Severe or acute malnutrition, most common among children and the elderly. Literally means "lacking nutrition."
Qabsin	(n.) 1. Appendicitis, (n.) 2. General abdominal pain, (n.) 3. Constipation or variably, (n.) 4. Over consumption of *khat* leading to myriad abdominal problems
Sanboor	(n.) Sinus infection, usually with an intense headache. This is a compound word, composing "san" (nose) and "boor" (blocked), and it refers mostly to blocked nose in children. For treatment, one usually goes to a "*sanboorrso*," or a woman who will scratch the nostrils of the baby to release the blood.
Shimbir	1. (n.) literally "bird disease;" refers to a sinus infection, like *sanboor,* when you blow your nose and there is only a small squeak like a bird, or 2. (n.) a diarrheal disease treatable by the ingestion certain tree leaves
Shuban	(n.) "soft" (not runny or watery) diarrhea. Most common word for diarrhea.
Shuban biyoot	(n.) watery diarrhea. An older term that simply meant diarrhea that is watery in consistency. Today some use this term to refer to the much more serious disease of cholera, acute watery diarrhea, or diarrhea that is watery and white in color. The variably definitions and uses of *shuban biyoot* is discussed in Chapter 4.
Shuban dhiiq	(n.) Bloody diarrhea or dysentery
Sorati	((n.) women's nonspecific illness and abdominal pain around the time of menstruation (like "PMS"). In its severest form, a build-up and possible infection of menstrual blood following infibulation or when the vaginal opening is too small to allow easy menstrual flows. Synonyms: *hindo hinduro, ubuuq, cubuq, uruuq*

Ummulow	(n.) abdominal pain or other problem of the woman just after she gives birth. (Unclear definition; unsure if this means an infection or hemorrhage or simply pain.)
Uruuq/Curuuq *Ubuuq*	1. (n.) a stomach problem, some said due to menstrual cycles or the build-up of menstrual fluid in circumcised or infibulated women prior to sexual intercourse or a surgery to enlarge the vaginal opening. 2. (n.) stiffness and build-up of menstrual blood if a woman sits all day during her period. Symptoms of uruuq include, variably, tiredness, joint pain, and muscle weakness, and sometimes, pain in the back. Usually it is treated by "*duugid*" – which is massaging performed mostly by older women. Synonyms: *hindo hindhuro* and *sorati*
Xooq/Xoq	1. (v.) to scratch or scrape 2. (n.) a disease that people describe as affecting children's stomachs and intestines. Female lay health experts will often say that the lower intestines are blocked or stopped by rashes, blisters, or parasites; a child's stomach becomes distended and he becomes constipated (*calool istaag*). To treat, someone "scratches" the child on the inside of the anus with a small stick in order to break any blisters or break up any blockage and induce bleeding. This treatment is most common among newborns who have not yet produced a stool, and other young infants with digestive problems.

Table 7. Structural illnesses or disorders of bodily organs

Somali Term/ Alternate Spelling	**Definition and Usage**
Babasir	(n.) hemorrhoids
Bajo	(n.) syphilis
Baralasiis	1. (n.) paralysis 2. (n.) a stroke that causes paralysis. *Baralaays:* (n.) a paralyzed person
Busbus	(n.) Chicken pox Synonym: *Hablo-bas*
Caateeya	(n.) HIV/AIDS, from the verb to make someone thin or loose weight Synonyms: *sidaa, libaaxa, AIDS*
Cadha	(n.) Scabies or a similar rash. Synonyms: *Isnadaamis or isnaamis.* Sometimes equated with or used to describe symptoms of *jabti.*
Danjef	(n.) Migraine or severe headache, usually described as being on one side of the head. Some persons argued that this is a kind of headache or stroke (affecting one side of the head) only in goats, not humans.
Dhaga fidiye	(n.) Meningitis, literally translated as "swollen ears" Synonyms: *Maskax qaraad, Qarxiyo, etc.*
Dhaxan	(n.) Common cold Synonyms: *Duray, Duri, Hargab*
Dhaxanxun	(n.) Severe cough or cold Synonym: *TB*
Dhicis *Dhiciswo*	(n.) miscarriage, often caused by a jinn Usage: *Way dhicisowday:* she had a miscarriage. (n.) premature baby (this definition not used in the northern Somali Region)
Duray/Duri	(n.) Common cold or simple cough. Synonyms: *Dhaxan, Hargab*

Duumo	(n.) malaria Synonyms: *Malaariya, Kaniico xanuunka, Kaneeco xanuunka*
Faluq/Faalug	(n.) stroke
Gabeen	(n.) trachoma or another eye infection usually in elderly persons, and usually the person is nearly or total blind, their eyes are closed or foggy. Synonym: *Taraakooma*
Gargariir	1. (v.) to shake or tremble 2. (n.) Parkinson's disease, described as a disease mostly in older persons and characterized by physical shaking and difficulty walking.
Gawracata	(n.) diptheria
Gooryaan	(n.) intestinal worms or parasites
Hablobas	(n.) chicken pox Synonym: *Busbus*
Hargab	1. (n.) Influenza virus 2. (n.) Common cold Synonyms: *Duray, Dhaxan*, etc.
Hargabka Doofaarka	(n.) swine influenza
Hargabka Shimbiraha	(n.) avian influenza
Hawl	(n.) lay term for any sexually transmitted infection, usually used to refer to an infection in a man.
Hole/Hule	1. (n.) extrapulmonary tuberculosis lesion or abscess on the body, most likely the neck 2. (n.) cancerous lesion that causes a very large lump to protrude from the skin somewhere on the body, or 3. (n.) a large abscess on the foot or legs
Inda xanuun	(n.) common eye problem or eye infection, typically treatable with eye drops or ointment. Often temporary, found in children, and less serious than *gabeen.*

Isnadaamis/ isnaamis	(n.) Scabies or a similar rash. Synonym: *Cadha.* Sometimes equated with or used to describe symptoms of *jabti.*
Jabti	(n.) gonorrhea
Jedeco	(n.) measles or a complicated and persistent skin rash. Sometimes confused with *busbus* (chicken pox) or *hablo-bas,* an uncomplicated rash
Jeeni wareen	(n.) pneumonia, persistent and difficult cough and fluid in the lungs.
Joonis/Jaandis	(n.) hepatitis
Kaneeco xanuunka/ kaniico xanuunka	(n.) malaria or literally, "the mosquito disease." Synonyms: *Malaariya, duumo*
Kelyo xanuun	(n.) kidney disease; often informally diagnosed in cases when chronic back pain has not been caused by an injury, or in urban areas when city water sources are suspected to be contaminated with heavy metals, salt, or other minerals.
Kofle/Gofle	1. (n.) Small lesion or abscess on the body. 2. (n.) Children's disease caused by creatures living in or crawling up the throat
Kojiye/ Kogiye	(n.) neonatal tetanus, a term likely derived from "*kog*" the verb that translates as "to recoil" or "shrink back"
Lafa garaac	(n.) arthritis in older persons, literally means "beaten bones" Synonym: *Lafa xanuun*
Libaaxa	(n.) HIV/AIDS, from the word for "lion" Synonyms: *AIDS, sidaa, caateeya*
Maskax qaraad	(n.) literally translates as, "exploded brain" and refers to meningitis. Synonyms: *Minanjaaytis, Dhaga fidiye, Qarxiyo, Qoorgooye*
Minanjaaytis	(n.) meningitis Synonyms: *Maskax qaraad, Dhaga fidiye, Qarxiyo, Qoorgooye*

Mindheeli/ Mendheeli	(n.) literally means "shifted uterus." *Mindheeli* is a common complaint of reproductively active women. It was most often interpreted by Somali male nurses as a urinary tract or sexually transmitted infection, and most often interpreted by Somali women as injury to the uterus (similar to a hernia or strained abdominal muscle) due to over-exertion. The most common cause of mindheeli, lay women said, was lifting and carrying 20 litre jeericans full of water too soon after giving birth.
Oof wareen	(n.) pneumonia, persistent and difficult cough and fluid in the lungs. Synonym: *Jeeni wareen*
Oof xanuun/ Oof karaa	(n.) lung problem, TB precursor
Qabow	(n.) an old word for malaria, used mostly before people widely understood malaria as from mosquitoes. "*Qabow umbaa asho*" meant complicated, long-lasting, probably cerebral malaria. People used to believe malaria was caused by eating the wrong diet, climate change, and not taking care of yourself. "*Qabow qunbacashuu kugu dilaa*" which means, "Qabow kills through complication." *Qabow* was treated with bitter things, i.e. tree leaves, aloe, etc. If you drink water from different places, you become more susceptible to *qabow,* so it was seen as best to stay in one place. Synonyms: *Malaariya, Kaneeco*
Qabsin	1. (n.) Appendicitis, 2. (n.) General abdominal pain, 3. (n.) Constipation, or 4. (n.) Abdominal pain or illness from the over consumption of *khat*
Qalijiye	(n.) neonatal tetanus
Qarxiyo	(n.) literally means, "explosions" but also refers to meningitis Synonyms: *Minanjaaytis, Dhaga fidiye, Qarxiyo, Maskax qaraad, Qoorgooye*

Qixi	(n.) Pertussis or whooping cough. Synonym: *Xiiqdheer*
Qoor qo oo	(n.) meningitis, but literally means, "stiff neck." Synonyms: *Minanjaaytis, Dhaga fidiye, Qarxiyo, Maskax qaraad, Qoorgooye*
Qufac	(n.) literally means "cough" and used to refer to tuberculosis. Synonyms: *TB, sallid, dhaxanxun*
Sallid	(n.) an older term for tuberculosis that refers to when a person becomes "soft." Symptoms of sallid included persistent cough, loss of weight, and hair loss. People have long known it was communicable – a sick person would get his own cup to use in the house, and this cup would be tied to his clothes. Synonyms: *TB, qufac, dhaxanxun*
Sidaa	(n.) HIV/AIDS (from the French acronym for AIDS) Synonyms: *Caateeya, libaaxa, AIDS*
Sindheere	(n.) literally means, "long hip" and refers to when boys reach puberty and become very skinny and tall and have pain in their legs and joints. To treat the pain, the family would slaughter of a ram and change the diet (*buulo*).
Sinyare	(n.) polio Synonyms: *Dabayl/Dabaysha*
Suuxdin	(n.) epilepsy Synonym: *Qalal*, less commonly Although at first the symptoms of epilepsy might be misinterpreted by lay persons as a spiritual disorder or possession by jinn, in fact *suuxdin* references the biomedical diagnosis. For most, all biomedical illnesses may be caused by the work of devils or demons, and are in fact caused by God, they may also be treated with pharmaceuticals.
TB	(n.) tuberculosis Synonyms: *Qaaxo, Dhaxanxun*

TB gangidhaha	(n.) extrapulmonary tuberculosis, or literally, "TB of the glands." May sometimes be confused or conflated with *hole.*
Tetane	(n.) tetanus
Taraakooma	(n.) trachoma or another eye infection in elderly persons; usually the person is nearly or total blind and their eyes are closed or foggy. Synonym: *Gabeen*
Uruuq/Curuq/Ubuc	1. (n.) a stomach problem or pain, some said due to menstrual cycles or the build-up of menstrual fluid in circumcised or infibulated women prior to sexual intercourse or a surgery to enlarge the vaginal opening. 2. (n.) stiffness and build-up of menstrual blood if a woman sits all day during her period. Symptoms of uruuq include, variably, tiredness, joint pain, and muscle weakness, and sometimes, pain in the back. Usually it is treated by "*duugid*" – which is massaging performed mostly by older women. Synonyms: *hindo hindhuro* and *sorati*
Wadna xanuun	1. (n.) Heart pain or heart disease 2. (n.) Having a *qoon*, or a particular *jin,* attack someone's heart or ability to love another person or spouse.
Xammo	(n.) sores on the mouth, gums, or lips likely due to a dietary deficiency or other illness. Very common among pregnant women.
Xidid xundaro	(n.) severe cramp in the spleen, abdomen, or uterus experienced by women that is more serious than menstrual cramps
Xidido	(n.) literally translates as, "veins" but refers to "varicose veins" especially when they become painful. Xidido are mostly a problem faced by women, and many reported, only after she has given birth to several children and faced a lifetime of hard work.
Xiiq	(n.) asthma

Xiiqdheer	(n.) whooping cough or pertussis. Literally, "long" or "chronic asthma" Synonym: *Qixi. Qixi* is the more common term.

Table 8. Psychological illnesses or disorders of the mind

Somali Term/ Alternate Spelling	**Definition and Usage**
Buufis	(Adj.) sad, depressed, or extremely disappointed
Is-dilid ah	(Adj.) suicidal
Niyad jab/ Niyajab	(n.) Literally translates as "spirit is broken," and means severely disappointed, depressed, or heart broken. This condition may be brought on by personal tragedy, excessive khat consumption, or for no reason at all.
Suuxdin	(n.) epilepsy Synonym: *Qalal*, less commonly Although at first the symptoms of epilepsy might be misinterpreted by lay persons as a spiritual disorder or possession by jinn, in fact *suuxdin* references the biomedical diagnosis. For most, all biomedical illnesses may be caused by the work of devils or demons, and are in fact caused by God, they may also be treated with pharmaceuticals.
Waali	(Adj.) psychotic or crazy

Table 9. Spiritual illnesses

Somali Term/ Alternate Spelling	**Definition and Usage**
Ma dhalays	(n.) infertility, often caused by a jinn or other spirit possession.
Suuxdin	(n.) epilepsy Synonym: *Qalal*, less commonly Although at first the symptoms of epilepsy might be misinterpreted by lay persons as a spiritual disorder or possession by jinn, in fact *suuxdin* references the biomedical diagnosis. For most, all biomedical illnesses may be caused by the work of devils or demons, and are in fact caused by God, they may also be treated with pharmaceuticals.
Quruumo	(n.) One type of spiritual disease or disorder that is treated by mullahs or sheikhs by several means, including prayer, recitation of the Qur'an, writing the Qur'an and placing the paper in a necklace around the person's neck, etc. Synonym: *Wadaado*
Wadaado	1. (pl. n.) Plural of sheik, mullah or spiritual healer 2.(pl. n.) Unseen spirits causing any type of disease in the body. Jinns affect people's mind (*qaldi*) mostly, while *wadaado* affects the physical body, and manifests as physical diseases. You have to go to a mullah for this kind of disease. 3. (n.) Also refers to one type of spiritual disease or disorder that is treated by mullahs or sheikhs by several means, including prayer, recitation of the Qur'an, writing the Qur'an and placing the paper in a necklace around the person's neck, etc. Synonym: *Quruumo*
Wadna xanuun	1. (n.) Heart pain 2. (n.) Heart disease 2. (n.) Having a *qoon*, or a particular kind of *jin,* attack someone's heart or ability to love another person or spouse.
Waali	(Adj.) psychotic or crazy

APPENDIX B.

RECOMMENDATION: SOMALI HEALTH SCIENCES EDUCATION

Many persons have asked me, both in Ethiopia and in the United States, what needs to happen most to address continuing health disparities in the Somali Region of Ethiopia? I argue here that educating a new generation of Somali health professionals, including substantial numbers of female health professionals, in the Somali language, with a revised and improved curriculum would be critical first steps. The development of responsive and sustainable forms of healthcare – including, as this dissertation argues forcefully, relations of trust between patients and providers – is fundamentally challenged by the dearth of Somalis well trained in the health sciences in Ethiopia. Jijiga University in the capital of the Somali Regional State has been in operation since 2006, but according to top officials at the university, it struggles to meet the demands of its students, particularly in health and human sciences – biology, physiology, physics, chemistry, medicine, and public health.

Jijiga University does not have a well-developed program in public health or the health sciences. The leading medical schools in Ethiopia are all located in the western part of the country, including those in Gondar, Jimma and Addis Ababa. Furthermore, public health, medicine, and health science graduate schools and vocational programs are all taught in English in Ethiopia, usually with substantial Amharic-language classroom and extracurricular discussions. For a host of reasons, including chronic displacement and substandard secondary schools, most Somalis graduating high school in the Somali

Region cannot speak fluent English or Amharic, and for this reason and others, struggle to gain admission to post-secondary programs.

The public education system in the Somali Region is hindered by the institution of English-language instruction and coursework at secondary and post-secondary school levels, because neither students nor their teachers are typically adequately fluent in English.[179] According to Ethiopian law, English is taught as a foreign language in primary school, while the regional language is used for all other instruction (e.g. Somali or Tigrinya, etc.). Once students enter secondary education, instruction is ideally all in English (with help from teachers who translate from their own fluent languages into English as needed). Secondary and post-secondary classes throughout Ethiopia are supposed to be conducted exclusively in the English language.

Yet six of the ten public school teachers I met who taught public primary or secondary education in the northern Somali Region were not fluent in Somali – or English. A few of the habasha teachers residing in Aysha did speak Somali because they had grown up and been educated at least through high school in Jijiga, the capital of the Somali Region. In Jijiga, the Somali language is taught as a foreign language even in high school, even in high schools located in parts of the city dominated by Amharic speakers. These teachers are the exception, however. Public school teachers in the Somali Region are not required by law or practice to speak Somali or any of the other regional languages where they might be assigned to work – and often, they cannot. Most

[179] In my experience in other regions of Ethiopia as well, *including Addis Ababa*, the capital of Ethiopia, the institution of English language public education makes education more difficult and less efficacious because of the lack of fluent teachers. Students who mastered English language often graduated with professional degrees outside education – such as in the health sciences or business.

public school teachers in eastern Ethiopia struggled with teaching the Somali students in their classrooms.

It is a vicious cycle: fewer Somali students succeed in school and gain admission to post-secondary vocational programs and universities, so fewer later become educators themselves, so fewer Somali teachers are available to teach in the Somali Region, and so on. Numerous students I spoke with throughout Ethiopia regretted that they could not understand much of what was taught in classrooms, and reported that they did not feel conversant in English upon high school graduation. In addition, most *woredas* (districts) in the Somali Region lacked a complete high school all the way to 12th grade (even the Aysha school only went up to 10th grade), and so students wishing to graduate had to move or stay with family in urban areas like Jijiga or Dire Dawa. Often students lacked family in nearby cities, especially when they had experienced prior displacement. And then, once high school students graduated or obtained a vocational degree, they were much less likely to return to their rural natal communities to work. Of course, these problems are systemic and global.

In Ethiopia, this puts Somali students at a significant disadvantage compared to other Ethiopians – on average they score less well in their entrance exams (which means they are severely limited in where they can gain admission), they struggle with coursework, and perhaps most importantly, they choose not to attend schools outside the Somali Region.[180] Young women I spoke with, in particular, said they did not want to live outside the Somali Region where they would lack family support (and therefore

[180] These are challenges many Somalis spoke to me about, but I do not have documentation of differential test scores and grades between Somalis and non-Somalis in public school.

chaperones as well) and where they would feel like an outsider vis-à-vis the non-Somali student body.

Therefore, I argue that the best way to increase the number of Somali students at the highest levels of medical education and medical practice is to focus on improving Jijiga University and put in place affirmative action measures to ensure that rural Somalis, and Somali women most of all, are able to gain admission then succeed once they get there. To begin with, if Jijiga University developed its own training program in the health sciences, taught the vast majority of these courses *in Somali* (with separate courses to teach the English language for health science professionals), and included a curriculum designed to respond to the popular health cultures and expectations of Somalis, the retention rate and quality of education would improve dramatically.

Below I list several specific aspects of a Somali health science curriculum I aruge would be important:

- A focus on instruction and literature (when possible) in Somali language.

- Courses in the English language for health science professionals and to aide with patient communication when English is a shared language.

- A social science course plus visiting lecturers by renowned herbalists, rural doctors, Qur'anic healers and other lay experts, to help outline the different aspects of pluralistic popular health cultures and health care challenges in the Somali Region.

- Contra the crude (and frequently vapid) statements in the current health education literature in Ethiopia about "harmful traditional practices,"[181] a Somali curriculum could help deconstruct this term and replace it with more useful and specific concepts in the Somali language. Student-led research would have to be done regarding what might constitute a "harmful" medical practice, and what are the potential and proven risks to health and well-being. Students would then be able to ask: Is it worth it to have a public health initiative to eliminated or ameliorate this practice, or are there more serious concerns facing Somalis? How should health policies and medical practices change to address the medical presentations that result from harmful practices?

- Student-led research initiatives should investigate the prevalence of infibulation and other forms of female genital cutting practiced in the Somali Region, as well as to investigate trends to change or eliminate various practices. Students would then be able to take an informed stance on whether or not they support any form of female genital cutting, and work to end negative health outcomes associated with the practice.

[181] "Harmful traditional practices" usually only refer to female genital circumcision or mutilation or early marriages practices (Assefa et al. 2005, FDRE 2006, Ministry of Health 2006, Jeppsson et al. 2003, Kebede 2006). However, in conversations with Somali staff at the Somali Regional Health Bureau and UNICEF in Jijiga, the practices of scraping the anus and nasal cavities of children and burning the skin at the suspected location of pathology were also considered "harmful traditional practices."

- At least one course required for all students in Somali women's healthcare and reproductive health concerns. This course should include specific information about how to prevent and treat maternal mortality, childbirth fistulas, pregnancy complications, and other morbidities during childbirth or the post-partum period.

- Female students should be encouraged to investigate specific culture-bound folk disorders or illnesses of the female reproductive system and illnesses experienced disproportionately by women as a group (e.g. *mindheeli* and *uruuq*, discussed in Chapter 3). Once the etiologies, symptoms, related co-morbidities, and barriers to diagnosis and care are clarified, a diagnostic and treatment protocol should be designed and disseminated to healthcare providers throughout Ethiopia.

- All students, but females most importantly, should examine the designs and protocols of current clinical facilities in the Somali Region and begin to identify ways in which privacy and communication between providers and patients might be encouraged.

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