Women and Childbirth in Haile Selassie's Ethiopia

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Short Abstract

As the first analytic history of Ethiopian medicine, this thesis explores the interchange between the institutional development of a national medical network and the lived experiences of women as patients and practitioners of medicine from the years 1940-1975. Using birth and gender as mechanisms to explore the nation's public health history allows me to pursue alternative threads of enquiry: I ask questions not only about state activities and policy pursuits, but also about the relevance and acceptance of those actions in the lives of the citizenry. This thesis is also the first medical history of a non-colonial African country, opening up new questions about the role of non-Western actors in the expansion of Western medicine in the twentieth century. I explore the ways in which the exceptional history of Ethiopia can be couched in existing narratives of African modernity, medicine, and birth history. Issues of local agency and the creation of new social elites in the pursuit of modernity are all pertinent to the case of Ethiopia. Through both extensive archival research and oral interviews of nearly 200 participants in Haile Selassie's medical campaigns, I argue that the extent to which the imperial medical project in Ethiopia 'succeeded' was highly predicated on pre-existing conditions of gender, class, and geography.

Long Abstract

In Haile Selassie's Ethiopia, modern medicine was used by the state to both secure the nation's prestige, and also actively develop Ethiopian communities through the alteration of 'traditional' life-styles. Women were particularly targeted in 'modernising' campaigns, given their primary responsibility for child rearing and household management. Influenced by new guidelines of the World Health Organisation and other foreign health experts, medical administrators in Ethiopia set out to alter traditional customs of child-bearing and 'mothercraft' based on new international standards, hoping to align the East African Empire more closely with its Western allies. Hospitals with modern maternity wings were built in the capital, Addis Ababa, while the rural countryside was swiftly populated by new 'health centres,' manned by Ethiopian health auxiliaries who focused on preventive rather than curative medicine.

In concentrating on the principles of community development and preventing disease rather than curing it, however, Haile Selassie's medical mission was deeply misaligned with both the needs and predilections of Ethiopian communities intent on benefiting fully from the presence of modern medicine. While dozens of health centres had opened in rural areas, the health teams trained to man the centres were overwhelmed with patients demanding medical cures unavailable in traditional medical custom. Especially in the case of maternal health, women refused the preventive health and social re-education programmes of the new clinics, seeking out medical practitioners only in the case of physiological distress at the time of delivery. Poorly equipped to provide treatment in obstetric complications, maternal deaths continued in rural areas and health centres failed in the provision of either preventive or curative maternal health services. In urban areas, hospitals became increasingly elite institutions with classed wards, where wealthy women could

afford high quality lying-in services, and lower-class women were forced into crowded corridors to deliver.

In the early 1970s, as Haile Selassie's hold over his regime crumbled, it was increasingly obvious that the two goals of modern medicine in Imperial Ethiopia had failed. Prestige through modern medicine was secured only for a privileged few urban residents, while rural communities were both incapable and uninterested in altering living standards at the expense of inadequate curative treatment. With little investment in pragmatic improvements in the economic livelihoods of rural residents, public health administrators were naïve in imagining that communities would be able to modernise their lifestyles, given the persistence of material poverty in the nation.

The story of modern medicine's expansion in Ethiopia is largely unexamined, and as the first analytic history of Ethiopian medical history, this thesis fills a considerable historical gap. I narrate this history both from the perspective of the state, and also the community, describing the ways in which women in particular coped with state efforts to modernise the nation through medicine. Methodologically, I focused both on archival and oral materials, spending the first year of research in government archives in the United Kingdom and United States, in addition to the World Health Organisation materials in Geneva. I then spent another year in Ethiopia conducting nearly 200 interviews of participants in the imperial medical project, both practitioners and patients.

The dual nature of my study in charting both official and community histories of medicine in Ethiopia is reflected in the organisation of chapters. The first two chapters concentrate on the administrative history of medicine and modernity in Ethiopia, while the third and fourth focus on the oral narratives of women as practitioners and patients. The final chapter returns to the official narrative,

outlining the failures of the Haile Selassie regime to create a comprehensive medical network for Ethiopia.

The first chapter answers questions related to the interests of the Ethiopian state: what was the official definition of modernity, and how did medicine play a part in modernising the empire? I describe the ways in which Haile Selassie solicited aid from foreign governments and institutions in constructing Ethiopia's first modern medical network. The emperor was intent on building prestigious medical institutions in the capital to secure his prestige, while foreign advisors attempted to sway state policy towards the creation of a preventive health network in the expansive rural areas of the empire. This contention between medicine as a symbol of imperial prestige versus community development is fundamental to my thesis. Debates between the emperor and diplomatic aid corps demonstrate the ways in which modern medicine was used for ulterior ends in Ethiopia. The clinic and hospital were used strategically by the state as a way to enhance the modernisation of the empire, whether in beautifying the streets of the capital, or re-orienting customs of the countryside.

In the second chapter, I focus on the question of women and childbirth within the medicine-as-modernisation narrative. The medicalisation of childbirth in both Africa and abroad has long been implicated in policies for the modernisation of the state and development of communities. With the creation of the World Health Organisation, global standards for maternal health were first codified, and the connection between childbirth and culture made explicit. Attacks on maternal morbidity and mortality prioritised the reversal of harmful traditions in indigenous cultures, and the expansion of medicalised maternity in countries like Ethiopia was focused less on the institutionalisation of parturients, and instead on a re-orientation of domestic living practices. Women were asked to attend ante-natal and Well-Baby

Clinics to ensure they adequately prevented potential problems in both the birth and rearing of children through alterations to basic customs related to the provision of water, sanitation, and nutrition. The onus for community development rested on women, and it was believed that with sufficient re-education of overly 'traditional' Ethiopian families, the entire nation could be 'modernised.'

I move from narrating the official intentions for medicine in Ethiopia to its actual practice by female nurses, midwives, and physicians in the third chapter. This chapter narrates the experiences of seven female practitioners active at the time of Haile Selassie. I use the oral histories collected in my fieldwork to describe the ways in which the state's expectations of modernity were negotiated by female practitioners of medicine. These women entered medical professions both with the intent to serve their fellow man, and also secure an improved standard of living for themselves and their families. Practitioners largely assumed the role of moderniser in imperial Ethiopia, intent on educating their patients to reform harmful traditions, especially as related to maternal and child health. At the same time, by virtue of their gender, these women confronted numerous restrictions in modern Ethiopia. The official place for women was highly limited: not only were women nominally restricted to the professions of nursing and midwifery, but their incomes and status were consistently placed second to male superiors. Throughout their careers, however, the women interviewed clearly assumed more senior responsibilities in their practice of medicine. There was a consistent push-back against official expectations of the prescribed role of professional Ethiopian women. In narrating the contentious space for women as female practitioners, the limitations of modernity in Ethiopia are made evident.

The fourth chapter focuses on the experience of women as medical patients in Haile Selassie's Ethiopia. As a companion to the practitioner narratives above, I use

this chapter to describe the ways in which Ethiopian women coped with the persistent state strategies to co-opt them into national modernisation campaigns. I narrate women's reproductive histories, explaining how their choices in times of pregnancy and childbirth became symptomatic of their own definitions of health, risk, and the place of modern medicine in indigenous maternity customs. Women by and large rejected the official narrative related to maternity care and cultural change: the clinic was viewed as a vehicle for cure in times of medical distress, not lifestyle reformation. There were exceptions to this narrative, however, most notably those women who deliberately sought out modern maternity care at the hospital from the outset of the pregnancy. These women were all part of the upper classes of Ethiopian society, exposing the role of wealth and status in shaping the patient experience with modern medical care. This chapter manifests the intersection of class, geography, and medical choices in modern Ethiopia, emphasising once more the varied definitions of 'modernity' in Ethiopian community life.

In the final chapter, I narrate the ultimate failure of Haile Selassie's medical mission. Given the emperor's penchant for prestige projects, the actual impact of his medical policies was minimal. There was no wide-scale alteration of customs related to health, disease, or reproduction, and the pressing needs of the population were overlooked in favour of elitist campaigns. Funding for the operation of medical facilities was severely limited, so that the quality of clinics and hospitals deteriorated rapidly during the emperor's reign. In rural areas, the persistent poverty of the population hampered the effectiveness of the preventive health education network designed by foreign aid partners. While services directed at women largely concentrated on their capacity as mothers and homemakers, the reproductive needs of women were wholly ignored: family planning was not introduced in Ethiopia

until the late 1960s, despite the fact that death from unsafe abortion was the most common cause of maternal mortality.

I conclude the thesis with a discussion of the contributions of this research within existing academic enquiry. I argue that this thesis helps expand on histories of reproduction and women's health, exposing the ways in which narrow state narratives which define women solely within their reproductive capacity overlook the agency of women in determining their own maternal histories and securing the greatest degree of health and safety for themselves and their families. I also argue that as a case study of a non-colonial African country developing a modern medical network in the twentieth century, the history of Ethiopian medicine complicates existing narratives on what is 'local' and 'global' in biomedicine, and presents a compelling case for the creation of new medical norms among non-Western actors. Finally, I explain the implications of this thesis for further research in other historic and geographic contexts. My criticisms of the imperial medical project can be extrapolated both to subsequent regimes in Ethiopia, and also on a broader scale to the creation of 'global health' norms with the WHO and other international aid bodies.

Preface

In the third year into this project, on 25 April 2014, I gave birth to my first child. I find it necessary to explain my own experience with giving birth because of the ways in which it informed my understanding of the history of medicine and its interaction with childbirth in Ethiopia. Undergoing pregnancy and labour myself while writing a thesis on women and childbirth has inevitably led to certain biases and insights.

I gave birth to my son in England, at the John Radcliffe Hospital's birthing centre in Oxford. The centre is midwife-led and 'intervention-free.' There are no epidurals or episiotomies in the birthing centre. There is even a sturdy piece of fabric hanging from the ceiling of one birthing suite so women can squat in labour, leveraging the pressure of delivery by pulling against the fabric. I gave birth without complication. I was in labour for fourteen hours, eleven of those were at home in my own flat with just my husband at hand. Once in the hospital, I was given a short examination to confirm that my cervix was seven centimetres dilated, but from then on, the midwives attending merely observed on the side-lines as I went through the cycles of contractions and into the pushing stage. I pushed my son out squatting in a birthing pool, and was back home in less than a day.

I relate this experience because, aside from the birthing pool, the management of my birth fits well within Ethiopian custom. While I did not use the hanging fabric for support in labour, this is a long-standing birthing tradition in neighbouring Sudan. European colonisers and aid workers worked hard in the last century to eradicate such supposedly dangerous forms of birth management, including the upright birth position and rope-support. In Sudan, British midwifery instructors taught traditional birth attendants how to manage women birthing in a supine position and preached against the hanging rope. Midwives who were not trained under the British were actually labelled '*habel* midwives,' or 'midwives of the rope,' and generally derided.

The John Radcliffe in Oxford is one of the top hospitals in the world, renowned for practicing the most up-to-date innovations in medicine, and here I was, birthing without medical assistance, with traditions long eradicated in Africa by British colonisers and diplomatic aid corps. This experience demonstrated how profoundly subjective the term 'modern' is in relation to childbirth. In my personal experience with the swinging pendulum of history and maternity care, it was evident that there are varied 'modernities' which overlap and contradict one another. While history tends to describe an ascendant 'medicalisation of childbirth,' it became quite clear to me that there is no teleological trajectory in relation to the practices of birth management.

I have written this thesis influenced from my personal experience with hospital birth in the UK. The thesis is entirely my own work, unless otherwise indicated by quotation and citation. Any mistakes in the thesis are my own.

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Introduction

When Helina Petros narrated her experience of delivering ten children in southern Ethiopia in the years 1960-75, she explained how her husband was the sole care-giver at the time of birth and the postpartum.[1] She tearfully recounted how happy she was in her husband's care: from the time Helina reached seven months gestation, her husband took over all household duties, allowing Helina to store up strength for the ardours of labour. He prepared ample food, washed her clothing, and readied the home for the birth. At the onset of labour pains, he held her and repeated the comforting Amharic plea, '*ayzosh, ayzosh*.' His care continued after the birth, including rinsing the cloths used during delivery, despite their being soaked in blood, a common taboo. Helina rested for the expected forty days after each of her ten deliveries, which she felt assisted her to 'recover the blood lost at birth.'

Helina admitted that the role of her husband was exceptional. Typically female relatives or neighbours would assist in delivery and postpartum care, but Helina had moved frequently throughout the southern region of Ethiopia, remote from any close kin. Her husband was employed as a policeman in the Haile Selassie regime, and his frequent re-stationing was symptomatic of the empire's expansion within the previously peripheral zones of the south. With each relocation, Helina would have little time to properly engage with neighbouring families, so the intimacy of delivery care responsibilities rested with her husband. With a husband in the imperial police service, Helina was able to attend the state-run police clinic where she and her children received necessary vaccinations and basic treatment. While Helina sought ante-natal care at the clinic, there was little use for a government health worker at

[1] Author interview with Helina Petros, Jinka, 15 May 2013. Helina Petros is a pseudonym. To protect the anonymity of all women who shared with me their reproductive histories, I will use pseudonyms throughout this thesis.

the time of birth: 'he would give me advice, but he knew nothing of the steps of delivery.' Helina's births were not without crisis, however. She bled heavily, but her husband managed to slow the bleeding by massaging her abdomen and applying pressure with rags to the perineum, not uncommon practices in rural Ethiopia. More alarming, three of Helina's children died within hours of delivery. The deaths were sudden— Helina explained that 'they sneezed, then died.'[2]

Helina's experiences in birthing on the periphery of an empire exemplify several themes in the history of women and childbirth in Haile Selassie's Ethiopia. The primary concern of both Helina and her husband was maternal well-being. From the onset of conception, the family used multiple resources for both medical cure and social care as deemed appropriate. The husband, as the most proximate kin, provided all critical aspects of care-giving: food and home preparation, and emotional support to withstand the labour pains. The rudimentary clinic dispensed appropriate cures in the form of vaccinations for children and basic ante-natal consultation to identify potential signs of abnormality or risk in Helina's pregnancy. Mortality was a common outcome both for mothers and particularly for infants, and women prepared themselves for such challenging eventualities, both by gathering support from close kin, while also undergoing lengthy periods of physical rest both in times of pregnancy and postpartum. On the occasion of the birth itself, Helina felt confident in the caring support of her husband, and did not see the need to call for the low-level auxiliary working in the police clinic. Births were expected to be normal, and her husband was able to manage the mild haemorrhaging on his own. Should any additional complication arise, Helina would have sought out further medical support, but her confidence in the clinic as a source of emergency obstetric care was minimal.

[2] Ibid.

Narrating the experiences of women in Haile Selassie's Ethiopia

This thesis explores the interchange between the institutional development of a national medical network and the lived experiences of women within the imperial state of Ethiopia. In Ethiopian historiography, there is no analytic work on the history of medicine to date, a gap this study intends to fill. While I provide an institutional history of Haile Selassie's mission to expand modern medicine in Ethiopia, I present that history primarily from the lens of women and their experiences in pregnancy and birth. Using birth as a mechanism to explore the nation's public health history allows me to pursue alternative threads of enquiry: I ask questions not only about state activities and policy pursuits, but also about the relevance and acceptance of those actions in the lives of the citizenry. Exploring the experiences of women and childbirth helps delineate the ways in which the Imperial Ethiopian Government worked to engage the population in modernisation through health services, while also revealing how the population actively participated or did not participate in the state project.

Birth is a relevant entry point within these enquiries not only because it is a defining life experience for nearly all Ethiopian women, the vast majority of whom begin delivering children early and often throughout their lives, but it is also a profound signifier of the junction between culture and biology. Considering that neither pregnancy nor birth are illnesses to be cured from, the insertion of biomedicine into the processes of maternity has been a fraught issue for labouring women throughout the last century. In Ethiopia, the main thrust of birth's medicalisation was cultural reformation, not large-scale institutionalisation. Instead of driving women to the hospital in times of labour, health workers used preventive

health education to target mothers into domestic modernisation schemes. The imperial medical network set out to reform indigenous practices related to birthing care and child-rearing with the intention of modernising the empire from the community level upwards. Home birthing continued under the direction of auxiliary nurses trained at a new public health college established in Gondar, while 'Well-Baby Clinics' proliferated across the countryside to instruct mothers on proper nutrition and sanitation practices for themselves and their families.

Medicine was primarily a tool of modernisation for Haile Selassie, whether in rural public health schemes or in the construction of lavish hospitals in the capital. In the imperial definition, 'modernisation' was largely restricted to Westernisation: to be 'modern' meant to alter domestic practices along European lines. Given the ideological thrust of medicine's expansion in imperial Ethiopia, the development of a national medical network became immensely symbolic for the emperor, a fact which limited its effectiveness. In the case of maternity care, there were exceptional circumstances that demanded actual medical intervention in the prevention of illness or death of the mother, but with clinical services oriented primarily to public health instruction, auxiliaries were ill-equipped to manage obstetric complications. Helina's experience with the police clinic auxiliary is symptomatic of the limitations of modern maternity services in Ethiopia: Helina understood that the low-level health worker was not trained to manage conditions of obstetric distress, so avoided clinical services at the time of her labour.

The symbolic nature of modern medicine's introduction in Ethiopia also meant that the number of people with access to clinical services remained marginal throughout the emperor's reign. At Haile Selassie's deposal, national health

coverage was estimated to be just 15%.[3] This meant that 85% of the population lived over 50 kilometres from any health facility. While I explore the practices of modern medical practitioners in Haile Selassie's Ethiopia in this thesis, it must be emphasised from the outset that these services were extremely limited in reach. In discussing the historical medicalisation of childbirth in Ethiopia, I am describing the experiences of a mere handful of women. The majority of Ethiopians continued their lives under Haile Selassie untouched by biomedical services.

The level of access to medical services within the population was highly predicated on geography. In the narration above, Helina relied on a mere auxiliary for her curative needs in rural Ethiopia, but the situation for urban women differed greatly. Given the prestigious image of the modern hospital, Haile Selassie was intent on constructing numerous medical institutions in the empire's capital, Addis Ababa. These hospitals not only dispensed advanced medical cures in cases of obstetric emergency, but women began to choose hospital births deliberately to assert their own individual modernity. Birth choices began to determine a woman's status in modern Ethiopia, while access to the clinic began to intersect with pre-existing conditions of education, profession, and ethnicity.

The discrepancy between urban and rural medical services speaks to larger issues in Ethiopia's modernisation and the creation of new social elites. In dealing with the explicit themes of childbirth and modernisation in Ethiopia's medical history, this thesis therefore exposes implicit issues of wealth, status, and gender. Women were co-opted into national medical schemes for their potential to reorient and modernise domestic practices. In exercising their personal predilections regarding healthcare, however, women were more deliberate in utilising a multiplicity of home and clinical services. The overlapping nature of health systems

[3] H. Kloos and Z.A. Zein (eds.), *The ecology of health and disease in Ethiopia* (Addis Ababa, 1988), p. 3.

was driven out of a necessary pragmatism in dealing with the limitations of state medical policy. The actual paucity of medical services meant that for the majority of women, medicine was not able to adequately penetrate community life or over-turn domestic practices without consideration to issues of livelihood and the persistence of poverty.

Literature review

To understand the historical intersection between gender, poverty, and access to medicine in Haile Selassie's Ethiopia, I draw from diverse fields of academic literature, including Ethiopian history, imperial medicine, modernisation in Africa, and the global history of childbirth's medicalisation.

I begin my literature review with a discussion of the disputed meaning of modernity in Ethiopian history. As an exploration of Haile Selassie's failed medical project, this thesis contributes to the multiple definitions of modernity both in Ethiopia and Africa at large. I discuss both the ways in which Ethiopian scholars have argued against a linear conception of Westernised modernity, and also the larger African debates on ambiguous modernities in the continent. In examining Ethiopia's historiography, I also briefly discuss the lack of scholarship on Ethiopian medical history: while cursory overviews of state activities in developing a modern medical network exist, this thesis is the first analytic study of Ethiopian medical history to date.

The first sections on modernisation are followed by a discussion of the history of childbirth in the twentieth century, both in Africa and abroad. Birth practices around the globe experienced a pronounced shift in the last century in parallel with the ascendency of biomedicine and modernist teleologies. The hospital replaced the

home as the appropriate site for delivery, and women's reproductive choices began to affirm their position in relation to modernity. I explain the exceptional case of African countries, which were especially targeted for reformation of maternal health practices due to racist anxieties about the embodied ill-health of African cultures. Educating mothers was a main feature of colonial medicine and intended to trigger larger social reform and modernisation. I provide a brief overview of the lack of statistical basis for such assertions: while maternal death did exist in Africa, death in childbirth is a danger for all women, and is related to the lack of emergency obstetric care, not pre-existing conditions of race, culture, and geography. The problematic pathologisation of African mothers is a further symptom of the biased and Eurocentric thrust to the twentieth-century advancement of biomedicine as a tool for modernisation. This historical context is critical in relation to the case of Ethiopia, as will be made evident in the chapters which follow.

Modernisation in Ethiopian history

The first chapter of this thesis discusses the history of Haile Selassie's modernist reforms in greater detail, but for the purposes of the review of literature to follow, it is necessary to briefly introduce the contradictory and performative nature of modernisation in Ethiopian history here. In Ethiopian historiography, Emperor Tewodros II is considered the first ruler to 'usher in the modern age' for the nation.[4] After ascending the throne in 1855, Tewodros' modernisation efforts concentrated first on the secularisation of the imperial administration, and also the development of the Ethiopian military to assist in imperial expansion. The emperor famously asked British missionaries in the country to build him a cannon, privileging the

[4] B. Zewde, *A History of Modern Ethiopia, 1855-1991* (Oxford, 2001), p. 27.

foreigners' potential for weapons over religion. Tewodros died before his goals of secularisation and expansion were met, and it was only under Haile Selassie that such reforms were secured.[5] While serving as regent, Ras Tafari Makonnen had already begun enacting modernist reforms, influenced by radical intellectuals like Gebra-Heywat Baykadagn. The regent made diplomatic overtures to Europe, securing Ethiopia's entrance to the League of Nations in 1923, and performing a 'grand tour' of the continent the following year.

Once Tafari was crowned Emperor Haile Selassie, his penchant for Western-style modernisation of the imperial regime was more profound. The emperor set up a constitution in part to appease European diplomats, but the constitution's impact was limited, serving only to solidify Haile Selassie's absolute power. A two-house parliament was set up, but the emperor retained all control over the appointments and dismissals of its members. There was an underlying belief that the Ethiopian people were 'not yet ready' for active participation in political processes. As the emperor's constitutional adviser, Germatchew Takle-Hawaryat, explained, 'democracy has caused too much bloodshed even among the civilised nations.'[6]

Haile Selassie made additional solicitations towards Europe by inviting foreign dignitaries and journalists to his coronation in Addis Ababa in 1928. In the months preceding the elaborate ceremony, the emperor attempted to 'beautify' the capital with both the rapid construction of modern schools and the first hospital (Bet Saida, adjacent to the imperial palace), and also a mass clearing of poor slum areas. A correspondent from the London *Times* was unconvinced by the cosmetic reforms of Addis, writing that Haile Selassie's purpose in conducting his coronation with such overt pageantry was mainly 'to impress his European guests with the fact that

[5] Recently, John Markakis has provided one of the best overviews of the state-building enterprise in Ethiopia. J. Markakis, *Ethiopia: The Last Two Frontiers* (Rochester, 2011).
[6] Zewde, *History of Modern Ethiopia,* p. 143.

Ethiopia was an up to date, civilised nation.' The correspondent considered such efforts a failure, stating that 'the Abyssinians are still backward in culture and progress,' and that 'there was more to admire in the degree of success with which the authorities were able temporarily to disguise the nature of the people. . . . It is absurd to pretend that Ethiopia is a civilised nation in any Western sense of the word.'[7]

Modernisation as Europeanisation

The *Times* correspondent mocked Haile Selassie's performances of modernity, contrasting the African nation's continued backwardness with the 'civilisation' of Western Europe. The conflation between modernisation and Europeanisation is easily contended, but this comparison between European modes of administration with those of Ethiopia has characterised nearly all studies of Haile Selassie and his modernist reforms in the mid-twentieth century. In the 1950s and 60s, numerous books on Haile Selassie and his government emerged, and while many are mere hagiographies of the emperor, still others are intent on carefully dismantling the imperial regime and its failures to adequately reform Ethiopia along a European model.[8]

Such comparisons extended not only to metropolitan European states, but also their colonial outposts in neighbouring African countries. In her study of the imperial regime, Margery Perham wrote that 'compared with what has been

[7] L.O. Mosley, *Haile Selassie: The Conquering Lion* (London, 1965), p. 170.

[8] Hagiographies of the emperor include: Mosley (1965); C.L. Sandford, *Ethiopia Under Haile Selassie* (London, 1946), and C.L. Sandford, *The Lion of Judah hath prevailed: being the biography of His Imperial Majesty Haile Selassie I* (London, 1955); H.W. Lockot, *The Mission: The life, reign, and character of Haile Selassie I* (London, 1989). For more critical studies, see: C. Legum, *Ethiopia: The Fall of Haile Selassie's Empire* (London, 1975) and P. Schwab, *Ethiopia and Haile Selassie* (New York, 1972).

achieved in these spheres by European governments in Africa - and that, in relation to the need, is little enough - the Ethiopian government, lacking both the knowledge and the administrative power, has done even less.'[9] Ethiopian intellectuals themselves began comparing their nation unfavourably to the European-administered, colonial neighbours: Gebra-Heywat Baykadagn returned to Ethiopia after a visit to British Sudan and publicly criticised the backwardness of Ethiopian customs and administration.[10]

It is significant that as an independent African nation, Ethiopia was seen as inferior to its colonial neighbours. Haile Selassie's installation of modern institutions like schools and hospitals was viewed by critics as mere symbolic gestures, covering the inherent backwardness of the population. Perham had written that when contrasted to the considerable health networks in colonial Africa, 'it is impossible to write about the health and medical services of Ethiopia except in the most fragmentary and provisional terms.'[11]

While Ethiopia never fell under the administrative rule of a European power aside from the brief war-time occupation by Italy, several commentators felt certain that the nation would best be served by strong-handed foreign assistance. John Melly, a British physician who worked in Ethiopia in the 1930s, attempted to solicit funds from England to establish the first Ethiopian medical school. Melly died in Ethiopia during the Italian occupation, and in a biography of the late physician, he was praised for wanting 'so badly to bring civilisation to the haughty, ignorant peoples of Ethiopia [who] badly needed him.'[12]

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[9] M. Perham, *The Government of Ethiopia* (London, 1969), p. 237.
[10] Zewde, *History of Modern Ethiopia*, p. 106.
[11] Perham, *Government of Ethiopia,* p. 237.
[12] K.S. Nelson and A. Sullivan, *John Melly of Ethiopia* (London, 1937), p. 113.

The characterisation of Ethiopians as 'haughty and ignorant' is largely rooted in their historical independence. Aside from Liberia, Ethiopia was the only African nation to escape European conquest at the height of colonialism on the continent. For European commentators, this independence not only meant that the nation was more backward in their traditions, but also that they were fundamentally incapable of self-administering western-style institutions, including medicine. When considering supporting Haile Selassie through the donation of medical aid in 1944, one British official noted that 'any medical assistance given to Ethiopia without external control would be wasted.'[13] Two decades later, a similar debate among British officials on the wisdom of granting aid to the East African Empire was met with the warning, 'however much [aid] they deserve, I wonder whether they really enjoy being lectured to in this way?'[14] It was believed that to receive foreign assistance, Ethiopia must come under some degree of control from the European donors. There was little confidence in Haile Selassie's capacity to administer a modern medical network 'without external control,' given the continued belief in the emperor's languid traditionalism. By the 1960s, the British understood that the independent state was wary of receiving the accompanying 'lectures' of foreign donors, but it was never suggested that aid be given solely on Ethiopia's own terms.

The independence of Ethiopia from European control was a central problem in the foreign conception of Haile Selassie and his empire. Given the emperor's own penchant for appeasing foreign dignitaries with the construction of western-style schools and hospitals, he opened himself up for external censure and comparison.

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[13] United Kingdom National Archive, FO 371/41488, Dr. Barkhus, Advisor to the UK foreign office, Addis Ababa, Activities of Miss E. Sylvia Pankhurst during her visit to Ethiopia: British policy towards Ethiopia, Code 1 File 202 (London Kew Gardens, 1945).

[14] United Kingdom National Archive, FO 1043/83, Dr. E.D. Pridie, Medical advisor to the British Middle East Office, Ethiopian/US relations and military aid (London Kew Gardens, 1967).

Haile Selassie spoke of inducing a 'foreign-inspired civilisation' into his empire, and frequently characterised his own people as overtly backward and steeped in tradition.[15] While it is dangerous to fall into the trap of continuing to criticise the emperor based on external, European markers of modernity, he himself repeatedly defined his modern project within the boundaries of Westernisation. Haile Selassie built Western-style schools, hiring American Peace Corps volunteers to teach the pupils in English. He fully rejected any indigenous model of healing in favour of European medicine, importing physicians from across Europe and North America. Within the government, the emperor wrote a constitution and installed a parliament, both of which were clearly modelled off Western European modes of governance.

At the same time, it can be argued that the emperor's reforms were mere performances of a Western-style modernity, most notably within his governing structure. Despite their overt indebtedness to Westernised administration, these reforms only served to further entrench the emperor's own existing position as absolute monarch. Haile Selassie may have outwardly declared his interest in 'foreign-inspired civilisation,' but such interest was largely conditional to his personal interests for power.

'Zemenawinet': the coup of 1960 and grassroots modernisation

Critics of the emperor were right to note the discrepancy between the appearance of a 'European modernity' in Ethiopia and the perpetuation of indigenous traditions, especially as related to the retention of a monarchical hierarchy. In pitting European modernity against national traditionalism, however, external critics ignored not only

[15] H. Selassie, *My life and Ethiopia's progress, 1892-1937: the autobiography of Emperor Haile Selassie I* (Oxford, 1976), p. 6. See also, H. Selassie, *Important utterances of H. I. M. Emperor Haile Selassie I, 1963-1972* (London, 1994).

the multiple meanings of Ethiopian modernity - *'zemenawinet'* in Amharic - but also several groundswell movements among the nation's citizens for more substantial reform.

In the last years, the work of Ethiopian intellectuals, most notably Bahru Zewde and Andreas Eshete, has helped fill the gaps in historiography on Ethiopia's modernisation. Up to this point, debates and critiques of Haile Selassie have been driven by Western scholars who largely neglect indigenous movements opposed to the emperor in favour of comparative studies of the imperial regime to Europeanised counterparts. It is dangerous to assume that the imperial definition of modernisation-as-Westernisation was universal among the Ethiopian population, and a more inclusive re-writing of Ethiopian historiography is necessary.[16] Modernity in Ethiopia was driven not just by state directives, but also community actions. Both Zewde and Eshete are prominent figures in reclaiming some of the more radical elements of Ethiopian history to assert the plurality of modernity in the Ethiopian case. In Eshete's estimation, modernisation is defined by the 'popular legitimate rule by free and equal citizens, the abolition of all privileges of birth or inherited position, equality of faiths and cultural communities, industrialisation, and secularism.'[17] For Zewde, definitions of the word 'modern' in Ethiopia have too often been measured by a yardstick of Westernisation. There are historic alternatives

[16] In addition to the work cited here, see also the work of Elizabeth Wolde Giorgis and Paulos Milkias for further explorations on the multiplicity of meanings of modernity in the Ethiopian context. E.W. Giorgis, 'Charting out Ethiopian Modernity and Modernism', *Callalo Special Issue: Ethiopia, Literature, Art and Culture*, vol. 33, no. 1 (Winter 2010), pp. 82-99; P. Milkias, *Haile Selassie: Western Education and Political Revolution in Ethiopia* (Youngstown, NY, 2006).

[17] A. Eshete, 'Modernity: Its Title to Uniqueness and its Advent in Ethiopia', in *What is 'Zemenawinet'? — Perspectives on Ethiopian Modernity* (Addis Ababa, 2012), p. 12.

to European modernisation that are equally relevant to the Ethiopian case, most notably from Japan and Russia.[18]

For both authors, the historic movements of Ethiopian intellectuals and students in the twentieth century are prominent examples of the ways in which the nation's communities worked to undercut the limitations of official discourses on modernity. The attempted coup of June 1960 was especially critical in galvanising imperial critics to fight for modernisation in the form of greater freedom of expression. The coup was led by a combination of students and Imperial Guard members, and saw the short imprisonment of government ministers and declaration of Haile Selassie's eldest son, Asfaw Wossen, as emperor. While Haile Selassie rapidly quashed the attempted coup and eliminated its leaders, the events of 1960 had repercussions over the next decade, culminating in the eventual successful overthrow of the emperor in 1974. Students coalesced into a movement, organising against the emperor and airing grievances on his authoritarianism and lack of reform.

Andreas Eshete calls this student movement the true 'midwife to modernity' in Ethiopia.[19] Before the student marches, Ethiopia had seen mere preludes to modernity, the most notable being the nation's own independence from colonial conquest. Eshete notes that in defeating the Italians at the Battle of Adwa in 1896, Ethiopia led the charge for modernity in Africa by proclaiming a space for independent self-expression.

Unfortunately, this bold assertion was short-lived with the failure to innovate under Haile Selassie. In 1960, Gabre-Heywat asked, 'can one really say that we Ethiopians are independent? Independence does not consist in merely having one's own government. It presupposes self-sufficiency. And the people of Ethiopia have

[18] B. Zewde, *Pioneers of Change in Ethiopia : the Reformist Intellectuals of the Early Twentieth Century* (Oxford, 2002), p. 1.
[19] Eshete, 'Modernity: Its Title to Uniqueness and its Advent in Ethiopia', p. 13.

yet to be self-sufficient.'[20] Just as neighbouring countries languished under the oppression of foreign colonial rule, the static authoritarianism of imperial Ethiopia quelled citizens' potential from adequately modernising. Takle-Hawaryat noted that his 'countrymen would face certain humiliation unless they modernised.'[21] But the vehicle to modernisation was not state-led reform and 'blind imitation of the West.' Bahru Zewde censures colonial African regimes for merely importing the institutions of the West into the African context in the name of modernity. While Takle-Hawaryat actually asked if 'it would have been better if the civilised nations had colonised us for a short period of time,'[22] both Zewde and Eshete reject the colonial model for modernisation in Ethiopia. In their estimation, Haile Selassie himself fell into the trap of his colonial counterparts by merely copying Western institutions in the name of modernity, ignoring the larger meaning of modern reform for the Ethiopian population. In contrast to their colonial neighbours, Eshete explained that 'gaining entry into the modern world posed peculiar problems for Ethiopia, problems that do not readily arise in the rest of Africa.'[23] While colonialism had abolished indigenous institutions in neighbouring African countries, it was the very continuation of institutional 'relics of a pre-modern past' in Ethiopia that inhibited its modernisation. Eshete's commentary on the distinct case of Ethiopian modernity in relation to colonial Africa is instructive and worth quoting at length:

> [In Ethiopia,] an absolutist crown, an established religion, an official language and privileged public culture became constitutionally entrenched, institutionally bolstered by a standing army and a bureaucracy and their claim to legitimacy cultivated and instilled through modern schools and media. . .For most of Africa, as seen in the ruling ideologies of the time, such as Négritude, liberation could be seen as becoming free from what is

[20] Zewde, *Pioneers of Change in Ethiopia*, p. 101.
[21] Ibid., p. 100.
[22] Ibid.
[23] Eshete, 'Modernity: Its Title to Uniqueness and its Advent in Ethiopia', p. 22.

> unmistakably alien and affirming what was deemed truly one's own. For Ethiopia, emancipation was a rather different matter of going against the grain, calling for a clean break from a political landscape and a public culture that deeply defined our collective self-identity.[24]

For Eshete, citizens of colonial states had to find a comfortable place between reclaiming indigenous tradition without 'regressing' into a pre-modern past. In Ethiopia, by contrast, the traditions themselves were propped up as pseudo-modern and progressive under the emperor. Haile Selassie used Western modes of administration to justify his own traditionalism, so his opposition were forced to turn to alternative expressions of modernity.

Eshete explains that this is why the student movement turned to Russian-style socialism in fighting against 'absolutist public authority as well as debilitating claims of inherited class and cultural privilege.'[25] The socialist thrust to the imperial opposition culminated in the successful coup of 1974, which installed the Derg military regime. The Derg would craft its own mission to modernise Ethiopia, not by imitating the West, but in importing socialist rhetoric from East Germany, Russia, and Cuba. Similar to Haile Selassie, the Derg faced its own home-opposition in the form of the current regime who came to power in 1991, and the meaning of modernisation in Ethiopia has continued to be contested. In re-locating the debates on Ethiopian modernity within the nation itself, it is evident that state narratives are largely inadequate in defining modernisation for the nation. Ethiopia's modernity cannot be measured in comparison to either Europe or colonial Africa, but within its own borders and among its own citizens.

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[24] Ibid.
[25] Ibid., p. 23.

The question of Ethiopian exceptionalism

While the intellectual debate on the meanings of modernity in Ethiopian history is highly instructive to my own study of women and childbirth under Haile Selassie, I am aware of the problematic nature of discourses on modernity in twentieth-century history. Stacy Pigg has rightly stated that 'modernity is quite literally a worldview: a way of imagining both space and people through temporal idioms of progress and backwardness.'[26] Throughout the thesis, I discuss Haile Selassie's expansion of Western medicine in Ethiopia in the context of 'modernisation' as defined both by the emperor and medical practitioners at the time. When I use the terms 'modernisation' and 'modernity' in this thesis, I define them within the emperor's own conceptual framework of Westernisation. In this text, modernisation often becomes synonymous with Europeanisation, as this was largely the intention of Haile Selassie and his national development policy.

At the same time, in discussing the history of Ethiopia's early modernisation in this way, I could easily fall into the trap described by Pigg to 'produce the very differences' in my subject on the invented lines of tradition versus progress that I aim to critique.[27] I am also conscious of Donald Donham's caveat to historians who could operate on the 'apparently simple fact' that actors like Haile Selassie 'view their societies as "behind" and in need of a way to "catch up."'[28] While this thesis presents the history of medicine as a means of modernisation, or 'catch-up' for Ethiopia, I present that narrative only within the official definition of the emperor and his retinue of advisors. I operate within such actors' contemporaneous

[26] S.L. Pigg, 'The Credible and the Credulous: The Question of "Villagers' Beliefs" in Nepal', *Cultural Anthropology*, vol. 11, no. 2 (May 1996), p. 163.
[27] Ibid.
[28] D.L. Donham, *Marxist modern: an ethnographic history of the Ethiopian revolution* (Berkeley, 1999), p. xv.

definitions of tradition and modernity throughout the thesis, but also describe multiple counter-narratives of women's experiences under the imperial regime. These women all interacted with modernisation schemes through medical encounters, but were not beholden to official rhetoric on a universal and teleological modernity.

In presenting these additional experiences with modernity in imperial Ethiopia, I hope to undercut the limitations of official definitions and expose the plurality of modernities within the Ethiopian context. Medicine was a state enterprise and tool for the modernisation of Ethiopian life. Women were peripheral members of the state with little administrative power or economic control who were then co-opted into the state's modernist enterprise. Despite this co-option, women were deliberate in seeking the most appropriate avenues into modernist campaigns that would benefit themselves and their families. Their expressions of 'modernity' were more varied than the singular Westernised discourse prescribed by official policy. As both practitioners and patients, women negotiated their relationships to the externally-biased modernisation of imperial Ethiopia based on intersecting conditions of class, gender, and geography.

This community rejection of official narratives is unsurprising, and hardly unique to the Ethiopian case. Twentieth-century African history is characterised by this contentious relationship between communities and modernising enterprises of the state. James Ferguson's seminal study of the Zambian Copperbelt, *Expectations of Modernity*, exposes the myth of state-driven modernity in relation to community life. Official narratives dictated a tidy teleology for the Copperbelt, where increased industrialisation and urbanisation would lead to the creation of European-style families and standards of living. Such expectations were thwarted by economic

collapse in the global copper market, and alternative livelihoods proliferated within Zambian communities as they coped with the failed promises of modern life.[29]

In an essay to follow the publication of *Expectations of Modernity*, Ferguson explains that his study of Zambia works against what he deems 'the modernist metanarratives through which urban life in Africa has so far been understood.'[30] Ferguson not only fights against the Eurocentrism of singular modernism, but also asserts the importance of failure and disappointments in our analysis of social change. A 'failure to modernise' may mean a failure to Europeanise, but this does not mean that the society is trapped in some level of invented 'backwardness.' A certain level of subjective bias is inherent in any definition of 'modern' and 'backward.'

Indeed, Jean and John Comaroff have argued that 'there are, in short, many modernities,' and that even in Europe, there has been no linear progression of a single modernisation. When the vision of Europe was extended outwards to the colony, the actual contention against Westernised modernity was made more obvious. Colonial 'citizens struggled, in diverse ways and with differing degrees of success, to deploy, deform, and defuse imperial institutions.'[31] Frederick Cooper has stated that modernity was 'an imperial construct, a global imposition of specifically Western social, economic and political forms that tames and sterilises the rich diversity of human experience.'[32] Elísio Macamo has argued that 'there is something ambivalent about the experience of modernity in Africa,' and that African subjects

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[29] J. Ferguson, *Expectations of Modernity: Myths and Meanings of Urban Life on the Zambian Copperbelt* (Berkeley, 1999).

[30] J. Ferguson, 'Global Disconnect: Abjection and the Aftermath of Modernism', in P. Geschiere, B. Meyere, and P. Pels (eds.), *Readings in Modernity in Africa* (Oxford, 2008), p. 8.

[31] J. Comaroff and J. Comaroff, *Modernity and its Malcontents: Ritual and Power in Postcolonial Africa* (Chicago, 1993), p. xii.

[32] F. Cooper, *Colonialism in Question: Theory, Knowledge, History* (Berkeley, 2005), pp. 113-114.

were forced to 'carve a space for themselves' within authoritarian state enterprises that used Europeanisation as a measurement of a community's adherence to modern life.[33]

At the same time, given the lack of colonial conquest in Ethiopia, it is surprising to see such strikingly similar patterns of behaviour among state subjects, especially in regards to medicine. I chose to explore the history of women and childbirth in Ethiopia in part because of the historic exceptionalism of the independent African nation. Without the history of prolonged colonial conquest and foreign administrative control, the modernisation of both the nation and its medical systems was driven primarily by internal forces. In the field of academic enquiry, there is an existing framework for African medical history that has largely focused on the role of colonial regimes in developing modern medical systems as a mechanism for imperial expansion. Scholars have clearly demonstrated how modern medicine was used by colonial regimes to assist in campaigns of domination and control, with concerns for population health and morality, in addition to the economic protection of colonial labour forces, primarily driving the widespread medicalisation of maternity. Insomuch as Haile Selassie was engaged in his own state-building enterprise modelled on European institutions, several themes within the existing colonial framework are relevant to the Ethiopian case. However, because all direction for the development of a modern medical network in Ethiopia originated with a local ruler and local administrators, notions of indigenous appropriation and agency within histories of both medicine and modernity across Africa are duly complicated.

It is important to note here that my study of the Ethiopian state is largely exclusive of the Eritrean territory. Unlike the rest of Ethiopia, Eritrea was colonised

[33] E.S. Macamo, *Negotiating Modernity: Africa's Ambivalent Experience* (Dakar, 2005), p. 1.

and administered by Italy from 1890 until the ousting of Italian forces from the region in 1941. The territory of Eritrea was annexed into Haile Selassie's rule in 1947, but then declared its long-sought independence in 1993. At the time of Haile Selassie, Asmara was the second-largest city in the empire, had its own nursing school, auxiliary training college, and expansive hospital network. This network was founded on the backs of Italian institutions, and the legacy of colonialism was no doubt profound in shaping the population's interaction with modern medicine. While there are references to the Asmara nursing school within the text, I do not have space in this study to explore the case of Eritrea in detail. The colonial legacy in Asmara necessitates an additional field of enquiry that is not readily comparable to the history of Addis Ababa. While Eritrea came under Ethiopian rule for the duration of my study period, I did not have the resources or space to consider the comparative nature of the two nations' histories in relation to medicine. Further, while Ethiopia's medical history is largely unwritten, there are a number of Italian scholars who have published histories on Eritrea's medical past, most notably Chelati Dirar and Giulia Barrera.[34]

This study therefore examines Ethiopia both from a state of exception and also similarity in relation to Africa. Omitting the Eritrean experience, I consider both the introduction and development of modern medicine in Ethiopia to be indigenous efforts. I am interested in the Ethiopian case not only because of the unique history of an indigenous African regime appropriating European institutions to assert their own modernity, but also because of the ways in which this exceptional case enriches the definitions of modernity and medicine for the continent as a whole. The history of medicine under Haile Selassie is largely a history of failure: failed institutions

[34] C. Dirar, 'Curing Bodies to Rescue Souls: Health in Capuchin's Missionary Strategy in Eritrea, 1894-1935', in D. Hardiman, *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (Amsterdam, 2006), pp. 251-280.; G. Barrera, *Dangerous Liaisons: Colonial Concubinage in Eritrea, 1890-1941* (Evanston, 1996).

with limited outreach and no measurable impact in the health and well-being of the population. But within this 'failed modernism' are complex stories of indigenous agency and individual protest against state narratives. When I say that Haile Selassie's modernisation failed, I do not mean that Ethiopia is un-modern or pre-modern, but that the state's conception of modernisation and social change was limited within a Western-driven narrative of teleological change. Considering both Ferguson's call for a broader inclusion of failure in modernist discourses, and Eshete's discussion of the radical fight against imperial definitions of modernity and progress in Ethiopian history, the case of Ethiopian medical history provides a rich source of new material on the question of modern development in Africa.

Exploring 'local agency' and the role of indigenous actors in negotiating state medical enterprises

Given Ethiopian subjects were reacting against indigenous leadership, not foreign colonisers, in negotiating the terms of their modernity through medicine, it has been instructive for me to expand my literature review to explore the notion of local agency both inside and outside Africa. In the introduction to *Gendered Colonialisms in African History*, the editors argue for a widened understanding of local agency even within colonial contexts, arguing that 'colonised African subjects were not always or only creatures of colonial hegemonic institutions.'[35] Lynn Thomas' work on the female circumcision crisis in Kenya has demonstrated that to situate medical histories in Africa 'within a bifurcated narrative of indigenous responses to European impositions would flatten the complexity of local conflicts,

[35] N.R. Hunt, T.P. Liu, and J.H. Quataert (eds.), *Gendered Colonialisms in African History* (Oxford, 1997), p. 5.

dilemmas, and meaning-making that were at the core of social action.'[36] It is necessary to explore more varied, social entry-points into the institutionally-driven histories of modern medicine's expansion on the continent.

Over thirty years ago, John Janzen and Steven Feierman proposed a shift in focus 'in historical writing about medicine in Africa from the history of a single medicine, usually colonial medicine and its victories.' Instead, the authors called for a 'social history of concurrent perspectives on diseases, forms of therapies, accompanying social conditions and the underlying reasons for the ascendance, persistence, and decline of constellations within a society's or region's general medical system.' Such social histories would thus expose 'how disease has been perceived and how it has been dealt with' directly by relevant populations.[37]

In the years since Janzen and Feierman's call for an increase in social histories of medicine, there have been numerous notable studies that divulge the overlapping responses of African communities both to state medical projects and their individual health concerns. This includes new studies on the practice and persistence of local medicine alongside state-driven biomedical projects, most significantly the edited volume, *The Professionalisation of African Medicine*.[38] In addition, the role of indigenous actors in the construction of national medical networks as auxiliaries, physicians, and administrators has been duly investigated, particularly in the works

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[36] Ibid., p. 4.

[37] J.M. Janzen and S. Feierman, 'Introduction: The Social History of Disease and Modern Medicine in Africa', *Social Science & Medicine. Part B: Medical Anthropology*, vol. 13, no. 4 (December 1979), p. 239.

[38] M. Last and G. L. Chavunduka, *The Professionalisation of African Medicine* (Manchester, 1986). For an excellent review of the continued development of traditional maternal health systems alongside state-driven medical projects in Africa, see: T.M. Kanogo, *African Womanhood in Colonial Kenya, 1900-50* (Oxford, 2005).

of John Iliffe, Maryinez Lyons, and Jane Turrittin.[39] Turrittin's study of Auoa Kéita, a Malian midwife trained at the École de Sages-Femmes in Dakar is an especially useful example of the ways in which local practitioners both utilised their medical training to improve professional practice and prestige, while simultaneously subverting colonial discourses of race and power.

Nancy Rose Hunt's work on childbirth in the Belgian Congo also explores in vivid detail the ways in which indigenous nurses and midwives worked both within the parameters of the colonial mission to medicalise birth, while also incorporating local traditions and custom into medical practice.[40] More recently, Ryan Johnson and Amna Khalid have published a notable edited volume on the use of intermediaries and subordinates in the practice of public health in the British Empire at large, again arguing that the pivotal role of indigenous practitioners of health in shaping British policy remains overlooked. As the editors argue, 'it was the intermediary and subordinate workers that often determined people's experience of public health,' thus a population's uptake of imperial medicalising missions was much more determined by local forces than previously conceded in literature driven by a top-down rhetoric.[41]

At the same time, scholars of colonial India have made significant strides in demonstrating the role of local elites in perpetuating and expanding colonial medical

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[39] J. Iliffe, *East African Doctors: A History of the Modern Profession* (Cambridge, 1998); M. Lyons, 'The Power to Heal: African Medical Auxiliaries in Colonial Belgian Congo and Uganda', in D. Engels and S. Marks (eds.), *Contesting Colonial Hegemony: State and Society in Africa and India* (London, 1994), pp. 202–225; J. Turrittin, 'Colonial Midwives and Modernizing Childbirth in French West Africa', in J. Allman, S. Geiger, and N. Musisi (eds.), *Women in African Colonial Histories* (Bloomington, 2002), pp. 71–94.

[40] One notable figure in Hunt's narrative, Nurse Lofts, was described as a 'midwife-witch' for the ways in which she integrated indigenous prayers and medications into the clinic. N.R. Hunt, *A Colonial Lexicon of Birth Ritual, Medicalization, and Mobility in the Congo* (Durham, 1999), pp. 202-220.

[41] R. Johnson and A. Khalid (eds.), *Public Health in the British Empire: Intermediaries, Subordinates, and the Practice of Public Health* (New York, 2011), p. 4.

missions. David Arnold has argued that the British were aware that 'the future of Western medicine in India lay not with Europe's colonisers but with India's emerging elites.'[42] Mark Harrison and Pati Biswamoy have shown how in Madras City, prominent local individuals gave substantial endowments to the building of hospitals, dispensaries, and the construction of sanitary engineering projects.[43] This support was by no means universal in India, but the British operated under a long-term logic that it would be 'indigenous agency' that would ultimately 'make Western medicine effective.' Indeed, even after their departure, the adoption of medical and other social programmes initiated by the colonial administration would truly become the 'basis for [Indians'] own right to rule.' Conceding the limitations in manpower and resources within the colonial project, Arnold argues that once the local administration took over, they would be able to use medicine to 'transform society on a scale the British had never thought practical or politically expedient.'[44]

The adoption of Western medical approaches by non-Western regimes was not only a feature of post-colonial administrative hand-over, however. Indeed, the last decade has also seen a welcome expansion of academic enquiry into the indigenous development of medical systems within non-colonial contexts. As a scholar of 'mixed medicines' in Southeast Asia, Sokhieng Au has argued that we must historicise the 'globalisation of medicine:' instead of viewing the historic development of biomedicine as merely a European and/or colonial enterprise, we

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[42] D. Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley, 1993), p. 294.

[43] B. Pati and M. Harrison, *Health, Medicine and Empire: Perspectives on Colonial India* (New Delhi, 2001), p. 5. In M. Harrison, *Public Health in British India: Anglo-Indian Preventive Medicine, 1859-1914* (Cambridge, 1994), the author also asserts that the extent to which Indians played an active role as policy makers at local and municipal levels of health administration has been overlooked.

[44] D. Arnold, 'Public Health and Public Power: Medicine and Hegemony in Colonial India', in D. Engels and S. Marks (eds.), *Contesting Colonial Hegemony: State and Society in Africa and India* (London, 1994), p. 151.

must expand the historic vision to see how medicine was literally globalised in the twentieth century, adopted and appropriated by a multitude of independent actors in parallel with colonial expansionism, but not always in relation to the colonial project.[45] David Sowell has examined the ways in which the Mexican Government 'aimed to enhance its authority through advancing healthcare' in a Western model, weakening indigenous medical systems.[46] Anna Afanasyeva has also published a useful study on the 'internal colonisation' of Kazakh steppes by the Russian Empire in the early 19th century through the means of medical expansion.[47] Lastly, Hormoz Ebrahimnejad has pioneered several studies on the development of modern medicine in Iran.[48]

It is this thread of enquiry that is perhaps most informative for my own study of Ethiopia. I hope that this thesis will help build off of recent scholarship on the development of Western medicine in non-Western contexts. Within this field, Hibba Abugideiri's work is especially useful to my studies because it confronts the history of gendered constructions in modern Egypt, examining the place of women in modern medicine's development both as patients and as practitioners. Abugideiri argues that in fixating on the construction of a modern state project, the Egyptian government actively utilised medicine to create new social orders within communities along gendered lines. She has shown how the position of women in medicine was highly restrictive, and that the administration 'emasculated midwives

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[45] S. Au, *Mixed Medicines: Health and Culture in French Colonial Cambodia* (Chicago, 2011).

[46] D. Sowell, 'Multiple Colonizations: State Formation, Public Health and the Yucatec Maya, 1891-1960', in A. Digby, W. Ernst, and P.B. Mukharji (eds.), *Crossing Colonial Historiographies: Histories of Colonial and Indigenous Medicines in Transnational Perspective* (Cambridge, 2010), pp. 77–98.

[47] A. Afanasyeva, 'Russian Imperial Medicine: The Case of the Kazakh Steppe,' in A. Digby, W. Ernst, and P.B. Mukharji (eds.), *Crossing Colonial Historiographies: Histories of Colonial and Indigenous Medicines in Transnational Perspective* (Cambridge, 2010), pp. 57–76.

[48] H. Ebrahimnejad (ed.), *The Development of Modern Medicine in Non-Western Countries: Historical Perspectives* (New York, 2009); H. Ebrahimnejad, *Medicine, Public Health and the Qājār State: Patterns of Medical Modernization in Nineteenth-century Iran* (Boston, 2004)

to the level of caretakers and assistants.'[49] Abugideiri argues how 'medicine was more than instrumental in the creation of Egyptian national identity and belonging,' and that the crafting of such an identity precipitated an emasculation of women.[50]

The history of medicine in Ethiopian studies

The field of global history has expanded considerably in the last decade to explore the varied experiences of non-colonial actors in modernising their states through medicine. Ethiopia has been a neglected case study in this global narrative, however. Not only has the place of Ethiopia's modernisation in global history been overlooked, but even within Ethiopia's own historiography, the role of medicine as a vehicle for modernisation has not been explored.

There have been a handful of superficial overviews of Ethiopia's medical history published both by historian Richard Pankhurst and Ethiopia's own Public Health Association. While these studies provide cursory accounts of significant historic events in medicine's development, neither author offers any further analysis on the meaning of modern medicine in Ethiopia's larger history and development. [51]

Before 1900, travelogues and official correspondence of European travellers and diplomats to Ethiopia are helpful in narrating key events in the history of modern

[49] H. Abugideiri, *Gender and the Making of Modern Medicine in Colonial Egypt* (Farnham, Surrey, 2010), p. 6.
[50] Ibid., p. 17.
[51] R. Pankhurst, *An Introduction to the Medical History of Ethiopia* (Trenton, 1990); R. Pankhurst, 'The Beginnings of Modern Medicine in Ethiopia', *Ethiopia Observer,* vol. 9, no. 2 (1965), pp. 114–160; Y. Kitaw, *The Evolution of Public Health in Ethiopia 1941-2010* (Addis Ababa, 2012). In addition, Pankhurst has contributed several targeted studies on specific diseases and treatments in Ethiopia: R. Pankhurst, 'The History of Cholera in Ethiopia', *Medical History,* vol. 12, no. 3 (July 1968), pp. 262–269; R. Pankhurst, 'The History and Traditional Treatment of Smallpox in Ethiopia', *Medical History,* vol. 9, no. 4 (October 1965), pp. 343–355; R. Pankhurst, 'Old-time Ethiopian Cures for Syphilis, Seventeenth to Twentieth Centuries', *Journal of the History of Medicine and Allied Sciences,* vol. 30, no. 3 (1975), pp. 199–216.

medicine in the country.[52] These accounts are filled with tales of exploratory medical campaigns and the dispersion of Western medicaments to court officials. It seemed impossible for any European visitor to Ethiopia to not engage in amateur medical work, and the imperial court was happy to receive whatever treatments were doled out. Medical diplomacy in Ethiopia reached its apex under Menelik II, as the emperor became increasingly debilitated by syphilis. A dozen nations sent medical envoys with the promise of cure. Such promises were dubious at best, and the relationship between Western medicine and the imperial court was momentarily staid.[53]

Aside from these studies, in 1988, Helmut Kloos published an overview of the *Ecology of Health and Disease in Ethiopia* that is the most useful source in examining the connection between modern medicine and community life in Ethiopia.[54] The source is limited in its historic breadth, however, as it largely discusses the conditions of medical care in Ethiopia in the decade of the 1980s.

This thesis aims to fill a considerable historic gap, investigating the historical development of modern medicine in Ethiopia both from the perspective of the state and community. I both describe the state's activities, and also counteract official policies in narrating community experiences with the nation's medical apparatus. I couch this study within larger global trends of modernisation, development, and medicalisation, asserting the place for Ethiopia within a wider historiographic framework. This thesis represents the first analytic overview of medical history in

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[52] F.C. Dunckley, *Eight Years in Abyssinia* (London, 1935); J.L. Krapf and E.G. Ravenstein, *Travels, Researches, and Missionary Labors, During an Eighteen Years' Residence in Eastern Africa* (London, 1860); D.R. Buxton, *Travels in Ethiopia* (London, 1967); A.W. Hodson, *Seven Years in Southern Abyssinia* (London,1927); A.B. Wylde, *Modern Abyssinia* (London, 1901); R. Pankhurst, *Travellers in Ethiopia* (Oxford, 1965).

[53] C.P. Rosenfeld, 'The Medical History of Menilek II, Emperor of Ethiopia (1844-1913): a Case of Medical Diplomacy', *Munger Africana Library Notes*, no. 45/46 (October 1978).

[54] H. Kloos and Z.A. Zein, *The Ecology of Health and Disease in Ethiopia* (Addis Ababa, 1988).

Ethiopia, and opens the field for further enquiries into the historic meaning of both modernity and medicine in the independent East African Empire.

Historiographies of birth and modernity in Africa

While this thesis contributes to global histories of African medicine and modernity, it also provides an additional case study into the larger history of childbirth's medicalisation in the twentieth century. I have drawn heavily from the literature on birth, gender, and the medicalisation of maternity both in Africa and abroad, and am especially indebted to the pioneering studies of Nancy Rose Hunt, Tabitha Kanogo, and Lynn Thomas on the socio-political meanings of birth reform in the Belgian Congo and British Kenya. Ethiopia was by no means unique in targeting women's reproduction as a means of national development: Hunt, Kanogo, and Thomas all expose the ways in which birth choices in the colonies intersected with notions of status and modernity. When investigating shifting birth practices across Africa, it is evident how cultures of modernity were embodied in female reproduction. As in Ethiopia, both the state and women themselves began to assert their modernity by means of the clinic.

Hunt admits that her study of the Belgian Congo began with her own scepticism of the remarkable statistics on clinical births from the Belgian Colonial office: in 1935, just 1% of births were medically supervised, a number which jumped to 28% in 1952 and to 43% in 1958.[55] This is by far the highest percentage of clinic births in post-WWII Africa, and Hunt began her investigation by querying 'why Congolese

[55] Hunt, *Colonial Lexicon*, p. 4.

women complied with colonial desires in such great numbers, and if they did so with the ease the colonial documents imply.'[56]

In exploring this question on women's compliance, *Colonial Lexicon* begins to expose the ways in which the colonial state crafted a narrative of medical superiority which encouraged women to the clinic. Significant subsidies were given to women who chose clinic births, while mining and other industrial enterprises were all built with accompanying birthing centres. Missionaries were responsible for marketing the clinic, and local midwives were trained and deployed to communities as medical ambassadors. The state's intention to secure an expansive colonial labour force through improved reproduction was widely acknowledged, but some women were evidently attracted by the prospect of the new clinics out of personal interest. With the emergence of a Congolese middle class in the 1950s, birth choices began to be increasingly tied to an individual's social status. When Hunt conducted fieldwork in the 1990s, the jest *'moi, je suis né à la maternité, mais toi, tu suis né à la case'* was still commonly used.[57] In 1950, a journal in the Congo published an essay stating 'we must no longer tolerate the attitude of certain of our compatriots who prefer to give birth on the ground while our cities are endowed with maternity wards equipped with all modern scientific equipment.' Hunt concludes that 'maternity wards joined bicycles and sewing machines as markers of social class, as the signs of rising, middle status in Belgian colonial Africa.'[58]

In *Curing their Ills*, Megan Vaughan described how obstetrics became one of the most accepted and sought after medical practices by the emergent African middle

[56] Ibid., p. 5.
[57] 'I was born in the clinic, but you - you were born in a hut.' Ibid., p. 13.
[58] Ibid.

class.[59] This was clearly the case in the Congo, and both Thomas and Kanogo's work in Kenya have likewise demonstrated how the British colonial state used medicine as a mark of modernity for Kenyan women. There was a moral thrust to the Kenyan case, particularly within the numerous missions which worked to 'clean up' female recruits, both in terms of physical and moral sanitation.[60]

Not only was medicine the ultimate marker of modernity, but those African women who participated in medical enterprises displayed external markers of modernity in comportment and dress.[61] Modernity was seen as an external and measurable quality, especially for newly-trained nurses. Thomas quotes one missionary in describing a group of recently-trained Kenyan nurses as 'bright, intelligent young creatures with their white gowns and caps.'[62]

In Ethiopia, nurses were the first generation of professional women, and given the radical nature of their position in the state medical enterprise, nurses were explicit in outwardly displaying their status in relation to the traditional society around them. Indeed, the sartorial demonstration of modernity was in many ways part of the appeal of the new professions open to women. In an interview with Shewaye Gebre Kirkos, a nurse who trained at the Princess Tsehai Hospital in Addis Ababa in the 1960s, Shewaye explained how when nurse probationers from the Tsehai Hospital came to recruit at her school, 'the uniform was the first thing I saw. The uniform - with the cape and everything - it was so attractive!' Retelling the day

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[59] M. Vaughan, *Curing their Ills: Colonial Power and African Illness* (Stanford, 1991).

[60] T. Kanogo, 'Mission Impact on Women in Colonial Kenya', in F. Bowie, D. Kirkwood, S. Ardener (eds.), *Women and Missions: Past and Present. Anthropological and Historical Perceptions* (Oxford, 1993), p. 169.

[61] Timothy Burke's work on the commodification of cleanliness in Zimbabwe is the best investigation of external markers of modernity, status, and health in Africa. T. Burke, *Lifebuoy Men, Lux Women: Commodification, Consumption, and Cleanliness in Modern Zimbabwe* (Durham, 1996).

[62] L. Thomas, *Politics of the Womb: Women, Reproduction, and the State in Kenya* (Berkeley, 2003), pp. 55-56.

of her recruitment, Shewaye laughed as she recalled how the Westernised wardrobe of the medical nurse was what drew her first to the profession.[63] And similar to the Kenyan missionary noting the 'bright' intelligence of the gowned nurse recruits, American faculty members at the Itegue Menen School of Nursing in Asmara asserted that 'students look very professional in their white bibs and aprons reporting "on" and "off" duty.'[64]

Defending indigenous birthing cultures

While increasing numbers of African women were recruited into the clinic, both as patients and practitioners, with the promise of improved social status, the privileges of modern medicine were largely predicated on existing conditions of wealth and class. The absorption of official rhetoric on the importance of altering birth customs in the name of national modernisation was by no means universal, and there are numerous accounts of local resistance to clinical birthing models. In *Politics of the Womb*, Thomas describes in detail the fraught campaigns of the British against home birthing traditions, and the ways in which Kenyan women inverted official prejudices against indigenous practices. Home birth was considered a 'repugnant' practice aligned with female excision, and Kenyan women were strident in their defence of local customs, largely as part of anti-colonial political expression.

For birth itself, there was a prevailing understanding throughout the 1930s-40s that 'no Kenyan women came to hospitals to give birth,' but instead arrived only in

[63] Author interview with Sister Shewaye Gebre Kirkos, Addis Ababa, 15 October 2012.

[64] United States NARAs and Records Administration (NARA), RG469 UD756, Records of US Foreign Assistance Agencies: Health Reports Relating to Ethiopia compiled 1955-1958 (College Park, MD, 1958). From this point onwards in the thesis, I will use the acronym NARA when referring to the United States NARAs and Records Administration.

the case of serious abnormalities and malpresentation.[65] Kanogo has explained how colonial authorities had to contend with the 'prevailing belief that maternity is a natural condition that does not call for hospitalisation.'[66] The British began recruiting Kenyan elders to convince village women to deliver at the new modern clinics, but for most women, 'childbirth was a closely guarded affair because it could readily be threatened by outsiders.'[67] Women were anxious that the very presence of medical outsiders on the occasion of labour and delivery could cause undue distress for both the mother and infant. There was an acknowledgement that birth was a 'transformative and potentially dangerous process,' so it must be managed carefully. Given the majority of deliveries were normal, women considered it necessary to remain at home in the protection of trusted birth companions.

In the case of complication, however, the hospital and its modern cures were welcome. Thomas recounts the experience of Beatrice Tiina, an informant who had sought care for a breech presentation at a maternity hospital. Tiina sought medical care because 'at the hospital they had more knowledge than at home.' Indeed, Tiina was convinced that she would have died had she continued to deliver her malpresented baby at home.[68]

In examining the history of birth's medicalisation in Africa, it is evident that there were varied reactions to the introduction of modern maternity care. For some women, birth choice and proximity to medicine became a marker of social status, while others continued to view birth as a normal event that required medical intervention only in face of obstetric complication. With the persistence of home birthing, African states continued to target women in medical recruitment

[65] Thomas, *Politics of the Womb,* pp. 55-56.
[66] Kanogo, 'Mission Impact on Women in Colonial Kenya', p. 168.
[67] Thomas, *Politics of the Womb,* p. 63.
[68] Ibid., p. 65.

campaigns, using arguments on the relation of reproductive practices to larger messages of social reform. Even if in physiological terms women were able to give birth healthfully outside the clinic, the continuation of home birthing practices signified a troubling adherence to pre-modern tradition, and greater social change would not be secured unless such customs were eradicated. Women's birth choices were heavily implicated in national modernist teleologies, signifying once more the cultural significance of biomedicine's ascendency. The clinic was touted as the appropriate location for all births, even those that did not necessarily require medical intervention. The medicalisation of birth was not a question of biological necessity, but instead contributed to the transformation of national cultures and orientation toward modernity.

Birth's reform from 'a normal biological event [to a] pathology in waiting'

The social implications of shifting birth cultures in the last century has been thoroughly criticised by both medical anthropologists and historians over the last three decades. In 1977, Sally MacIntyre asserted that 'childbirth is socially controlled in all societies. In no society is the process of pregnancy and parturition treated as simply a physiological process, untouched by a cultural context, prescriptions, proscriptions, and customary practices.'[69] In addition, Andrew Symon has argued that the rapid medicalisation of childbirth in the twentieth century meant that the conditions of maternity began to straddle the fence between being a normal biological event and pathology in the waiting.[70] Increased medicalisation of birth is not only 'socially controlled,' but also symptomatic of the push towards

[69] S. MacIntyre, 'Childbirth: the myth of the golden age', *World Medicine*, vol. 12, no. 18 (June 1977), p. 18.
[70] A. Symon, *Risk and Choice in Maternity Care: An International Perspective* (Edinburgh, 2006).

pathologising parturients and the processes of female reproduction. Indeed, in 1975, a physician writing to *Social Science and Medicine* argued that given the potential for pathologies in pregnancy and the advancements in medical treatments for maternity, 'it would be more appropriate and useful to regard pregnancy as an illness for which Western society has already devised an elaborate system of prevention and treatment.'[71] Biomedical discourses were intent on ordering the seemingly chaotic stages of pregnancy and childbirth into an easily defined teleology of progression. Medical practitioners seemed to have 'cured' women of maternity and its discontents.

At a 2001 Wellcome Trust conference investigating the rapid changes in maternal healthcare in the twentieth century, Hilary Marland identified three issues which have dominated maternal care in the twentieth century: the increase in hospital births, the changed and declining fortunes of midwives, and the stepped up use of medical technologies.[72] These three issues all highlight the controversies surrounding the extent to which childbirth should be seen as a pathological event, and the degree to which a parturient should be medically treated throughout pregnancy, labour, and the postpartum. Soo Downe has argued that due to the revolutionary changes in twentieth century maternal care, one is now unable to define 'normal childbirth' without speaking of technical intervention.[73] While forceps and other interventionist tools had been used by both obstetrician and midwife for centuries in the Western and non-Western worlds, they were by no means used universally, and births were by and large conducted at home until the

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[71] W. Hern, 'The Illness Parameters of Pregnancy', *Social Science & Medicine*, vol. 9, no. 7 (1975), pp. 365–372.

[72] H. Marland, 'Introduction,' in D.A. Christie and E.M. Tansey (eds.), *Maternal care: a witness seminar held at the Wellcome Institute for the History of Medicine, London, on 6 June 2000* (London, 2001), pp. i-iv.

[73] S. Downe, *Normal childbirth: evidence and debate* (Edinburgh, 2004).

first decades of the twentieth century. This rapid shift towards a near-automatic technological birth was really only evinced in the post-WWII era, when hospital births became the norm in the United States and Europe.

Beginning in the 1970s, medical anthropologists and historians began to question the practice of treating labouring women as medical patients. Authors like Emily Martin, Margaret Lock, and Patricia Kaufert have all pointed to the alienation women are meant to feel in this system of medicalised birth, cut off from their bodies and accompanying physiological processes.[74] Robbie Davis-Floyd has explained that in the hospital, women are treated as defective machines incapable of undergoing birth properly, and must therefore be fixed and aided by a more advanced technology.[75]

Janice Boddy's narration of the life history of Aman, a Somali woman, explains this state of confusion and lack of control of the parturient within modern hospital care. Aman delivered her first child in an Italian-run hospital in Mogadishu in the late 1960s. She states that over the course of delivery, 'the labour pains were gone, and this was a new pain – the doctor pain.'[76] Aman explains how the doctor walked and talked around her, telling his assistants they would have to 'cut her.' It was unclear whether this meant a caesarean section or episiotomy, but the very confusion in the re-telling evinces the lack of inclusion experienced by Aman throughout the hospital birth. She explains how they asked her husband to restrain her to the bed, then the doctor 'cut me and he was putting his hand in my vagina doing something.' After the baby was delivered, Aman retells how 'they sewed me up, alive again. .

[74] E. Martin, *The Woman in the Body: A Cultural Analysis of Reproduction* (Boston, 1987); M. Lock and P.A. Kaufert, *Pragmatic Women and Body Politics* (Cambridge, 1998).
[75] R. Davis-Floyd, *Birth as an American Rite of Passage* (Berkeley, 1992).
[76] Aman, V.L. Barnes, and J. Boddy, *Aman: the story of a Somali Girl* (London, 1994), p. 237.

.and he cut me in so many places – at least two or three places. Each cut took four or five stitches – imagine, they were sewing me just like clothes.'[77]

Megan Vaughan has explained how there is 'no "natural history" of disease,' but that socio-cultural markers have helped define the life of an illness.[78] For Aman, it was not the birth itself that was pathological, but rather the method of treatment during her labour and delivery. Aman's description is an extreme case in which her body is the locus of constant treatment imposed on her by the physician, administered without consultation and with no apparent reasoning aside from the potential harm which may occur should the labour continue its physiological course. There is no consideration of the iatrogenic effects of this preventative care: modern medicine has 'cured' the conditions of maternity, and Aman must quietly acquiesce to the authority of the physician in charge.

Obstetrics in the tropics: the trouble with African bodies

The case of Aman is complicated by virtue of her Somali identity. Aman was treated by an Italian physician in post-colonial Somalia, and her extreme exclusion at the time of delivery signifies larger issues of troubled African bodies and need for foreign instruction. Throughout the last century, contradictory myths of African birth have been perpetuated both in popular and medical literature. On one hand, African women are praised for their unique capacity to give birth pain-free due to

[77] Aman, Barnes and Boddy, *Aman: the story of a Somali Girl*, p. 238.
[78] Vaughan, *Curing their Ills*, p. 6.

their closer proximity to nature.[79] Conversely, the same women have also been degraded as especially risky in regards to reproduction. In his 1940 treatise on missionary medicine abroad, Clement Chesterman expressed his own paradoxical attitudes, at once stating that 'the course of childbirth should ideally be uneventful and unalarming. The healthy mother in the primitive societies does not make an invalid of herself, but with the new-born babe strapped to hip or back carries on, hardly noticing the interruption.' And yet just a few lines further on, Chesterman cautions that in the tropics, 'complications occur which no text-books describe, simply because they could never have been allowed to develop where expert midwifery was available.'[80]

In 1967, two obstetrician/gynaecologists working in Nigeria and Jamaica published *Obstetrics and Gynaecology in the Tropics*, a textbook written to educate physicians on the unique maternal morbidities evinced in tropical environments, including obstetric fistula and uterine rupture. The authors explain that often obstetrician/gynaecologists transplanted to the 'under-doctored,' low-resource settings in the tropics are forced to learn for themselves, a gap filled by their textbook.[81] Throughout the text, it is argued that the non-Western parturient is essentially pathologised by virtue of her environment, and that her births necessitate further medicalisation than those of her European counterparts.

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[79] Suzanne Arms, for example, has asserted that it is only Western medicine which has caused pain and complication in childbirth, and that 'primitive' cultures have managed to preserve birth in its natural, 'uncomplicated and inherently safe' state. S. Arms, *Immaculate Deception: A New Look at Women and Childbirth in America* (Boston, 1975). Obstetrician Grantly Dick-Read also attempted to instruct women in modern Britain on how to re-capture the pain free, natural birthing techniques of 'primitive' African women. G. Dick-Read, *Childbirth Without Fear: the original approach to natural childbirth* (London, 1951).

[80] C.C. Chesterman, *In the Service of the Suffering: Phases of Medical Missionary Enterprise* (London, 1940), p. 68.

[81] J.B. Lawson and D.B. Stewart, *Obstetrics and Gynaecology in the Tropics and Developing Countries* (London, 1967), p. 1.

In promoting this medicalised discourse, the textbook also discusses the necessity of 'selling' the idea of medical care to reluctant indigenous women. The authors argue that if this campaign of medical promotion is not undertaken 'with enthusiasm, the benefits of scientific maternal care will not reach beyond the enlightened minority, and amongst women whose lives still follow traditional patterns, the morbidity and mortality will remain unaltered.'[82] Often it is only 'the more adventurous and emancipated women' who begin to seek for medical treatment during pregnancy, but even then a home birth may follow. It is asserted that medicalised birth is a necessary companion to modern female liberation, for as it is explained, 'where women are emancipated and the pregnancy is respected, large open clinics and communal wards are suitable because the patients enjoy their clinic visits and stay in hospital as social occasions.'[83] The textbook also discusses the relation between birth's medicalisation and social class: 'It is inevitable that the better-educated and more prosperous people in any community will be first to make use of improved services, because they understand their purpose and can afford their cost.'[84]

Obstetrics and Gynaecology in the Tropics is significant in its advocacy for medical intervention not just in the period of labour and delivery, but throughout the pregnancy and postpartum. The authors contend that women need medical guidance, and up to this point it has only been the elite, emancipated, and educated classes who have benefited from medicalised motherhood. Rima Apple has shown how, increasingly in the twentieth century, it was believed that women required expert scientific and medical advice not only in the act of childbirth, but also to raise healthy children. One mother writing in an 1899 issue of the *Ladies Home Journal*

[82] Ibid., p. 1.
[83] Ibid., p. 306.
[84] Ibid., p. 305.

expressed the view that 'ideal motherhood, you see, is the work not of instinct, but of enlightened knowledge conscientiously acquired and carefully digested. If maternity is an instinct, motherhood is a profession.'[85]

The professionalisation of motherhood was not to be achieved alone, however, but with the careful instruction of a medical expert. In Margaret Myles' *Textbook for Midwives,* first published in 1953, Myles includes a lengthy chapter on 'mothercraft.' She emphasises the importance of midwives to instruct mothers in matters of infant and child care, in addition to matters of personal and household cleanliness and order.[86] Mothercraft was especially relevant for African women: the Millmans' *Mothercraft Manual* was written in the 1920s to indoctrinate colonial subjects in proper motherhood techniques, including pre-natal care, hygiene, and child-rearing. The authors argue that as the book is taken up by younger African women, 'later on their example and usefulness will overcome the prejudices of other native women.'[87] The manual preaches against those 'native' practices assumed harmful to both mother and child, including the constant carrying of infants to let them breastfeed whenever they need – a practice thought to promote overfeeding and improper digestion. In the manual's preface, it is promised that 'if the advice contained in this book is followed, a great advance will have been achieved toward that end which every true colonist has in view, namely the happiness and prosperity of the natives and the development of the country by a numerous and healthy people.'[88] Indeed, in a second printing, the preface states that 'these pages have for ten years helped

[85] R.D. Apple, 'Constructing Mothers: Scientific Motherhood in the Nineteenth and Twentieth Centuries', *Social History of Medicine*, vol. 8 (1995), p. 166.
[86] M.F. Myles, *A Textbook for Midwives* (Edinburgh, 1972).
[87] E.R. Millman and W. Millman, *A Mothercraft Manual for Senior Girls and Newly Married Women in Africa* (London, 1929), p. vii.
[88] Ibid., foreward.

African women to attain this ideal [of motherhood], and are now offered to a wider circle of the best-loved but worst-treated of all mankind – our mothers. God bless them.'[89]

The statistics of African pathology

The persistent emphasis on correcting the African mother was rooted more in racial prejudice than physiological necessity. Reliable statistics on maternal mortality in colonial Africa are not widely available, and are usually limited to individual clinics or districts. A colonial report from Uganda in 1930 estimated that the national maternal mortality ratio stood at 15 deaths per 1,000 live births, and in the Gold Coast the rate was believed to be 8 per 1,000 in 1932.[90]

These rates are slightly higher than those in Europe - England's rate in 1935 rested at 4 deaths per 1,000 live births - but this is to be expected given the lack of emergency obstetric services in colonial Africa.[91] Irvine Loudon's seminal survey of declining maternal mortality rates in Europe and North America in the twentieth century has demonstrated that those nations which provided quality obstetric care

[89] E.R. Millman and W. Millman, *A Mothercraft Manual for Senior Girls and Newly Married Women in Africa: Second Edition* (London, 1942), foreward. The installation of mothercraft classes was not limited to Africa, but was common across Imperial Europe. Anna Davin has shown how England embarked on a scheme to improve conditions of infancy and childhood in the first decades of the twentieth century, with maternity courses set up for factory girls and health visitors employed to conduct home visits to ensure proper childcare methods were practised, for 'child rearing was becoming a national duty, not just a moral one,' and if it was done badly, the state could in fact intervene. A. Davin, 'Imperialism and Motherhood', in F. Cooper and A. Stoler (ed.), *Tensions of empire: colonial cultures in a bourgeois world* (Berkeley, 1997), p. 91. See also: H. Marland, *Health and Girlhood in Britain, 1874-1920* (Basingstoke, 2013).

[90] United Kingdom National Archive, CO 536/178/5, UK Foreign Office in Uganda, Annual Report on the Social and Economic Progress of the People of Uganda, 1935 (London Kew Gardens, 1936), p. 12; United Kingdom National Archive, CO 1071/157, UK Foreign Office in Gold Coast, Annual Report, Gold Coast, 1930-31 (London Kew Gardens, 1932), p. 41.

[91] R. Schofield, 'Did the mothers really die? Three centuries of maternal mortality in the world we have lost', in L. Bonfield (ed.), *The world we have gained: histories of population and population structures* (Oxford, 1986), pp. 231-60.

saw a more rapid decrease in maternal death than others. He stated categorically that the most influential factor in determining maternal health was the standard of obstetric care, not social and economic differences.[92] Maternal mortality dropped in Europe only with the rapid spread of obstetric technologies that could prevent common crises in labour and delivery. Death in childbirth is caused most often from post-partum haemorrhaging, obstructed labour, or septic infection. For both haemorrhage and obstruction, medical intervention is necessary either through the administration of medicine to induce uterine contractions to stop the bleeding (e.g. ergometrine), or with assisted delivery by forceps, vacuum extractor, or caesarean section in the case of an obstruction. Sepsis is spread through unsanitary conditions, and was a common feature of European lying-in hospitals throughout the first half of the twentieth century.[93] Before sterilisation or assisted labour technologies were made more universal, all women were at risk of infection during childbirth, a risk that was not predicated on race or geography.

Indeed, Ruth Young, a British nurse who worked in Ethiopia throughout the 1930s-40s, remarked how rarely she encountered death in childbirth among her patients. She conducted a survey of 122 women, asking if among their neighbours and relatives they knew of any women who had died in childbirth. The answer 'was nearly always in the negative.' Young admitted that 'the position proved to be different from what I expected, and my conclusion was that the great majority of deliveries are normal.' Young was even more astonished at the lack of death given 'deliveries normally take place on the floor of the hut, with domestic animals in close proximity.' However, the nurse argued that Ethiopia lacks the 'Mrs. Gamps,' or

[92] I. Loudon, 'The transformation of maternal mortality', *British Medical Journal*, vol. 305 (19-26 December 1992), p. 1557.
[93] See: M. Tew and S. Kitzinger, *Safer Childbirth?: A Critical History of Maternity Care* (London, 1998).

dangerous folk midwives prevalent in England. There is no comparable tradition of midwifery in Ethiopia— instead women are attended by relatives and neighbours close at hand. Young felt that given the lack of intervention of Ethiopian birth attendants, women were saved from the spread of septic infection and undue complication.[94]

Young's survey is anecdotal, and no reliable maternal mortality statistics were produced for Ethiopia until well into the 1970s. Her conclusions are useful, however, in exposing the prejudice against African home birthing as immediately dangerous, and African women as naturally prone to obstetric disorder. Throughout the colonial period, European physicians were intent on finding the physiological cause for African birth complications— most famously through the comparative measuring of the pelvises of African patients and European nurses.[95] Such studies were always contradictory and inconclusive, and are mere evidence of racial prejudice, not biology.

This is not to discount the deaths that did actually occur in Africa, and continue to occur today. While childbirth is a risky venture for any woman, the consistent pathologisation of African women has no physiological determinant, and is a dangerous feature of the ethnocentrism of modern medicine's expansion in the continent. Medical policies were designed with the belief that African women were prone to obstetric disorder because of their race and culture. This meant that the methods to attack maternal mortality were rooted in programmes of cultural re-

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[94] R. Young, 'Medicine and nursing in Ethiopia', *The Lancet*, vol. 243, no. 6303 (June 1944), pp. 797-798.

[95] See: B.P. Harris and J.O.W. Angawa, 'Rupture of the uterus in East Africa', *British Journal of Obstetrics and Gynaecology,* vol. 58, no. 6 (1951), pp. 1030-1033; E.M. Sibthorpe and D.B. Allbrook, 'A radiological survey of the female pelvis in Uganda with addendum on the measurements of specimens of the female bony pelvis', *The Journal of obstetrics and gynaecology of the British Empire*, vol. 65, no. 4 (1958), p. 600. Even as late as 1975, a similar study was conducted in Ethiopia: S.M. Ross, 'A radiological survey of the female pelvis in Ethiopia', *Ethiopian Medical Journal*, vol. 13, no. 4 (1975), pp. 153-159.

orientation, not the expansion of medical services that were physiologically necessary to safeguard against maternal death. This is one of the central tenets of my thesis that will be expanded throughout the following chapters. The second chapter, in particular, provides a more detailed investigation on the problems of targeting cultures of maternity both in Ethiopia and across Africa.

Methodology

This thesis examines that complex relationship between the institutional framing of maternity in Haile Selassie's Ethiopia and the lived experiences of women as both patients and practitioners working both within and against official narratives. My prevailing method of enquiry was to follow Victor Azarya's call to 're-order state-society relations,' that is to focus not only on state activities, but instead to privilege the ways in which society copes with state movements.[96] In designing this study, I was also heavily influenced by Helen Pankhurst's excellent ethnography of rural Amhara women at the time of the Derg.[97] Pankhurst uses her informant's voices to counter the institutional narrative of Derg development policy, noting the struggles of women to work against inappropriate state incursions within daily life.

In this instance, because the institutional history of Ethiopian medicine remains largely unwritten, I structured my methodological enquiries so as to accommodate both official (written) and social (oral) narratives. My first point of entry was to work within the archives of those governments, medical institutions and aid organisations primarily responsible for the construction of Ethiopia's medical systems. With the foundations of the institutional narrative in hand, I could then move on to the

[96] V. Azarya, *Reordering State-society Relations: Incorporation and Disengagement* (Jerusalem, 1988).
[97] H. Pankhurst, *Gender, Development, and Identity: An Ethiopian Study* (London, 1992).

fieldwork portion of the study. In 2012-2013, I spent nine months in Ethiopia collecting oral life histories of persons affected by maternal health systems in Ethiopia under the emperor, both as patients and practitioners.

My method thus followed on that of multiple preceding historians of Africa, including Luise White, who argued that juxtaposing oral and written sources of evidence helps 'to provide a more reliable, representative, accurate history.'[98] I was also influenced by Arima Mishra and Suhita Chopra Chatterjee's recent edited volume, which includes narratives of health and illness by lay practitioners and traditional healers, examining the ways in which the everyday experiences of 'doing health' influenced larger social trends towards medicalisation and the expansion of public health policy.[99] In this sense, I was fortunate in writing a relatively recent piece of history, as there are ample witnesses and participants in Ethiopia's imperial history still living and willing to retell events as remembered. In her study of reproductive health in South Africa, Susanne Klausen admitted frustration in working with maternity clinic records from the 1930s, stating that it was 'difficult to reconstruct the experience of the thousands of so-called ordinary women who utilised the clinics' solely from the institutional evidence available.[100] It has been rightly asserted that any society's 'medicalisation is produced by the medical profession in conjunction with consumers of medical services.'[101] In my own study, it became imperative to fill in the gaps of institutional narratives by recording the perspectives of multiple routine participants in the medical establishment.

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[98] L. White, '"They Could Make Their Victims Dull": Genders and Genres, Fantasies and Cures in Colonial Southern Uganda', *The American Historical Review*, vol. 100 (1995), p. 1381.
[99] A. Mishra and S.C. Chatterjee (eds.), *Multiple Voices and Stories: Narratives of Health and Illness* (Delhi, 2013).
[100] S. Klausen, *Race, Maternity and the Politics of Birth Control in South Africa 1910-1939*, (London, 2004), p. 10.
[101] M. Lock and P.A. Kaufert, *Pragmatic Women and Body Politics* (1998).

Archival research

To first reconstruct the institutional development of Ethiopian medicine, I began work in five principle archives: the National Archives in both the US (College Park, Maryland) and the UK (Kew Gardens), the World Health Organisation archive in Geneva, the British Library, and Library of Congress (Washington DC).[102] Inside Ethiopia, documents relating to the medical administration of the Haile Selassie era are unfortunately either destroyed, or inaccessible to researchers. When the emperor was overthrown, the incoming military regime destroyed substantial amounts of documentary material from the imperial regime, though there are rumours that a large store of archives from the Haile Selassie era are currently held underneath the Presidential Palace in Addis Ababa. I have heard of no researcher, either foreign or national, who has been allowed access to this storage facility, however, so its existence may be mere myth. There is a National Archive in Addis Ababa, but the holdings from the imperial era are scant, and are restricted to official, printed reports and secondary sources whose copies can be found either online, or in other international libraries. In terms of medical records, there is a policy in Ethiopian hospitals to destroy all patient records after ten years of use. The sole exception to this policy was found at the Gandhi Maternity Hospital in Addis, where there is a large store of patient records dating back to the 1950s. However, despite repeated attempts over the duration of my fieldwork, I was unable to get permission from Ethiopia's National Ethics Committee to access these records.

[102] In addition to these principal archives, I also worked within more 'minor' archival stores, including the Wellcome and Lambeth Palace libraries in London, the Rockefeller Archive in New York, and the New York Academy of Medicine. When I reference a manuscript from an archive throughout the text, I begin the reference with the title of the archive, then provide the call number, description, location and date of the manuscript. A full list of the manuscripts referenced in the text is organised by their home archive in the bibliography.

The archival situation in Ethiopia is therefore challenging: much has been destroyed, and the materials that do exist are shrouded either in rumour or plainly inaccessible to researchers. The libraries of Addis Ababa University do house several useful sources from before 1974, but I was not able to access any large-scale medical record or archive within Ethiopia, and instead relied on the documentary evidence extant outside the country. These external sources proved incredibly varied, rich, and useful, however, as while the impetus for modern medicine in Ethiopia came directly from the imperial regime, the funding and initial administration for the nation's public health system came primarily from foreign government assistance. Sweden, Norway, and the USSR were all significant contributors in the construction of hospitals and the provision of doctors in the country, but it was mainly the UK and US who most heavily invested in Ethiopian medical projects. While the British supplied the majority of health services in the country during the Italian occupation and aftermath, from the early 1950s onward, the United States provided the largest portion of foreign medical aid to Emperor Haile Selassie. Both the College Park and Kew Garden archives house large stores of official documentation chronicling both nations' consular activities in Ethiopia, including their use of medical assistance as a diplomatic tool. Documents included inter- and intra-government correspondence, policy reviews, progress reports, budgets, contracts, and minutes of meetings. This material helped to explain the priorities and intentions of both Ethiopian and foreign officials working in partnership to construct national medical systems.

Within this official documentation, I began to concentrate on two key institutions which played instrumental roles in furthering the mission to modernise Ethiopia through medicine. The first was the British-funded Princess Tsehai Memorial Hospital and Nursing School in Addis Ababa. Built to be the 'most modern hospital in Africa,' the Tsehai Hospital proved a critical first step in the institutionalisation of

childbirth in Ethiopia. As a nursing school, the hospital was also instrumental in crafting a new professional class of Ethiopian women. While the hospital was considered a national British project, the impetus and fund-raising efforts for the hospital's construction originated with famed Suffragette and anti-Fascist campaigner, Sylvia Pankhurst. To investigate the Tsehai Hospital further, I concentrated on the collection of Sylvia Pankhurst's Ethiopia papers, housed in the British Library. These included Pankhurst's lengthy correspondence with Ethiopian officials, including Haile Selassie, in addition to prominent British figures who supported the hospital project. I also read through the minutes from meetings of the Princess Tsehai Memorial Council, detailing the purpose and intentions of the hospital as an institution primarily for the advancement of Ethiopian women, in addition to detailed schema and administrative documents from the hospital once operational in 1951.

The second institution of focus was the Gondar Public Health College and Training Centre, a joint venture by both the US government and WHO in partnership with the Emperor. The Gondar College opened in 1954, and worked to train young Ethiopian men and women as health officers, community nurses, and sanitarians to work in rural areas. The primary intention of the college was to fill the widening gap in institutional care and modern advancement between urban and rural zones of the country. Both the WHO and US National Archives had ample source material on the both the administration of the college and the work of the graduates once dispatched to rural health centres. Official visits by WHO and US personnel to Gondar always elicited a lengthy report, while the US aid mission also produced monthly and quarterly updates on the college's progress from 1954 up to the late 1960s.

Additional printed primary sources

While these official sources of documentation were remarkably helpful in narrating the nuts and bolts of the institutional development of Ethiopian medicine, it became increasingly clear that the voices of local participants in the institutions were (unsurprisingly) absent from the foreign documentary material. In the case of the Gondar College, I was fortunate to have met Dr. Dennis Carlson, an American physician and public health expert who served as Dean of the College in the 1960s. As Dean, Dr. Carlson had encouraged students to pursue independent research on local health concerns and publish their results. He kindly shared with me his own library of student papers and journals published by the College, helping reveal alternative voices within the institutional narrative. In addition to these sources from Dr. Carlson, I was able to access a large collection of student newsletters, pamphlets, and yearbooks from the Gondar College at the library of the Institute of Ethiopian Studies at Addis Ababa University. Unfortunately, the library of the present-day University of Gondar has disposed of all material related to the Public Health College to accommodate the increasing volumes of material related to current university operations.

To compliment archival documentation related to hospital construction in Ethiopia, I read through numerous medical studies published by physicians working within the nation's medical institutions. These studies concentrated on the demographic and pathological backgrounds of patients, in addition to detailing hospital treatments and procedures. In the beginning, Ethiopian medicine was dominated by foreign physicians who published their studies in their home country medical journals, including Austria's *Wiener Medizinische Wochenschrift*, the *Medical Journal of Australia*, and Sweden's *Läkartidningen*. By 1962, however, there were

enough local medical professionals to merit the creation of the Ethiopian Medical Association and its accompanying Medical Journal. With all issues of the *Ethiopian Medical Journal* available at the library of the London School of Hygiene and Tropical Medicine, I was again able to access critical local voices in the development of the Ethiopian medical mission.

Oral histories

The greatest addition to the various documentary sources I collected, however, were the oral histories I recorded during my fieldwork in Ethiopia. I spoke to nearly 200 individuals relevant to the history of women, childbirth, and medicine in Ethiopia at the time of the emperor. Forty interviews were performed with medical professionals active at the time, including a handful of foreign medical missionaries, physicians, and instructors, but primarily local practitioners and professors of medicine and public health. I spoke with nurses, midwives, doctors, and a large number of male and female graduates of the Gondar Public Health College.

These interviews were all conducted in English, given the tertiary education of all Ethiopian medical practitioners. In Ethiopia, both secondary and tertiary schools are taught in English, a custom began under Haile Selassie that continues to the present-day. The conversations were lengthy, sometimes stretching to multiple interviews of several hours each. While I had a basic framework of questions for each interview (i.e. general demographics of the interviewee), I did not use any comprehensive questionnaire, but let the conversation progress based on the practitioner's own intentions. The conversations mostly focused on the practitioner's own life history and opinions on the medical policies and services under both Haile Selassie and subsequent regimes. I found all of my informants exceptionally open, hospitable,

and willing to share their personal experiences. Few were overly nostalgic, but instead provided frank criticism of the state medical project. Such frankness was welcome, especially given the critical nature of this thesis.

Beyond practitioners, I also recorded the life histories of 150 women aged sixty and over. The time spent with these 'ordinary women' swiftly became my most valuable resource in charting the history of both birth and medicine in Ethiopia. Surprisingly open and honest in their narration, these women explained how the state medical project was actually perceived and utilised within communities. They explained the ways in which medicine was both appreciated and rejected, and also described the plurality of responses to conditions of maternity, even within a single woman's life.

For all women contacted, I asked variations on questions about forms of pregnancy and birth management, both traditional and modern, and probed the women to explain why different methods of care would be utilised within specific circumstances. I asked the women about their own daughters' births, and any births they had witnessed or attended in later life. This helped me chart longitudinal histories and shifts in maternal health practices. I concentrated on the priorities and choices of women, both in terms of general life trajectories (place of residence, marriage, employment), and also in relation to reproduction and motherhood. This included questions regarding the woman's desired number of children, in addition to any external influences on choices made throughout her period of reproduction. It became clear that individual autonomy was - as in all societies - shaped heavily by the influences of proximate actors: family, husbands, neighbours, state officials, and health workers. Women were often taken to health facilities without consultation, while a small number of informants reported being deliberately forbidden from attending medical institutions at the time of delivery. Many women expressed

frustration at wanting alternatives unavailable to them, especially those women resident in rural areas who lamented the high mortality rates of their children or the excruciating pain of repeated births.

I conducted interviews with women in three sites: Addis Ababa, Gondar, and Jinka town. As the capital city of Ethiopia, Addis was a natural choice, not only given the large number of women from multiple regions of Ethiopia who have made their residence there, but also because of the higher concentration of medical facilities historically available to women within the sprawling urban centre. I worked in Gondar because of the presence of the Public Health College: I spoke with women both in Gondar town and Kossoye, a neighbouring village, to see the impact of the college's project first-hand.

Jinka, a small town in the Southern Omo Valley, was another strategic choice to see how medicine interacted with the overall imperial project of expansion and state-building. Jinka was founded around 1957 as an administrative outpost of the expanding Ethiopian empire. Amhara officials moved to the region to extend control over the numerous ethnic groups resident in the Omo Valley. A health centre was built in Jinka in 1962, staffed by Gondar graduates, while the Norwegian Lutheran Mission also had a significant presence in the region with clinics, schools, and a hospital. I interviewed women in Jinka from both the Amhara and local Ari ethnic groups, hoping to explore the participation of 'peripheral' women within the state's medical project. This was also a way for me to interview patients of a Gondar health centre far from the college grounds, again revealing in greater detail the daily operation of a government-run health centre, in addition to the actual appropriateness of the Gondar approach within a rural setting.

Interviews were conducted in Amharic and Oromifya. Having studied the basic foundations of Amharic, I was able to participate more fully in the interviews with

Amharic-speaking women, but in all cases, I made use of local research assistants fluent in English to ensure I accurately understood the woman's responses. In each selected research site, I also worked with the community Health Extension Workers (HEWs). Nearly all women, HEWs are part of a government health scheme which promotes preventive health measures through home visitations. With an intimate knowledge of their target communities and a trusted relationship with residents, using HEWs as an intermediary made it easier for me and my research assistants to be accepted by informants within their homes. As all but one of my research assistants were also women, there was an ease of communication and warm rapport that helped facilitate honest and open exchanges during the lengthy interview process.

I was never met with hesitation to participate in the study, though at first most women were surprised I would even be interested in interviewing them about the seemingly mundane details of their lives. At the onset of interviews, many women also apologised to me that they did not know much about Haile Selassie or the politics of Ethiopia. I assured them it was their own histories I was interested in, not that of the emperor. This says something about the making of Ethiopian history, which traditionally concentrates on the movements of elites, with peripheral groups mentioned only in bulk or in passing. It also speaks to the ways in which Ethiopians frame their nation's history as separate from their own lived experiences. To me, this emphasised further the importance of locating the voices and life histories of peripheral groups within the national story of modern Ethiopia.

I deliberately concentrated on poorer neighbourhoods because both in the past and today, the vast majority of Ethiopian women live in a state of material poverty, and I wanted to work with the most accurate picture possible of the communities reached - or not reached - by state medical services. Because medicine was associated

so pervasively with an elite modernisation/Westernisation, it was important for me to locate the interchange between the ideals of the medical mission and its quotidian practice for the average Ethiopian. That being said, ten of the women I interviewed come from the wealthiest sector of Ethiopian society. For these women, the responses to my queries on the management of their births were remarkably different from those of the other women interviewed. Differences in responses between rural and urban settings, and even between the capital and the smaller urban community of Gondar, were also notable, evincing the ways in which the medical project was subject to local conditions, practices, and priorities.

There are a few problems and weaknesses in my collection of oral testimonies that should be noted: as with any exercise in oral history, problems of memory inevitably arose. I was speaking to very elderly men and women who were recounting experiences that took place between forty and sixty years ago. For those women re-telling experiences of childbirth, it was often those who had undergone traumatic deliveries that were able to recount the labour in far greater detail. In the case of 'normal delivery,' I often had to probe women for information on details of their maternity care: the memories were simply not as vivid. This variation in the degree of memory is of course problematic when considering the information presented in this thesis.

Beyond issues of memory, there were additional political constraints to my interview methodology. In general, Ethiopia is a closed society, with no history of press freedom or capacity to openly criticise the government. This makes research in the country notoriously difficult. There is great scepticism of foreign researchers, as it is assumed that they have a hidden agenda in collecting information. I tried to assuage any potential doubts on the part of my informants by using trusted connections as intermediaries before the interview. For practitioners and officials, I

began with one informant, first introduced to me by Dennis Carlson, and then asked if I could be connected with additional colleagues of this initial contact. For 'ordinary women,' I used government health workers, as mentioned above. This method of contact is potentially problematic, however, as it aligned me with the Ethiopian state from the first introduction to my informants. It is possible that the women viewed me in coalition with the government health workers, and skewed their answers to what they thought was the most agreeable response based on popular state policies. Some women were quite defensive in their answers about receiving maternity care outside the clinical environment, and this reactionary tone may well have been caused by the perception that I was representing, or even reporting back to the state in some way.

While there were clear risks in using the HEWs to facilitate my patient interviews, I do believe that had I arrived at women's homes unannounced, I would have caused additional layers of suspicion on my intentions in conducting the interviews. This would also have alarmed local authorities on my presence in their *woreda* or *kebele* (local governing units in Ethiopia), and could have led to my project being shut down. I chose to go through the official government channels to avoid any undue suspicion, cognisant of the potential ways in which this could corrupt the information gathered. At the same time, given the high quality of the discussions I had with women in Ethiopia, I doubt that the use of HEWs was overly problematic in shaping the content of the material gathered. I had a great variety of answers to my queries, and while there were times in which women became defensive, the issues of childbirth and reproduction tend to elicit strong emotional reactions. The women could have expressed their opinions in these matters with the same tone regardless of my cooperation with local government workers. The notable weaknesses in my methodology notwithstanding, the wealth of material gathered

and presented below must speak to the inherent strengths in my interview processes.

Ethical considerations

Because I was discussing matters of reproduction and individual medical history, ethical considerations in the collection and use of women's life narratives were naturally a significant factor in my fieldwork preparation. I sought approval for the study from relevant ethical review boards both at the University of Oxford and also Addis Ababa University, my host institution while in the field. I also provided each woman with a formal disclosure agreement written in Amharic. I never asked my informants for any revealing personal details, including their names or date of birth.

Beyond these formal measures, within the interview process, I was conscious to allow each woman to direct the content and length of our session. Some interviews were cut short because discussing more difficult aspects of reproductive life histories proved upsetting to the women interviewed, particularly in instances of infertility or repeated infant death. If a woman did not respond to my query in a forthwith manner, I tried to steer the conversation to more suitable territory. I tried to avoid asking questions which would force the woman to unwillingly reveal personal details of her life history, but rather allowed the informant to direct the narrative as prompted by my generalised enquiries. As mentioned above, overall I found the women I approached to be open and honest to discussion. I believe that using female assistants wherever possible, and also conducting interviews within the homes of the women, where they could remain surrounded by supportive family members, helped create a relaxed atmosphere for all parties involved. The relaxed honesty of

the informants' answers is reflected in the rich narratives I collected and weave throughout the study in subsequent chapters.

Chapter outlines

The dual nature of my study in charting both official and community histories of medicine in Ethiopia is reflected in the organisation of chapters. The first two chapters concentrate on the administrative history of medicine and modernity in Ethiopia, while the third and fourth focus on the oral narratives of women as practitioners and patients. The final chapter returns to the official narrative, outlining the failures of the Haile Selassie regime to create a comprehensive medical network for Ethiopia.

The first chapter answers questions related to the interests of the Ethiopian state: what was the official definition of modernity, and how did medicine play a part in modernising the empire? I describe the ways in which Haile Selassie solicited aid from foreign governments and institutions in constructing Ethiopia's first modern medical network. The emperor was intent on building prestigious medical institutions in the capital to secure his prestige, while foreign advisors attempted to sway state policy towards the creation of a preventive health network in the expansive rural areas of the empire. This contention between medicine as a symbol of imperial prestige versus community development is fundamental to my thesis. Debates between the emperor and diplomatic aid corps demonstrate the ways in which modern medicine was used for ulterior ends in Ethiopia. The clinic and hospital were used strategically by the state as a way to enhance the modernisation of the empire, whether in beautifying the streets of the capital, or re-orienting customs of the countryside.

In the second chapter, I focus on the question of women and childbirth within the medicine-as-modernisation narrative. The medicalisation of childbirth in both Africa and abroad has long been implicated in policies for the modernisation of the state and development of communities. With the creation of the World Health Organisation, global standards for maternal health were first codified, and the connection between childbirth and culture made explicit. Attacks on maternal morbidity and mortality prioritised the reversal of harmful traditions in indigenous cultures, and the expansion of medicalised maternity in countries like Ethiopia was focused less on the institutionalisation of parturients, and instead on a re-orientation of domestic living practices. Women were asked to attend ante-natal and Well-Baby clinics to ensure they adequately prevented potential problems in both the birth and rearing of children through alterations to basic customs related to the provision of water, sanitation, and nutrition. The onus for community development rested on women, and it was believed that with sufficient re-education of overly 'traditional' Ethiopian families, the entire nation could be 'modernised.'

I move from narrating the official intentions for medicine in Ethiopia to its actual practice by female nurses, midwives, and physicians in the third chapter. This chapter narrates the experiences of seven female practitioners active at the time of Haile Selassie. I use the oral histories collected in my fieldwork to describe the ways in which the state's expectations of modernity were negotiated by female practitioners of medicine. These women entered medical professions both with the intent to serve their fellow man, and also secure an improved standard of living for themselves and their families. Practitioners largely assumed the role of moderniser in imperial Ethiopia, intent on educating their patients to reform harmful traditions, especially as related to maternal and child health. At the same time, by virtue of their gender, these women confronted numerous restrictions in modern Ethiopia. The

official place for women was highly limited: not only were women nominally restricted to the professions of nursing and midwifery, but their incomes and status were consistently placed second to male superiors. Throughout their careers, however, the women interviewed clearly assumed more senior responsibilities in their practice of medicine. There was a consistent push-back against official expectations of the prescribed role of professional Ethiopian women. In narrating the contentious space for women as female practitioners, the limitations of modernity in Ethiopia are made evident.

The fourth chapter focuses on the experience of women as medical patients in Haile Selassie's Ethiopia. As a companion to the practitioner narratives above, I use this chapter to describe the ways in which Ethiopian women coped with the persistent state strategies to co-opt them into national modernisation campaigns. I narrate women's reproductive histories, explaining how their choices in times of pregnancy and childbirth became symptomatic of their own definitions of health, risk, and the place of modern medicine in indigenous maternity customs. Women by and large rejected the official narrative related to maternity care and cultural change: the clinic was viewed as a vehicle for cure in times of medical distress, not lifestyle reformation. There were exceptions to this narrative, however, most notably those women who deliberately sought out modern maternity care at the hospital from the outset of the pregnancy. These women were all part of the upper classes of Ethiopian society, exposing the role of wealth and status in shaping the patient experience with modern medical care. This chapter manifests the intersection of class, geography, and medical choices in modern Ethiopia, emphasising once more the varied definitions of 'modernity' in Ethiopian community life.

In the final chapter, I narrate the ultimate failure of Haile Selassie's medical mission. Given the emperor's penchant for prestige projects, the actual impact of his

medical policies was minimal. There was no wide-scale alteration of customs related to health, disease, or reproduction, and the pressing needs of the population were overlooked in favour of elitist campaigns. Funding for the operation of medical facilities was severely limited, so that the quality of clinics and hospitals deteriorated rapidly during the emperor's reign. In rural areas, the persistent poverty of the population hampered the effectiveness of the preventive health education network designed by foreign aid partners. While services directed at women largely concentrated on their capacity as mothers and homemakers, the reproductive needs of women were wholly ignored: family planning was not introduced in Ethiopia until the late 1960s, despite the fact that death from unsafe abortion was the most common cause of maternal mortality.

I conclude the thesis with a description of the contributions of this thesis to academic literature on gender theory and medical history. I describe the implications of my research, both within Ethiopian studies and global history. I narrate the meaning of my criticisms of Haile Selassie's medical projects in additional geographic and historic contexts, describing ways in which my own arguments can help shape further studies of biomedicine, modernisation, and maternal health in twentieth-century history.

Chapter 1: Modern foundations

> *My father had a strong desire to see the people get accustomed to the work of civilisation which he had observed in Europe and to make a start in his governorate. It was for this reason that he established the first hospital in the city of Harar.*
>
> *— Emperor Haile Selassie, My Life and Ethiopia's Progress*[103]

In 1954, W.A. McIntosh, an official representative of the Rockefeller Foundation, met with Emperor Haile Selassie in Addis Ababa to discuss the possibility of financial support for Ethiopia's burgeoning medical network. Going into the meeting, McIntosh was candid in explaining that foundation funds available for Ethiopia were 'very limited,' and that only 'minor contributions' were to be expected. Despite the reticence of his American guest, the emperor argued confidently for Ethiopia's readiness for Rockefeller aid. Haile Selassie wanted the foundation to fund the nation's first medical school, having first written to John D. Rockefeller III himself a decade earlier to solicit support. While foundation representatives were consistent in their refusal to grant such a large sum to his East African Empire, Haile Selassie continued his solicitations for a medical school, which, he argued, was necessary for the advancement not only of Ethiopian medicine, but for the nation at large.

This disagreement between Haile Selassie and Rockefeller representatives is symptomatic of the fraught discourses surrounding modern medicine's introduction in Ethiopia. For the emperor, medicine was a prestigious enterprise. Haile Selassie focused on elite projects like hospital construction and physician education, viewing medicine not just as a vehicle of health and cure, but also modern advancement. At the same time, to expand his modern medical network, Haile Selassie needed considerable foreign investment and aid. Foreign agencies like the Rockefeller

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[103] H. Selassie, *My Life and Ethiopia's Progress, 1892-1937: The Autobiography of Emperor Haile Selassie I* (Oxford, 1976), p. 17.

Foundation were sceptical of the emperor's plans for medicine in Ethiopia. The nation was considered too underdeveloped to merit the establishment of a medical school and elaborate hospital network, and diplomatic officials argued for an alternative, auxiliary model of health for the nation. McIntosh writes how he politely suggested to His Imperial Majesty the need to develop local leadership and recruit more advanced students before talk of grandiose projects like an elite medical school could begin. In response, 'the Emperor thanked me for my suggestion, but characterised my approach as "gradual" in contrast to what he thought should have a rapid development to meet a pressing need.'[104] For foreign advisers like McIntosh, Ethiopia lacked the necessary human resources for a national medical project, and needed to begin with much more basic steps like the development of a robust educated class.[105] In the view of the emperor, the first step to modernity for Ethiopia was to develop a complete national medical apparatus, including an elite training school. Once the prestigious institutions of medicine were established, the rest of the nation would quickly follow the path towards modernity, adapting to modern standards of health and domestic life. Rockefeller and Haile Selassie were arguing for inverse scenarios: to the former, the nation first needed modernisation before medicine, but for the emperor, it was medicine itself that would help modernise his empire.

This chapter provides a summary outline of the activities of Haile Selassie and his foreign donors in setting up the Ethiopian medical service. I describe the opposing sides of the debate, first the imperial penchant for hospital construction in urban areas, and then American and WHO-led campaigns for rural health centres. In

[104] Rockefeller Foundation, RF: 02.1948/477-423 #2853, Ethiopia General Correspondence (New York, 1948).

[105] At the time of their meeting, there were just 100 tertiary students in all of Ethiopia. (United States NARA, RG469 P248, Records of US Foreign Assistance Agencies: Unclassified Central Files Compiled 1951-1961 (College Park, MD, 1961).

summarising the movements of the imperial regime and its donors, I expose both the state's intentions to use medicine as a tool for modernising Ethiopia, and also foreign anxieties about the suitability of either modernity or medicine in the independent African nation. Several threads emerge in this discourse, most notably the contradictory perceptions of Ethiopia both at home and abroad. While the nation was praised for its independence, it was also criticised for its 'backwardness.' The paradoxical view of Ethiopia influenced medicine's introduction and development, as debates continued throughout Haile Selassie's rule on what type of medicine and doctor best suited the rising nation.

Both this and the next chapter are based largely in archival research and secondary literature review. I use these introductory chapters to establish the historic foundations of medicine's expansion in Ethiopia and the ways in which medicine was incorporated into the nation's modernisation campaigns. After this historic background is set, I will then move on to a more narrative discourse on the experiences of women as they engaged with modern medical services as both practitioners and patients. While this chapter does not expand on the issues of women's health and childbirth, I present a focused discussion on the intentions to use maternal health for modernising ends in the second chapter. Maternal health programming was couched in a larger trajectory of national modernisation, and it is important to first understand what the imperial government intended in their development of a medical network for the nation's prestige as a whole. This chapter explores the contradictions of Haile Selassie's medical mission, prefacing the challenges the state would face later on as it attempted to engage women in community modernisation efforts by means of the clinic.

For the sovereignty of a nation: Imperial intentions for medicine and modernity in Ethiopia

Haile Selassie's repeated arguments for a medical school rested on his belief that as an independent African emperor, he was uniquely positioned to lead Ethiopia into modernity. Haile Selassie did occupy a radical position in 1950s Africa, when other nations were only beginning their first steps towards independence from decades of colonialism. The Ethiopian leader believed that it was the 'envy' of his independence and modernity that had led Italy to invade in 1935.[106] In their meeting, McIntosh reported Haile Selassie 'alluding to the Italian invasion [of Ethiopia] as disrupting and delaying the program of progress of his reign.'[107] In his autobiography, *My Life and Ethiopia's Progress*, Haile Selassie describes the historic beginnings of medical care in Ethiopia as his own personal initiative— an effort in which he solicited the aid of outsiders, but always at his own behest and instruction:

> But from 1922 onwards, We had many hospitals established at Addis Ababa and the other major cities; We gave permission and financial aid to various missions and as hospitals were being built, the health of many people began to be safe-guarded. Furthermore, We had arranged to have the Swedish physician, M. Hanner, appointed to the hospital which We had named Bet Saida and which We had established at Addis Ababa with our private money. The hospital became well-known and widely respected.[108]

While Addis Ababa's Menelik Hospital was the first medical institution established in Ethiopia in 1902, it was only when Haile Selassie was appointed regent (as Tafari Makonnen) twenty years later that hospital construction began in earnest. The Bet Saida Hospital alluded to above was a special hallmark of medical

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[106] Ibid., p. 6.
[107] Rockefeller Foundation, RF: 02.1955/475-054 #0341, Africa - Resources and Needs for Training Facilities for Africans in British Africa, Ethiopia, and Liberia (New York, 1955).
[108] Selassie, *My Life and Ethiopia's Progress*, p. 70.

prestige: built on the grounds of the imperial palace, Haile Selassie explains how he financed the purchase of 'the diagnostic instrument called x-ray which had never been seen in Ethiopia.'[109] The emperor would attend surgeries at the hospital at his leisure, and routinely took diplomatic visitors to the premises as an advertisement for the modernity of his empire.

In 1935, a Hungarian journalist attended an appendectomy at Bet Saida and noted how 'the white doctors and his black assistants then worked together in perfect harmony. The theatre sister handed the instruments to the doctor with precision, everything proceeded as smoothly as in a European hospital.'[110] There is an undertone of surprise in the journalist's account at the working equanimity between 'white doctor' and 'black assistant,' and at the capacity of this Ethiopian establishment to operate to European standards. But with just 30 beds reserved mostly for the emperor and his elite entourage, Bet Saida's operations were more performative than effectual in treating the health needs of Addis Ababa's residents. In parading journalists through the operating theatre of his personal hospital, Haile Selassie used the institutional trappings of medical practice as a showpiece both of foreign-local cooperation and the modern potential of Ethiopia. Bet Saida's performative function was also entangled with the promotion of Haile Selassie's personal capacity as visionary sovereign. In an interview with Dr. Hanner, the Swedish medical director was careful to acknowledge Haile Selassie's generous, personal support of the facility, stating that 'everything that you see here is paid for by the Emperor.'[111]

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[109] Ibid., p. 207.
[110] R. Pankhurst, 'The Beginnings of Modern Medicine in Ethiopia', *Ethiopia Observer,* vol. 9, no. 2 (1965), p. 140.
[111] Ibid.

Haile Selassie was quick to promote his personal responsibility for the development of medicine in Ethiopia in part because the emperor's modernising reforms acted as an external barometer of his capacity to rule. In the 1940s, African independence was still a remote concept, and Haile Selassie's position as independent ruler of an expanding East African territory was considered a quaint anomaly. As one of the last hold-outs against colonialism, the embarrassing defeat of Ethiopia in the hands of the Italians in 1935 only renewed outside interest in claiming authority over the empire's scattered territories. The years after Italy's exit from Ethiopia in 1941 were fraught with attempted power grabs by the British, who, having contributed considerably to the fight against Italy on Ethiopian soil, now felt entitled to administer the East African territory. In 1942, the British drew up the first of two Anglo-Ethiopian Agreements, which essentially placed administrative control of Ethiopia into British hands. Historian Bahru Zewde has described how 'almost every article' of this first agreement 'underlined [Ethiopia's] dependency and the preponderant role of Britain.'[112] Essentially establishing a British protectorate, the first agreement was swiftly replaced by a less invasive version in 1944.[113] The British did retain control over both Eritrea and the Ogaden territories of Ethiopia, however, essentially transferring former Italian holdings from one colonial power to another.

In 1942, the sovereignty of Ethiopia was therefore an urgent and legitimate question, and Haile Selassie was determined to assert his capacity, not just for self-rule, but also for the reshaping of the territory into a modern state. The emperor believed fully that it was his modernising tendencies that had both made him a target of Italian aggression, and also justified his sovereignty against other

[112] B. Zewde, *A History of Modern Ethiopia, 1855-1991* (Oxford, 2001), p. 179.

[113] This included lifting the precedence of the British Minister over all other foreign representatives, and allowing the Ethiopian Government the freedom to appoint any foreign advisor as desired.

occupying interests. Cognisant of the fact that colonial powers were all too quick to justify their occupations of African territories as 'civilising missions,' largely through the tools of European education and medicine, Haile Selassie promoted his own capacity to fill this 'civilising' role for his subjects, donning similar trappings of a colonial state under the cloak of independent rule. In order to successfully deflect his would-be occupiers, the independent emperor would have to parade his modern reforms of the Ethiopian state to the world. The gleaming modernity of the Bet Saida Hospital, with its interracial staff and expensive x-ray equipment, was the ideal locus for such a performance.[114]

Simplistic narratives of change and the single-minded pursuit of the hospital

There was a perverse optimism in believing that a 30-bed hospital in a small capital city could make any significant contribution to the modernisation of a nation like Ethiopia, with an estimated 25 million inhabitants, over 90% of whom lived in rural areas. The modernity of Bet Saida was largely symbolic, and the actual improvement of Ethiopian health and living standards would require much greater effort than initially advertised by the emperor. Indeed, Haile Selassie's first steps in

[114] The symbolic use of the hospital as showpiece of both sovereign authority and modern civilisation has a long and pronounced history. Christine Stevenson has discussed the use of grandiose hospital architecture to secure the prestige of ruling elites beginning with King Charles II of England. (C. Stevenson, *Medicine and Magnificence: British Hospital and Asylum Architecture, 1660-1815 (*New Haven, 2000). In 1788, a French hospital director argued that 'hospitals are in some degree the measure of the civilisation of a people.' (J.R. Tenon, *Mémoires Sur Les Hôpitaux de Paris* (Paris, 1788), p. 1. Numerous historians have explored the ways in which modern hospital architecture must perform both a functional utility while also utilising the most modern - and often expensive - ornaments of design. In this way, hospitals fulfil a dual purpose: healing the sick, while simultaneously securing the social status of their patron. (F.N.L. Poynter (ed.), *The Evolution of Hospitals in Britain* (London 1964); G. Rosen, 'The Hospital: Historical Sociology', in G. Rosen (ed.), *From Medical Police to Social Medicine, Essays on the History of Health Care* (New York, 1974); J.D. Thompson and G. Goldin, *The Hospital: A Social and Architectural History* (New Haven, 1975); A. Forty, 'The Modern Hospital in France and England: The Social and Medical Uses of Architecture', in A.D. King (ed.), *Buildings and Society: Essays on the Social Development of the Built Environment* (London, 2003), pp. 32-49.

developing his national medical project are more symptomatic of a sovereign concerned with the image of his empire than the actual health needs of his subjects. Bet Saida's construction in 1924 was a mere prelude to the hospital construction boom to follow the emperor's return to the throne in 1941. In the immediate post-war years, the British army maintained control over Ethiopia's medical services, a fact frowned upon by the Ethiopian emperor eager to remove any undue outside influence from would-be colonisers. In a diplomatic snub of the British, Haile Selassie struck an agreement with the Soviets to build a 200-bed hospital in Addis Ababa in 1946, giving £40,000 of his own money to the Soviet project (ca. £1 million in today's currency). The next year, he founded another 100-bed hospital in the capital out of his own funds, while also giving a central plot of land to the Indian delegation for the construction of a new maternity hospital. These three institutions were in addition to the Bet Saida (then expanded to 130 beds and renamed Haile Selassie I Hospital) and original Menelik Hospitals, plus the Seventh-Day Adventist's Empress Zewditu Memorial Hospital (founded 1934), the American Presbyterian (1923), and Italian-founded Ras Desta (1934). Each of these facilities had between 100-200 beds, an inordinate number of medical services, considering the population of Addis Ababa was less than 100,000. In addition, these hospitals were all opened with three classes of wards, with the price for treatment varied between fifty cents a day for a third class bed and five dollars a day for a private room in first class. The second class wards had shared rooms, and charged two dollars per day.[115]

Not only was Haile Selassie's fervour for hospital construction problematic in its urban bias, but as multiple detractors pointed out, existing medical facilities had fallen into considerable disrepair, and it would have been more economical and

[115] These figures are in Ethiopian dollars, which was tied to the United States Dollar in the 1940s and early 50s. In today's currency, the third class bed cost $4, second class cost $16, and first class $43.

efficient if they were renovated before new institutions were constructed. As the emperor curried favour with the foreign governments and missionary agencies to build new facilities, the British were mulling over proposed plans to build a hospital in memory of Princess Tsehai, Haile Selassie's nurse daughter who had recently died due to complications in pregnancy. The Tsehai hospital project was proposed in 1942 by former Suffragette and activist, Sylvia Pankhurst, whose sympathies for the emperor and the Ethiopian cause was well-known.[116] She solicited private donations totalling £100,000 (ca. £2.9 million in today's currency) for the memorial hospital's construction, advertising it as the 'first modern hospital' in Ethiopia.[117] Lambasted with criticism from the outset, the project became symbolic of the tensions between imperial medical interests and foreign commentators at the time. Colonel McClean, the British head of Ethiopia's medical services after the war, stated categorically that the last thing Addis Ababa needed was yet another hospital, when the Menelik, Ras Desta, and American Presbyterian facilities were all crumbling from neglect during the Italian occupation. There were supply and personnel shortages across the city, but imperial medical efforts seemed fixated solely on new construction projects.

The British Foreign Office did finally agree to help fund the Tsehai Hospital, only after internal concern about the growing diplomatic power of other nations reached a hilt. Of the other foreign medical operations, Britain's Middle East Secretariat (then head of Ethiopian interests) wrote that he was 'inclined to think that certain countries are running these hospitals as a propaganda stunt under the guise of humanitarianism.' There was particular concern about the Russians' announced effort to use their hospital to train indigenous nurses and midwives, 'since in these

[116] Pankhurst had been publishing a pro-Ethiopia newspaper since the Italian invasion of 1935, the *New Times and Ethiopia News*, and had become close to Haile Selassie while he spent his exile in Bath.

[117] E.S. Pankhurst, 'Princess Tsahai Memorial Hospital: A Symbol of International Friendship', *New Times and Ethiopia News*, no. 387 (30 March 1943).

sorts of countries this is a good means of getting into direct touch with the masses and of getting into their homes and disseminating ideological propaganda under the guise of "medicine."'[118]

Ironically enough, this pushed the Secretariat to suggest greater British involvement in their own medical projects, most notably the Princess Tsehai Memorial Hospital with which Haile Selassie had a 'close, personal interest.' He cautioned, however, that any engagement with medical work 'must be very carefully designed to ensure that we remain popular and do not arouse the least suspicions of our motive in medical matters.' Indeed, in a response to the Secretariat, another Foreign Office diplomat argued that 'until British interest in Ethiopia-Lake Tana is settled to our satisfaction, I think we should make sure that no one can accuse us of having disinterested ideas in Ethiopia's progress and future development.'[119]

There was an undying confidence among the British that their influence would prove the most beneficial to Ethiopia, for as one member of the Foreign Office contested, 'Ethiopians, with all their pride and suspicion of foreigners, admire Britain and British institutions, and desire to mould their way of life on our model.'[120] There was no better way to remodel the Ethiopian way of life along British lines than in the support of an elite new hospital. Commentators were intent on showing Ethiopia that Great Britain was still the 'paramount power in this part of the world,' despite Haile Selassie's recent shift in interest to the United States, a move which led the British to accuse Ethiopians of 'oriental ingratitude and short

[118] United Kingdom National Archive, FO 371/53458, Dr. E.D. Pridie, Medical advisor to the Middle East Office, Report by Dr. E.D. Pridie on the Health Services of Ethiopia. Code 1 File 114 (London Kew Gardens, 1946).
[119] United Kingdom National Archive, FO 371/46078, Handwritten comment by un-named UK Foreign Office official, British Propaganda to Ethiopia (London Kew Gardens, 1945).
[120] United Kingdom National Archive, FO 924/184, Handwritten comment by un-named UK Foreign Office official, British Council Activities in Ethiopia, Code 452 File 108 (London Kew Gardens, 1945).



Figure 1: Sylvia Pankhurst and Emperor Haile Selassie at the opening of the Princess Tsehai Memorial Hospital, 1951, reproduced with permission of the Pankhurst family.



Figure 2: Sylvia Pankhurst and Emperor Haile Selassie inspecting an operating theatre at the opening of the Princess Tsehai Memorial Hospital, 1951, reproduced with permission of the Pankhurst family.

memories,' considering it was mostly Great Britain that had helped free the nation from Italian oppression.[121]

The essential point was to ensure that the Princess Tsehai Memorial Hospital was opened with an entirely British staff to assert Britain's 'prestige' in Ethiopia. While doubt on Ethiopia's capacity for a modern hospital remained intact, the prestigious nature of the hospital held sway: it was not just Haile Selassie who was cognisant of the symbolic effects of new medical institutions, foreign diplomats were just as eager to project their power through urban, hospital construction.

Combating the critics

There was an air of urgency surrounding Haile Selassie's hospital projects. This was a critical decade for the emperor in proclaiming his right to rule, and in pouring both his own personal funds and diplomatic energies into repetitive institutional markers of modernity, he was operating under a simplistic narrative of change for Ethiopia: if the capital city *looked* sufficiently modern, not only would Ethiopia be perceived as a rapidly developing nation, but his position as a legitimate, visionary monarch would be secured. In propagating the vision of a modern Ethiopia, Haile Selassie was actively countering not only his own critics, but also those convinced of the nation's inherent 'backwardness.' Indeed, there were many who felt that the very independence of Ethiopia was its largest impediment to development. Even in the late 1960s, Christopher Clapham still argued that the same features which protected

[121] United Kingdom National Archive, FO 371/46078, Handwritten comment by un-named UK Foreign Office official (London Kew Gardens, 1945).

Ethiopia from colonisation meant it had retained its traditions more firmly, impeding both development and modernisation.[122]

One member of the British Foreign Office explained his reluctance to fund Ethiopian medical projects, especially the Princess Tsehai Memorial Hospital, because of this problematic independent tradition: 'the Ethiopians will welcome British assistance provided we give them men and money *on their terms*.' This was deemed improper, as British funds should be governed by British interests, ideally with Ethiopia as a British protectorate. Another FO representative argued that he could not 'help feeling rather strongly that those who pay the piper ought to be able to call the tune.' The prevailing feeling was that Ethiopia would 'squander' any funds given due to their rampant 'ignorance and xenophobia and foreign jealousies.'[123]

Despite Haile Selassie's assertions of Ethiopia's imminent ascension to modernity, Ethiopians were viewed as being wilfully obstinate, 'callous and indifferent' to change and outside influence. After visiting Ethiopia in 1945 to assess the nation's potential to develop a public health service, Dr. E.D. Pridie of the Foreign Office proclaimed that any such operation was doomed to fail. Pridie argued that with a population 'inclined to be heartless as a race, and take poverty and disease for granted,' there was little chance for acceptance of an advanced medical model. Pridie even criticised Haile Selassie directly for having created a mere 'façade of civilisation' in towns, when overall, the nation remained 'primitive, sad, and miserable.'[124]

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[122] C.S. Clapham, *Haile-Selassie's Government* (London, 1969), p. 1.

[123] United Kingdom National Archive, FO 371/53548, Handwritten comment by un-named UK Foreign Office official (London Kew Gardens, 1945).

[124] United Kingdom National Archive, FO 957/39, Dr. E.D. Pridie, Medical advisor to British Middle East Office, Public Health: Ethiopia; Princess Tsahai Hospital; Tours by Dr E D Pridie (London Kew Gardens, 1948).

It was not only outside observers who labelled the population backward, however, but elite Ethiopians also worked to distance themselves from the perceived traditionalism of the general population. Bahru Zewde has noted that it was all too common for the educated classes to decry the lack of development within their own nation: 'radicals ranging from Gabra-Heywat Baykadagn in the early twentieth century to the unsuccessful coup makers of 1960 bemoaned the backwardness of independent Ethiopia,' especially in comparison to colonial Africa.[125] Dr. Asfaw Desta, a public health professor trained at the University of California Berkeley in the early 1960s, explained in an interview the gentle ridicule of classmates who asked how he could possibly return to such a backward country after having lived abroad. When I asked Asfaw how he dealt with such criticism, he asserted, 'well, it's true! Ethiopia was backward, you have to admit it. We have an old culture and history, but in the current, modern sense, we were backward.'[126]

Haile Selassie's contradictory modernism

No one was more ready to separate himself from the underdeveloped Ethiopian population than the emperor. In a 1942 meeting with US aid officials in Addis Ababa, Haile Selassie told the delegation that he 'welcomed American efforts to help backward peoples,' soliciting their aid in constructing medical and educational projects for the nation.[127] The emperor used the underdeveloped rhetoric to his personal advantage: while the nation may be backward, he himself was modern, and perfectly capable of leading his people away from out-dated traditionalism and into

[125] Zewde, *History of Modern Ethiopia*, p. 84.
[126] Author interview with Dr. Asfaw Desta, Addis Ababa, 15 February 2013.
[127] A.K. McVety, *Enlightened Aid: US Development as Foreign Aid Policy in Ethiopia* (New York, 2012), p. 73.

the twentieth century. In consistently asserting his own personal role in the expansion of hospitals, Haile Selassie was demonstrating his capacity as modern leader.

This personal assertion of modernity in many ways worked against the emperor, however, for as Christopher Clapham noted, in centring Ethiopia's modernisation potential solely on his own leadership capacities, Haile Selassie only succeeded in reinforcing the traditionalism of his empire. In his study of the Imperial Government, Clapham demonstrated how 'the emperor's authority has been vested directly in his own person… His personal initiative has therefore been needed for any innovation or improvement.'[128] Haile Selassie promoted the modernity of his reforms of Ethiopia, ignoring the irony that by commanding personal responsibility over every action, the emperor was merely re-enacting the model inherited from his predecessors.

Previous studies of Haile Selassie and his government have described in detail the contradictory nature of the emperor's civil and educational reforms and the ways in which such actions constituted mere performances of a Euro-centric modernity. The most sound analysis of the limitations of the emperor to reform Ethiopia can be found in the work of Bahru Zewde. Zewde's history of modern Ethiopia asserts that while Haile Selassie played a useful role in securing the independence of the empire following the Italian occupation, the symbolic figurehead rapidly became redundant as he continued to focus on mere prestige projects rather than significant structural reforms.[129] More recently, John Markakis' seminal history of Ethiopia's imperial expansion has explained how in promoting Western-style education, Haile Selassie merely produced a 'politically restless intelligentsia who challenged the authority

[128] Clapham, *Haile Selassie's Government*, p. 10.
[129] Zewde, *History of Modern Ethiopia*.

and legitimacy of the state.' Education was seen as a hallmark of modernisation, but the emperor intended the construction of schools to add to his 'façade of civilisation,' not engender actual social change.[130] Paulos Milkias' work on education and revolution in Ethiopia makes a similar conclusion: those who initially benefited from the advent of Western education in Ethiopia then used their education to turn against the emperor's authoritarianism in ideological revolt.[131]

While these studies have all contributed to the understanding of imperial limitations in national modernisation efforts, there remains a significant gap in the literature on the role of medicine in Haile Selassie's modernising mission. This neglect of medical history is surprising, considering the emperor's consistent acknowledgement of his eagerness to use medicine as a marker of Ethiopia's modernity. Indeed, the emperor explained how his father's first action to bring 'European civilisation' to his territory in Harar was the building of a hospital.[132] Christine Sandford's hagiography of Haile Selassie described the emperor's 'keen interest in the building of hospitals,' and how he would 'go down often to inspect, staying to watch operations in the theatre, paying visits to the patients in the wards.'[133] In an interview with Dr. Elisabeth Duncan, a Scottish obstetrician who worked at the Princess Tsehai Hospital in the 1960s, the physician described the imperial tendency to parade unannounced on the hospital grounds. Attending routine obstetric duties, Dr. Duncan was frequently caught unaware by Haile Selassie's presence in a ward corridor. All medical work would be put on standby as

[130] J. Markakis, *Ethiopia: The Last Two Frontiers* (Rochester, 2011), p. 13.
[131] P. Milkias, *Haile Selassie, Western Education, and Political Revolution in Ethiopia* (Youngstown, NY, 2006).
[132] Selassie, *My Life and Ethiopia's Progress*, p. 17.
[133] C.L. Sandford, *The Lion of Judah Hath Prevailed: Being the Biography of His Imperial Majesty Haile Selassie I* (London, 1955), p. 141.

a hospital administrator would rush to lead the emperor through the facility as staff bowed to their sovereign.[134]

A Seventh-Day Adventist fundraising campaign for their Empress Zewditu Memorial Hospital also describes how His Imperial Majesty's 'blue Cadillac' was often seen parked on hospital grounds, signifying not only the prestige of the Adventist hospital, but also the personal interest of the Ethiopian emperor in the work of medicine.[135] In 1963, another missionary publication explained that 'Ethiopia entered the Jet Age this year,' a reference both to the creation of Ethiopian Airlines and the rapid modernisation of the nation. The publication continues, 'we would like to think that we are keeping up with the times in our medical work.'[136] Despite the loud criticisms of detractors doubtful of the sincerity of Haile Selassie's modernising efforts, for those close to the emperor, including missionary partners in medical campaigns, Ethiopia's rapid progression required the swift development of a medical network worthy of this newly modern state. Medical institutions worked alongside modern enterprises like a national airline to confirm Ethiopia's ascendency. In the view of the supporters of the imperial cause, with the streets of the capital city lined with large, modern hospitals, the teleological rise of the nation

[134] Author interview with Dr. Elisabeth Duncan, Addis Ababa, 9 January 2013.

[135] J.A. Simonson, 'Emperor Presents Diplomas to Nurses', *The Advent Review and Sabbath Herald* (5 July 1956), p. 1.

[136] R.G. Rigsby, 'Proposed New Hospital in Ethiopia,' *Northern Light* (July 1963), pp. 4-5. Both *Northern Light* and *The Advent Review and Sabbath Herald* from the previous reference are Seventh-Day Adventist newsletters from the United States. They both published regular missionary news from overseas.

was obvious.[137]

The question of training: contentions between a medical school and auxiliary service

Aside from hospital construction, the training of indigenous medical manpower to staff the growing number of facilities was a crucial element in the development of Ethiopia's new health network. In 1951, there were eighty physicians working in Ethiopia, all of whom were foreign. That same year, the Princess Tsehai Memorial Hospital was opened, admitting 14 young women as students of its nursing school. In 1952, the Empress Zewditu Hospital opened its own nursing academy, and the WHO sent ten promising Ethiopian students abroad for medical and leadership training.[138] The first medical school in Ethiopia was not opened until 1966, and until that point, all indigenous medical training was focused on 'auxiliary' positions, including nurses and 'dressers,' a type of low-level medical assistant first established by missionaries in the early twentieth century to help staff clinics. Any Ethiopian interested in becoming a doctor would have to be trained abroad, either through a scholarship from the WHO, or at the American University of Beirut, which had established an exchange programme with the University College, the only tertiary establishment in Ethiopia and precursor to Haile Selassie I/Addis Ababa University.

[137] It is worth noting that the Seventh-Day Adventist's missionary network contributed a great deal to Ethiopian medicine at the time, with several rural hospitals in addition to the Zewditu facility in Addis. The Norwegian Lutheran Mission and Sudan Interior Mission (SIM) were also highly active in medical work in Haile Selassie's Ethiopia. Missionary medicine in Ethiopia is a vast, under-studied field that merits a separate investigation. While I allude to the work of medical missions throughout this text, I do not concentrate specifically on the meanings of missionary medical encounters in Ethiopia under the emperor, due to space restrictions, and my interest in concentrating on the activities of Ethiopian practitioners of medicine.

[138] United States NARA, RG460 P247, Records of US Foreign Assistance Agencies: Unclassified Central Files Compiled 1951-1961 (College Park, MD, 1961).

Recognising the dearth of indigenous medical personnel, Haile Selassie felt it necessary to set up a medical school from the outset, but the project was held up in two decades of debate among potential donors on whether Ethiopia was in fact ready for an elite physician training course. In lieu of a medical school, the United States government teamed up with the WHO to build the Gondar Public Health College in 1954, a training centre for three cadres of rural health auxiliaries: the health officer, community nurse, and sanitarian.

The construction of the Gondar College has several parallels in neighbouring African countries, including the Medical Training Centre of Dar es Salaam, Nairobi's King George VI Training Centre, and the Makerere School of Medicine in Uganda, which began training medical auxiliaries as early as 1924.[139] Given the widespread use of indigenous auxiliaries, the term 'health auxiliary' itself began to take on significant negative connotations in the history of colonial African medicine. With the expansion of colonial medical training programmes, it was common for indigenous medical practitioners to be deemed mere 'auxiliaries,' despite performing the same duties as their foreign counterparts. In British Sudan, an artificial hierarchy was imposed on indigenous medical practitioners who despite claims to seniority of age and experience, continued to be under the strict direction of imported colonial physicians.[140]

In the case of Ethiopia, American officials remained convinced that the auxiliary model was a more appropriate manpower solution than a traditional doctor-based medical model. With a population living almost entirely in scattered rural

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[139] For more information on these auxiliary programmes, see: E.F. Rosinski and F.J. Spencer, *The assistant medical officer. The training of the medical auxiliary in developing countries* (Chapel Hill, 1967); O. Gish, K.R. Hill, and K.M. Elliott, *Health, manpower and the medical auxiliary: some notes and an annotated bibliography* (London, 1971); and J. Iliffe, *East African Doctors* (Cambridge, 1998).

[140] H. Bell, *Frontiers of Medicine in the Anglo-Eqyptian Sudan, 1899-1940* (Oxford, 1999).

settlements and suffering primarily from preventable, communicative diseases, foreign advisers attempted to convince the emperor that the medical needs of his nation would be best met by a type of indigenous 'health army' akin to the famed 'barefoot doctor' programme in China.[141] Gondar graduates would avoid the city and work in a new network of rural health centres and health posts, engaging with the community on preventive health projects that tackled the source of disease, rather than its mere treatment. The Gondar school was a departure from the urban hospitals and 'façade of civilisation' promoted by the emperor, an intentional move by outside observers wary of the ineffectual grandiosity of Haile Selassie's contradictory modernism. While the emperor had succeeded in furnishing his capital city with a spate of elite hospitals, or 'prestige projects' as named by Clapham, foreign assistance in training local medical staff was largely reserved for auxiliary courses.[142]

What Kind of Doctors does Ethiopia need?

The conversations between Haile Selassie and the Rockefeller Foundation serve as only one example of the contentious discourse between the emperor and potential patrons on the question of appropriate medical manpower for Ethiopia. In 1965, the Ethiopian Medical Association convened an entire conference under the question 'What Kind of Doctors does Ethiopia need?' The conference brought together both local public health officials and foreign physicians working in Ethiopia to debate whether or not a medical school should be opened at all, and what category of health practitioner was best suited to work in rural areas of the empire. One foreign

[141] 'Barefoot doctors' were Chinese farmers who were given rudimentary health training in the 1930s.
[142] Clapham, *Haile Selassie's Government*, p. 49.

medical professor in attendance claimed that it would be best if Ethiopia simply '*avoided* doctors.' Summarising the general sentiment of attendees, Professor Shack argued:

> Divorced from the cultural characteristics of the population, the gap which exists between highly educated and Western-oriented doctors and the majority of their patients would compare unfavourably with the doctor-patient relationship as it is understood between the poor people of Ethiopia and their traditional medical man.[143]

That is to say, the population of Ethiopia was not yet ready for a Western-style medical model, and would likely reject elite physicians in favour of local practitioners.

It was believed that the gap between traditional life and modern medicine was simply too great, and there was need for an intermediary between the two worlds. With their combination of local upbringing and foreign education, Gondar graduates were expected to fill this role. The graduates presented two advantages: first, as local practitioners, they would be more effective at communicating modern principles to their lay audience; and second, they would be health officers, nurses, and sanitary workers, but *not* doctors. At the Ethiopian Medical Association's conference, Dr. Otto Jäger, a Swedish physician working in Addis, explained that 'foreign actors are unlikely to reach adequate understanding of their patients, or of communities, unless they stay in the Empire for significantly long periods— unless, indeed, they view the matter as a lifetime assignment.'[144] Perhaps speaking from his own personal experience, Jäger argued that the local context in Ethiopia was too opaque, the traditions so firm, that most foreign physicians would be lost for several years in a state of culture shock before they could be effective. But it was not just the

[143] 'What Kind of Doctors Does Ethiopia Need', *Ethiopian Medical Journal*, vol. 4, no. 1 (1965), p. 3.
[144] Ibid., p. 4.

foreignness of the physician that would be problematic, but the elite nature of the professional 'doctor.' On the question of health provision for rural areas, conference attendees agreed that the Gondar model was the only way forward. As one official noted, it was 'more urgent and realistic to staff these neglected areas with medical auxiliaries than to discuss what kind of doctors were required.'[145]

Health centres over hospitals: a 'foreign-inspired' medical model

Officials advertised the Gondar programme as the antithesis to the elite medical school model. Instead of training curative physicians, the public health college would produce graduates uniquely attuned to the needs of Ethiopian communities. Built in lieu of the medical school Haile Selassie campaigned for, supporters of the Gondar college were often defensive about the institution and its graduates. In 1968, one Ethiopian commentator queried what role the college's trainees were to occupy: 'is the graduate intended to be a scientist, a general practitioner, or an unfinished doctor who still has to specialise?'[146] Two years earlier, a British instructor at the college had defended the course in a letter to *The Lancet*, stating that 'these graduates are not "near-doctors," they are health workers specialised in fields of which the doctor has a general knowledge.'[147] Indeed, in the late 1970s, Wen-Pin Chang, a Taiwanese physician and public health expert instrumental in the construction of the Gondar model, continued to defend the college, stating that despite criticisms to the contrary, Gondar was 'not a second-rate

[145] Ibid., p. 5.
[146] R. Giel, 'Patterns of Morbidity in a General out Patient Population as a Guide to Priorities in Medical Curriculum', *Tropical and Geographical Medicine,* vol. 20 (1968), p. 281.
[147] F. Howarth, 'First Things First', *The Lancet*, vol. 287, no. 7434 (1966), p. 426.

medical school, nor a stepping stone to a university course in medicine, but a first-rate institution for training health workers for rural health services.'[148]

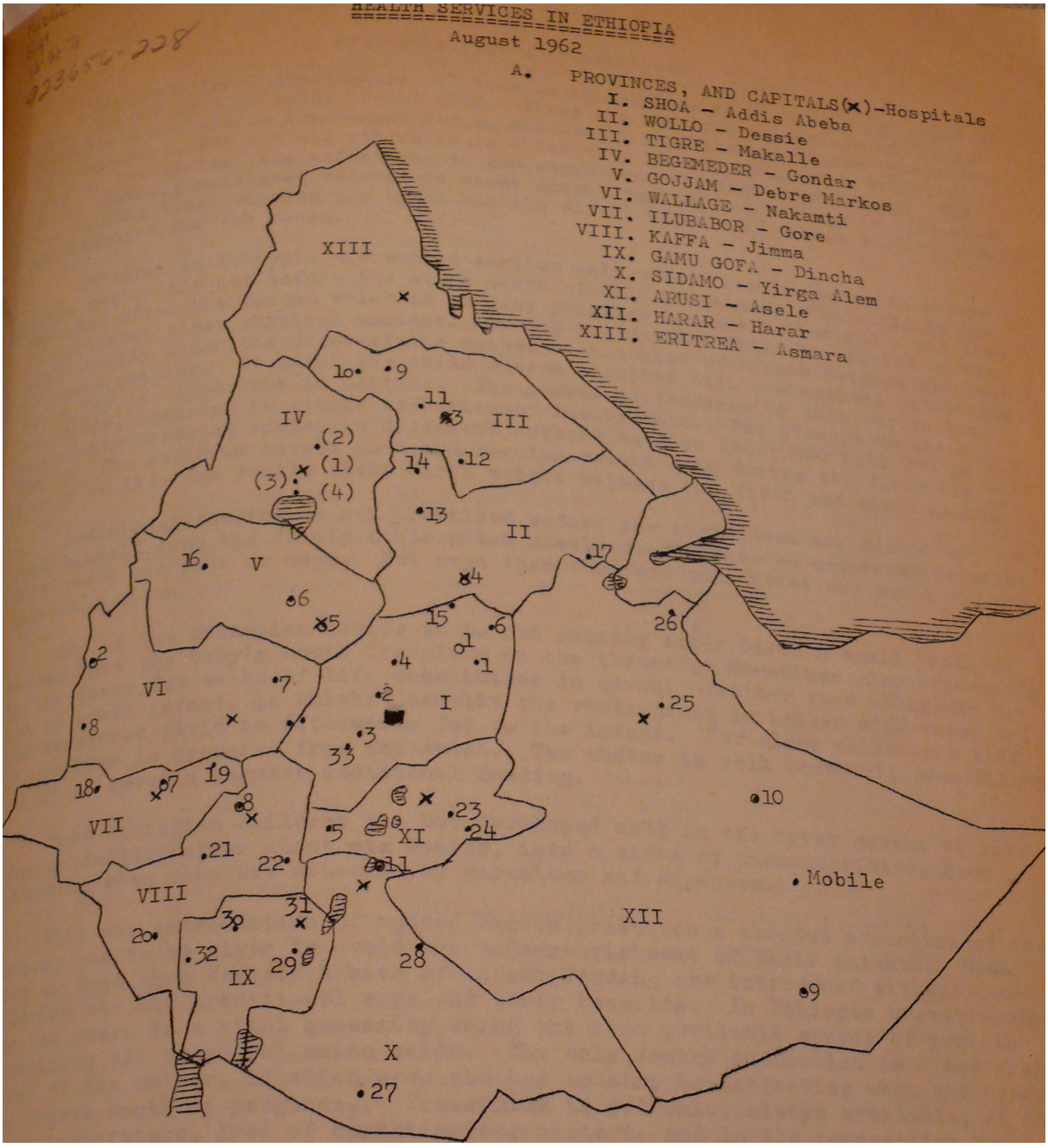

Figure 3: Map of Ethiopia in 1962 with Gondar health centres demarcated by dots and numbered 1-27. The hospitals are demarcated with 'x'. Reproduced from the Gondar Health Series, vol. 1, (Addis Ababa, 1962).

[148] W.P. Chang, 'Development of Basic Health Services in Ethiopia', *Taiwan Yi Xue Hui Za Zhi (Journal of the Formosan Medical Association)*, vol. 68, no. 6 (28 June 1969), p. 306.

While the interests of the Ethiopian population were paramount in the decision to open the college at Gondar, foreign officials were also reacting to their own feelings of frustration with modern medicine's limitations, both in Ethiopia and abroad. Many of the foreign physicians and administrators working in Ethiopia had fled to Africa to practice medicine out of a sense of frustration with their roles as practitioners in their home countries. Once settled in the East African Empire, many physicians chose to stay and take on positions as senior advisors and managers of public health policies under Haile Selassie. There was a prevailing sentiment among these expatriate medical men that in the '*tabula rasa*' of Ethiopia, the errors of Western medicine could be corrected.[149] Dr. Dennis Carlson, one of the early deans of the Gondar College, argued that in Europe and North America, physicians were increasingly dissatisfied with the medical model that removed them from their patients, and that in building a new health system for Ethiopia, the nation must avoid recreating an overly 'scientific' system of care. Carlson explained that the Western doctor now 'yearned for a past when he was also a friend and leader,' having the 'distinct impression that he has been replaced by a technician or a craftsman, an impersonal, dehumanised master of many machines and techniques.'[150]

As hospital construction moved forward in Ethiopia, foreign officials worried that a similar pattern of overly technical and elitist medicine was being recreated in the developing nation. At a 1964 conference on medical education policy in Ethiopia, B. Oscar Barry, President of the Ethiopian Medical Association, plainly asserted that elite models of institutional care were simply inadequate for the needs of the empire:

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[149] One British nurse named Ethiopia a 'doctor's paradise' because it provided 'a pretty clean slate on which to work.' R. Young, 'Medicine and Nursing in Ethiopia', *The Lancet*, vol. 243, no. 6303 (June 1944), p. 797.

[150] D.M. Carlson, 'The Necessity of a Social Science Emphasis in University Medical Education', *Ethiopian Medical Journal*, vol. 2, no. 2 (1964), p. 179.

> The provision of even the most elaborately scientific medical facilities, whether in clinical or preventive medicine, will be useless so long as they remain alienated from the people whom they seek to serve. To achieve this end there must be a blending of old and new, a combination of science and humanity, an understanding of the motivation, hopes, and fears of the people, with a thorough knowledge not only of the scientific bases of medicine and the clinical techniques available, but also of that scientific method of thought.[151]

In their first decades of operation, Ethiopian hospitals were concentrated in the capital and had indeed 'remain[ed] alienated' from the majority of the population. In addition, patients were accessing mere scientific cure at the facility, but they were not treated or cared for in a manner which elevated their standard of living or ensured they benefited from the modern development of the state. Barry and others thus argued that in Ethiopia, institutions could no longer be separated from intended patients in such a manner. Instead, science and medicine must be blended with social humanism in a new model of community care, and above all, practitioners must operate both as medical professionals and as compassionate care-givers.

Satisfying the needs of the citizen and the nation

These advocates of an alternative model of medicine in Ethiopia were also responding to local patients' own priorities and predilections in medical treatment. Medical anthropologist Simon Messing described the hospital as a mere 'last resort' for Ethiopians because of patients' reluctance to be 'separated from kinfolk and exposed to treatment of strangers.'[152] Messing acknowledged the fact that aside from

[151] B.O. Barry, 'Conference on Medical Education Policy', *Ethiopian Medical Journal*, vol. 2, no. 2 (1964), p. 143.
[152] S.D. Messing, 'The Highland-Plateau Amhara of Ethiopia' (Univ. of Pennsylvania Ph.D thesis, 1957), p. 583.

aristocratic patients, most Ethiopians saw the hospital as a distributor of scientific cures, but that the needs of social support at the time of illness were provided primarily by close relatives within the home. The entangled nature of Ethiopian medicine and need for complementary treatments was made evident to practitioners who saw patients arrive at facilities having just been treated by alternative healers, neighbours, and relatives. Dennis Carlson noted that there was in fact a profound difference between Western-trained physicians and local practitioners, given that the latter already 'knows about all aspects of life and has all resources at his disposal.'[153] Carlson saw the attraction of domestic caring models, and advocated for a greater interchange between the parallel medical systems. Not content to just import modes of medical education from the West, Carlson and many contemporaries began to argue that the entangled traditions of Ethiopian medicine should be foundational in informing the creation of a modern health network in Ethiopia. State administrators agreed that if a new model of health could be developed which abandoned the institution and operated directly within community structures, traditional healers and practices could eventually be replaced by modern systems of care.

The Gondar model would help bridge the perceived gap in Ethiopia between tradition and modernity, while also rectifying the failures of the hospital to adequately reform community life. The hope of medicine to develop Ethiopia was not diminished with the acknowledged inadequacies of the hospital model: instead, the state worked to rebrand medicine in a way more palatable to the population. Not only would this increase patients' access to medicine, it would also ensure communities more actively modernised their modes of living alongside the developmental trajectory of the state. Whereas the hospital had brought only 'indirect and partial modern change' to Ethiopia, preventive public health would

[153] Carlson, 'The necessity of a social science emphasis', p. 179.

work to fully modernise the nation through a form of grassroots, domestic re-development.[154]

Foreign advisors contended that indeed, medicine should not be merely curative, but instead have a transformative economic power in emerging nations. Julius Prince, an American physician and principal advisor on the Gondar project, explained that Ethiopia needed a new model of healing to deal with the needs of community development, for 'the medical approach in itself promises little with respect to the health component of the improved well-being of man.' He argued that the function of health must lead to economic betterment, and that economists and health workers were to work together to 'translate medical interventions into health, and in translating health into economic and social gains for the poor of underdeveloped lands.'[155]

The Gondar model of health would help satisfy the needs of both the state and its citizens: community traditions would be reformed, while patients themselves would access a more comprehensive treatment that provided social care alongside biological cure. This system would be more accessible to the Ethiopian patient, both geographically because of its concentration on building health centres in rural areas, and ideologically, given college graduates would be trained to treat both the social and biological causes of disease.

Lastly, the impact of the Gondar model would not only be considerably greater than the hospital's, but also achieved at a lower cost. Advisors argued that whereas hospitals were expensive enterprises that drained state health budgets, a community-based health practice would be cheap and effective in reaching large

[154] Messing, 'The Highland-Plateau Amhara of Ethiopia', p. 583.

[155] J.S. Prince, 'Demonstration and Evaluation Project: Ethiopian Health Centre Program Its Impact on Community Health in Three Towns', *Ethiopian Medical Journal*, vol. 5, no. 3 Conference Supplement - 3rd Annual Meeting Ethiopian Medical Association (July 1967).

portions of the population. The Minister of Public Health at the time, Ato Abbebe Retta, explained that 'public health medicine should be prioritised in the empire as the most adequate and cheapest way of improving the health of the present and future generations of Ethiopians.'[156] Indeed, Franz Rosa, a senior member of staff at the Gondar College, argued that 'the quality of a health programme is not so much related to its elaborateness or cost, but primarily to the degree to which it is successful in meeting the problems in the area.'[157] The Gondar model was correcting multiple failures of the hospital: it would reach a larger portion of the population for less money, while also bringing the benefits of modernity directly to the home community. Rural communities would now access both medical treatment and a method for social advancement and development previously unavailable at the remote medical institutions of the city.

Medicine versus health: Further implications of the Ethiopian debates

To end this chapter, I want to discuss briefly the ways in which the debates in Ethiopia were symptomatic of global contentions on the place of medicine and health in modern life. The early trajectory of modern medicine in Ethiopia, from imperial-directed hospital construction to foreign campaigns for community health, mirrored global concerns on the place of medicine in bringing about social and economic change. The shift to auxiliary-led, community-level, preventive medicine was seen across developing countries from the 1950s onwards, a trend governed by the rise of standardised models of global health. The entangled relationship between

[156] A. Retta, 'Introduction by the Minister of Public Health', *Ethiopian Medical Journal*, vol. 1, no. 1 (1962), p. 8.
[157] F.W. Rosa, 'Project of the Haile Selassie I Public Health College and Training Centre in Gondar', *Ethiopian Medical Journal,* vol. 1, no. 2 (1962), p. 72.

medicine and economic development was heavily debated in the decades of the mid-twentieth century, reaching its zenith with the publication of Thomas McKeown's *The Role of Medicine: Dream, Mirage, or Nemesis?* in 1979. McKeown's thesis - that the last hundred years of population growth and development occurred through economic change and improved public health, not medical intervention - derived from an abiding concern with the over-stated role of biomedicine and its potential iatrogenic effects for patients. While careful to distinguish his arguments from the work of predecessors, McKeown's book followed the example of other medical sceptics like Ivan Illich, whose study *Limits to Medicine: The expropriation of health* (1976) was particularly bombastic in its critique of the 'mythic prestige' of medicine in society. The debates among health officials working in Ethiopia on the role of medicine in 'curing the ills' of the nation did not go to the dramatic lengths of Illich and McKeown, but there was an underlying scepticism about the potential power of biomedicine in the Ethiopian context. Imperial policies demonstrated an unwavering faith in medicine's ability to both heal and modernise Ethiopia, but foreign commentators were more cautious on their endorsement of biomedical capacity.

This caution was driven both out of concern for Ethiopian 'backwardness,' but also doubts surrounding the mere performative advantages of imported medical practices in the developing country context. Haile Selassie had emphasised medicine's modernising capacity because of the prestige evident in its elite apparatus of hospitals, sophisticated equipment, and highly educated personnel, but if modernisation was to mean actual economic development, the limitations of medicine were obvious. As developing nations began expanding their medical networks alongside increased industrialisation, state officials and health practitioners across Africa began to assert the need for alternative models of health on the continent, including the Gondar model of preventive care. Large portions of

developing nations' populations lived in rural areas, and commentators noted the significant division between rural community life and industrialised urban spaces, with their prestigious medical institutions and specialised physicians. The Gondar Public Health College changed the locus of medical healing in Ethiopia from the hospital to the community, a move echoed across African countries searching for a more active role for medicine in national development campaigns.

Commentaries of foreign practitioners

As in other nations, state medical policies in Ethiopia were largely dictated by official politicians and diplomats. In the course of my fieldwork, I interviewed several foreign practitioners operating in Ethiopia during the reign of Haile Selassie, eager to understand their perspective on the imperial medical expansion. To conclude this chapter, I want to briefly discuss the perspectives of Sir Eldryd Parry and Dr. Dennis Carlson, both of whom were intrinsically involved in the early education of Ethiopian medical students.

Sir Eldryd Parry is a British physician who taught at the medical faculty in Addis Ababa at its opening in 1966. In the 1970s, Parry became renowned for developing a pioneering community-based education scheme for medical schools in Nigeria, a concept very much grounded in his observations of health education in Ethiopia. In our interview, Parry explained his frustration with the overly theoretical curriculum at the Addis Ababa medical school, a fact he blamed on the initial founder, Charles Leithead. As he explained, 'I called a meeting and said this was absolutely ridiculous, you couldn't go on like this, you must change it – get rid of all the lectures, there were lectures on everything – and get on with the clinical training. That was [Leithead's] inexperience in repeating the Scottish medical education

which he'd had.' For Parry, merely transposing European models of medicine and health education was impractical given the needs of developing nations like Ethiopia. While working in Addis, Parry visited the Gondar school, a programme he described as a 'revelation,' and 'way ahead of its time.' In seeing the work of health officers - auxiliaries trained to enact preventive health reforms at the community level - Parry was inspired to reform medical education in West Africa to be more development-oriented.

Having spent only three years in residence at the Addis Ababa medical faculty, there was not sufficient time to reform the Ethiopian education model, and even so - at the time of Parry's tenure, the Gondar programme was a thriving example of the community-based, preventive medicine he felt requisite in developing country contexts. In the 1960s, it seemed Ethiopia was leading the charge in terms of medicine for community development.[158]

In an interview with Dennis Carlson, he explained that while acting as Dean of the Gondar Public Health College, he received near-weekly visitors from the WHO and other diplomatic corps, eager to see what had been described as one of the 'best public health programmes in Africa,'[159] and 'one of the best examples in the development of basic health services among the developing countries in the world.'[160] The WHO archive is littered with scores of trip reports from visiting global health officials eager to transpose the 'lessons learned' and 'good practices' from one developing country to another. With the introduction of the Gondar school, the case of Ethiopia became a central locus in the global production of

[158] Phone interview by author with Sir Eldryd Parry, 6 November 2012.
[159] E.F. Torrey, 'Health Services in Ethiopia', *The Milbank Memorial Fund Quarterly,* vol. 45, no. 3 (1 July 1967), p. 280.
[160] Chang, 'Development of Basic Health Services in Ethiopia', p. 306. Author interview with Dr. Dennis Carlson, Addis Ababa, 4 May 2013.

knowledge surrounding health development both for Africa and developing regions in the Middle East, Latin America, and Asia.

The first medical school for Ethiopia and implications for Gondar

Despite the global prestige of the Gondar project, neither the public health model nor its foreign supporters represented the last word on medicine and its place in modern Ethiopia. Global debates on the mythic ascension of medicine aside, imperial interests in medical prestige projects were not fully eradicated. Haile Selassie's long campaign for a physician training programme finally succeeded in 1966 with the founding of the Haile Selassie I University Medical School. As to be expected, foreign criticisms of both the school and its accompanying 800-bed teaching hospital were immediate. The hospital became renowned as the ultimate 'white elephant' in Ethiopia's national development, and tensions continued between local and foreign interests in Ethiopian medicine.

In 1970, the head of the Ethiopian Medical Association wrote an apologetic essay attempting to assuage the tide of critics of the medical faculty. The essay admits that 'the reasons are numerous and logical enough' to consider such a faculty and large hospital 'inappropriate for a developing country.' The author admits that 'to build a palace in which to care for an infinitesimally small proportion of a population, and to provide it moreover in the capital city of a country with a basically rural and agricultural economy is an act unduly open to criticism if not indeed morally wrong.' Still, despite this frank recognition of the problematic construction of the elite medical institution, the essay concludes in turning the criticism around to the foreign detractors:

> On the other hand, it is probably difficult for a resident of the country concerned to hold these views, with his ordinary human, romantic and not forever logical pride in the immediate tangible assets around him. The view expressed above appeal most perhaps if they are strictly for export, like some of the dogma offered annually by the international army of airborne and brief-cased advisors. It is not a mere building, however opulent and irrelevant it might appear, that makes an ivory tower or a white elephant; it is the way in which it is used, only if the thoughts and pursuits of the men who inhabit it are opulent and irrelevant can the charge be made.[161]

This editorial is crucial in demonstrating the profound need for the Ethiopian regime to parade its modernity through the very prestige projects that elicited such criticism. While the Gondar Public Health College was the ultimate accomplishment for foreign observers of the developing nation, this essay exposes the significance of performative modernism within the local context. The author locates the construction of hospitals within the very 'ordinary human' and 'romantic pride' of a developing nation's residents. In the trajectory of modernisation, he argues that the population needed visual symbols of the nation's success. There is an optimism that even if these institutions were expensive and overly 'opulent' given the actual reach of their services, the intention of the men who built and would then work in these buildings were pure. The new teaching hospital was to be another integral piece in the larger national development project, and in that sense, would provide a fundamental contribution to the betterment of Ethiopian life.

Conclusion

One of the main critiques of the Haile Selassie I Medical School was the way in

[161] 'The New Teaching Hospital', *Ethiopian Medical Journal, vol.* 8, no. 4 (1970), pp. 1–3.

which it would diminish the work of the Gondar school.[162] The medical school represented a step back to the institution-focused, urban-biased health policies of the late 1940s and early 50s to which the Gondar model had been an antidote. While there is little doubt that the considerable budget of the medical faculty and teaching hospital could have been more widely distributed in more basic rural health services, it could be argued that the underlying intentions of both projects were largely the same. This chapter has described the two sides of the debate in modern medicine's introduction in Ethiopia, from imperial hospital construction to foreign-assisted auxiliary services. The policies advocated by Haile Selassie and his foreign advisors clearly diverged in terms of implementation, but their arguments often ran parallel to one another. With the former emphasising urban hospital development and the latter rural community care, both sides agreed that medicine was a relevant tool in recruiting populations to the benefits of modernity. There were performative elements of medicine in both urban and rural health schemes, as both worked to demonstrate scientific advancements to an otherwise 'underdeveloped' population. And while the first steps to modernise the nation through medicine were taken by a defensive emperor, striking out against his critics, the decades that followed demonstrate the ways in which developing nations and their residents became testing grounds for new global theories of public health and economic development. For all actors involved, there was little question about the potential for medicine to

[162] Before the faculty was constructed, J.M. Weir of the Rockefeller Foundation opposed its establishment on grounds of preserving the work in Gondar: 'The establishment of the medical school would have effectively pulled the rug out from under the Public Health College and Training Centre. With the opening of a medical school, students would inevitably be drained off into the prestige establishment which would train them for practice in the capital. The effect at Gondar would thus be vitiated, and the result of opening medical school would thus be a long step backward in trying to meet the real health needs of the country.' Rockefeller Foundation, RF: 02.1964/701, Ethiopia General Correspondence (New York, 1964).

modernise Ethiopia, whether in the opulence of an urban hospital, or the didacticism of a community health clinic.

In the next chapter, I explain how women were co-opted into state modernisation rhetoric by virtue of their perceived domesticity. The WHO produced a globally-unified rhetoric on the potential of the maternal and child health clinic to develop emerging nations, and Ethiopia swiftly incorporated such policy prescriptions into their own designs for public health's expansion. Throughout the rest of the thesis, the contradictions presented in this chapter will continue to arise: medicine was a prestigious enterprise, and while elite practitioners attempted to engage ordinary women in the act of community modernisation, the superficiality of medical reforms continued to limit their actual impact on patients.

Chapter 2: Educate the Mother, Reform the Nation

With the protection of mothers and children, one is safeguarding the human resources of the next generation so to produce citizens of high mental and physical calibre. One should always keep in mind this distinct parallelism between the development and welfare of the nation and better maternal health services.

— Dr. B.H. Bonnlander, Gondar Public Health College, 1971[163]

Throughout the five decades of his rule, Haile Selassie retained absolute power. All policies and initiatives in Ethiopia were funnelled directly through the emperor, and the nation's parliament and ministers were consistently deferential to the imperial opinion before enacting reform. Because of Haile Selassie's firm grip on the administration of his empire, the campaign for national modernity largely rested on his own personal rhetoric of Westernisation. At the same time, the emperor was also heavily indebted to his international supporters for the financing of modernisation efforts, especially the burgeoning medical network. As seen in the previous chapter, the absolutist ruler was often forced to negotiate his own predilections with international rhetoric on the appropriate place of medicine within modernisation campaigns.

This negotiation was especially evident in regards to maternal and child health. Swiftly after its formation in 1948, the WHO crafted a standardised, global message on the place of maternal health clinics in national development schemes. The international medical body pushed an agenda which focused on a new brand of cultural modernisation via the maternity clinic, both in Ethiopia and neighbouring African countries. In this rhetoric, the home was defined as the sphere of women, and it was believed that mothers would be crucial actors in rearing the next generation away from backward traditions. By educating the mother from

[163] B.H. Bonnlander (ed.), *Maternal and Child Health: Proceedings of the 5th Public Health Practice Conference* (Gondar, 1971), p. 102.

pregnancy onwards, a natural re-orientation to modernity would occur from the very onset of life. The increasing number of WHO-supported maternal and child health clinics across developing nations began to serve as vehicles for the state to both access and engage women in their own domestic modernising missions.

Haile Selassie himself encouraged the proliferation of the WHO's 'domestic' modernisation agenda in Ethiopia by soliciting the participation of every citizen in the nation's development. In numerous speeches, the emperor was forthright in his call to subjects to contribute to community modernisation efforts. In 1963, Haile Selassie spoke at the opening of a school in Debre Zeit, a town just south of Addis Ababa, arguing that it was the responsibility of every member of the community to 'work towards the betterment of their standard of living,' including formulating solutions to problems of water and home sanitation.[164] In 1969, Haile Selassie told Gondar College graduates that their work in public health was 'a necessary supplement to the development of the country,' asserting the connection between public health campaigns and the improved modernisation of Ethiopian life.[165] The participation of women in community betterment schemes was an implicit feature of the emperor's rhetoric: Haile Selassie had expressed his views on the essential nurturing nature of women at the opening of a nursing school in Addis Ababa a decade before, arguing that 'compassion and sympathy' are 'inherent in the heart of women.' The emperor argued that in modern Ethiopia, the capacity of women to care for others would now be 'widened' beyond immediate kin and extend to the entire community. [166]

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[164] Selassie, *Important Utterances*, p. 19.
[165] Ibid., p. 57.
[166] E.S. Pankhurst, 'Princess Tsahai Memorial Hospital Haile Selassie's Speech at Graduation Day', *New Times and Ethiopia News*, no. 1038 (7 April 1956).

This chapter explores the global origins of Ethiopia's maternal health policies. I begin the chapter with an overview of the political context at the time, and the ways in which the emperor shaped health policy in conjunction with external partners. I then describe in detail the construction of the domestic modernisation rhetoric within the WHO, and then explain how this influenced the administration of maternal and child health programming in the Ethiopian countryside. After this final chapter of historic context, I will then move on in the next two chapters to discuss the experience of Ethiopian women themselves as they reacted to both global and national policies for medical modernisation.

The origins of the state's narrative on the place of women in medicine's modernisation mission

In *Marxist Modern*, Donald Donham describes the pragmatic relationship between Emperor Haile Selassie and foreign missionaries. The emperor dictated that missionaries would only be allowed to proselytise in his nation if they brought with them either schools or medical aid.[167] Like preceding Ethiopian rulers, Haile Selassie was largely uninterested in fostering the expansion of Protestantism in Ethiopia, but was careful to exploit the capacity of Western missionaries to assist in his modernisation efforts.

In an interview with Dr. Johannes Olafsson, a former medical doctor who worked with the Norwegian Lutheran Mission in Ethiopia between 1960 and 1980, the physician explained how Haile Selassie essentially gave the whole of Southern Ethiopia over to the mission to create a medical network. Dr. Olafsson described the mission's 'close relationship with His Majesty's Ministry of Health,' as they were

[167] Donham, *Marxist Modern*.

contracted to administer eight hospitals across the south of the country.[168] Jean Soltkvine, a nurse who worked for four decades in rural Ethiopia with S.I.M. (Serving in Mission), described a similar hand-over of remote areas of the empire to foreign missionaries for medical work. Soltkvine was one of the first medical workers to live among the Mursi and Bodi peoples, as she explained that the emperor otherwise neglected the peripheral regions in favour of urban development.[169]

In the previous chapter, I described the ways in which Haile Selassie doggedly pursued prestigious medical projects as part of his national modernisation project. Within this mission to modernise through medicine, the emperor solicited the aid of numerous foreign governments, in addition to philanthropic and religious organisations, sometimes at the expense of his own policy predilections. The US and WHO were successful in swaying the emperor to build rural health centres over urban hospital projects, while the Rockefeller Foundation never gave in to imperial requests for support for a medical faculty. The emperor was forced to be pragmatic in crafting his modern medical network, negotiating the will of foreign donors within his own modernising priorities. His negotiations with foreign missions is symptomatic of his penchant to extract the greatest benefit from international bodies intent on engaging in the work of Ethiopian development.

Given this relationship between the indigenous emperor and his foreign donors, it is unsurprising that state rhetoric on maternal and child health in imperial Ethiopia was shaped by both local and international actors. I argue throughout the thesis that women were co-opted into Ethiopia's modernisation-through-medicine scheme at the clinic in their capacity as mothers and homemakers. This narrative of

[168] The hospitals were located in Yirgalem, Arba Minch, Gamu Gofa, Jinka, South Omo, and Sidamo. Phone interview by author with Dr. Johannes Olafsson, 21 September 2012.
[169] Author interview with Jean Soltkvine, Addis Ababa, 22 April 2013.

domestic modernisation was an explicit feature of global health in the mid-twentieth century. While domestic modernisation schemes were heavily influenced by precedents in colonial medicine, they were first standardised and exported on a mass scale with the establishment of the WHO.

Foreign officials working in Ethiopia helped entrench this global rhetoric within the emperor's own agenda for modern change. Officials worked off existing conceptions of women in Ethiopia as not only essentially domestic creatures, but also, by nature, more traditional. Haile Selassie himself had stated that 'our women folk suffer from diseases and complications that arise out of ignorance.'[170] A French anthropologist of the Oromo explained that 'women in general retain a closer attachment to traditional patterns of life.'[171] Franz Rosa, a professor at the Gondar College, also argued that because women in Ethiopia had a 'second role to the men, especially in the villages,' they were naturally 'less enlightened than the men.'[172]

While women were regarded as more 'ignorant' than men by both Haile Selassie and his international advisors, officials were, at the same time, confident that women would be especially instrumental in the national modernist agenda. Rosa explained that Ethiopian women must be considered 'key members in changing the pattern of living.'[173] Considering their prominent place as mothers and homemakers, women would be responsible for modernising basic customs of daily life, including the ordering of the home, food and water preparation, and health-seeking behaviours of the family.

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[170] H. Selassie, *Selected Speeches of His Imperial Majesty, 1918-1967* (Addis Ababa, 1967), p. 550.
[171] L. Bartels, 'Birth Customs and Birth Songs of the Macha Galla', *Ethnology,* vol. 8, no. 4 (1 October 1969), p. 406.
[172] F. Rosa, 'The Framework of Public Health in Ethiopia', *Gondar Health Series,* vol. 6 (1963), p. 192.
[173] Ibid.

In policy ideals, modern Ethiopian mothers were to attend frequent ante-natal clinics while pregnant, give birth with medical assistance, and exclusively breastfeed for the first six months of the baby's life. Her home would have a working latrine, she would cover and store her food in a cool place to avoid contamination, boil all drinking water and milk, and separate the animals from the family's main dwelling. She would cook a variety of nutritious foods for her family, including fruits, vegetables, and meat in addition to the customary *injera* and *wot*.[174] When her babies were six months old, she would begin to introduce additional food to their diet in addition to breast milk, including fruits and a *teff*-based porridge. The modern mother would not wait until her child was sick to visit the doctor, but instead attend regular 'Well-Baby Clinics' to have her children measured and viewed by a trained health worker.

In shifting the locus of national development onto the home, WHO officials also played off Haile Selassie's belief in community engagement in imperial modernisation. In a speech on Ethiopian development in 1961, the emperor proclaimed that 'the ultimate resource of a nation is its people,' and that it is only once the individual citizens of a nation are secured in a higher standard of living that Ethiopia's modernisation could be achieved.[175] The emperor placed the burden of this development squarely on the shoulders of his people, arguing in a separate speech that 'the fundamental purpose of a community development movement is to teach the rural people that through co-operative self-help, their own self-improvement can be translated into . . . an improve[ment in] their standard of living.'[176] Preventive medicine and public health work was an implicit feature in this

[174] This was, and remains, the staple meal of Ethiopia: *injera* is a sour, pancake-like bread made from the local grain, *teff*, and *wot* is a spicy sauce served alongside.
[175] Selassie, *Selected Speeches*, p. 460.
[176] Ibid., p. 519.

conception of community development. In a speech at the Gondar Public Health College in 1957, the emperor proclaimed that 'the raising of our country's standards of public health occupies an important and prominent place in the plans We have prepared for the peaceful growth and development of our nation.'[177]

Officials at the Gondar College contended that in order for the emperor to 'raise the standards' of health and living in Ethiopia, women would have to be deliberately targeted for their capacity to reform domestic traditions. State officials in Ethiopia were convinced of this gendered rhetoric to such an extent that by 1970, the Minister of Public Health himself blamed the failures of national public health efforts on the 'ignorant' cultural traditions of women. While the Minister expressed frustration that a 'large number of patients never think of benefitting from existing health services,' he emphasised the particular peril of mothers who neglect to attend maternal and child health services. He argued that it is 'our culture' that 'is definitely to blame' for the low efficacy of public health efforts among women, as they continue to view pregnancy and reproduction as 'normal process[es] of life' which 'do not need any medical care or attention.'[178]

The Minister was concerned that the full ideological agenda of modern maternity services was lost on Ethiopian women. They rejected medical intervention in matters of reproduction because of the general lack of disease or complication in their experiences with pregnancy and childbirth. This refusal to be treated only demonstrated the extent to which women rejected the modernising thrust to maternity clinics. In the view of health officials, even if the conditions of pregnancy and birth were normal, they demanded medical attention because the very cultures of reproduction in Ethiopia were now pathologised in the WHO model. Maternal

[177] Ibid., p. 537.
[178] Bonnlander, *Maternal and Child* Health, p. 110.

and child health were not about curing disease, but about re-orienting families and communities towards modern standards of health and living. Haile Selassie himself contended that the work of public health was essential to benefit both 'present and future generations,' and that 'however high the cost,' the work 'to improve conditions of life must be accomplished.'[179]

It must be mentioned briefly that the emperor's interest in public health was by no means restricted to maternal and child services. This thesis focuses on maternal health as an extended case study of the imperial regime's domestic modernisation policy, but these services fit within a cosmology of health initiatives supported by international health bodies, notably malaria eradication and epidemic control. Male graduates of the Gondar College were trained by WHO representatives to spray communities for mosquito eradication, and monitor the presence of possible epidemics like smallpox. Health workers routinely set up quarantines in rural areas in an effort to quell the spread of pernicious tropical diseases. Vaccination programmes came later to Ethiopia, and were only implemented nation-wide under the Derg, but international health priorities for the control and eradication of endemic tropical diseases were an extended part of Haile Selassie's public health policy. The existence of these projects, heavily subsidised by the WHO, speaks further to the significant interchange between the emperor and his international funders.

The following sections of the chapter provide further analysis into the development of the WHO agenda in regards to maternal and child health in conjunction with national modernisation schemes. The next two chapters of the thesis will describe how Ethiopian women reacted to these global ideals for maternal health as they became increasingly embedded in Haile Selassie's national modernist

[179] Selassie, *Selected Speeches*, p. 537.

agenda. As women began to push back against state narratives on maternal health provision, they were reacting not only to a national project, but also the global rhetoric on women's place in development schemes.

The global medicalisation of maternity

As first addressed in the introduction to this thesis, Ethiopia was not unique in targeting women for its national development. This is a well-known pattern across the modernisation of nations, especially colonial Africa, where the reformation of maternity practices has typically coincided with larger social change. Lynn Thomas has argued, 'reproduction became the subject of colonial and postcolonial debate and intervention because so many people viewed it as fundamental to the construction of political and moral order, and proper gender and generational relations.'[180]

The history of medicalising maternity in the name of modernisation fits a global pattern of social reform beginning with the first lying-in hospitals in Europe. Indeed, campaigns to reform birth in the name of national order were not limited to Africa. As Brigitte Jordan argued in her seminal cross-cultural study of childbirth: 'birth is everywhere socially marked and shaped,' and 'there is no known society where birth is treated as a merely physiological function.'[181] When seeking care at the time of pregnancy and birth, women often unconsciously engage in polarised social debates between tradition v. modernity and custom v. change. With the expansion of state-directed reproductive health services, new standards of maternal health are created, and alternative medical systems are swiftly ostracised. In choosing which methods

[180] L. Thomas, *Politics of the Womb* (Berkeley, 2003), p. 4.
[181] B. Jordan, *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States* (London, 1983), p. 1.

of maternal healthcare she will use, a woman is not merely reacting to the biological forces in her body. Rather, if a choice between alternative medical systems exists, this choice marks that woman's status in relation to changing societal norms. In campaigns to medicalise maternity, national modernist trajectories are domesticated, and women's reproductive choices become symbolic gestures in reaction to the state's medical enterprise.

Hilary Marland's exploration of Dutch campaigns to medicalise maternity both at home and in their East Indies colony has shown how local birth practices in all nations were shunned as dangerous, and local midwives viewed as incompetent. This was not a mere colonial enterprise, but instead a global campaign in which women were subjected to zealous propaganda convincing them of the superiority of medicalised maternity to safeguard their birth in the modern clinical environment.[182] These campaigns rested on the growing ascendancy of medicine as a marker of status, equating traditional midwives and the women who used them with an undesirable backwardness and uncleanliness. In this way, women's choices in seeking care either at home or at the clinic were tainted with markers of modernity. Charlotte Borst has shown how in United States history, it was largely patient choice that perpetuated the rise of medicalised birthing: 'midwives were not pushed out of practice by elitist or misogynist obstetricians. Instead, their traditional, artisanal skills ceased to be valued by a society that had come to embrace the model of disinterested, professionalized science.'[183] On the level of the individual, birth choice began to be a status symbol, and a woman's place in modern life was measured in part by her use of new birthing technologies.

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[182] H. Marland, 'Midwives, Missions and Reform: Colonizing Dutch Childbirth Services at Home and Abroad ca. 1900', in B. Andrews and M. Sutphen (eds.) *Medicine and Colonial Identity*, (London, 2003), pp. 61–78.

[183] C. Borst, *Catching Babies: The Professionalization of Childbirth, 1870-1920* (Cambridge, 1995), p. 11.

At the same time, research by Marjorie Tew has demonstrated that across Europe and North America, the sudden increase in clinical births in the 1920s coincided with a sharp rise in maternal mortality rates due to poor systems of septic control.[184] This indicates the power of mere social perception that modern medicine was in fact superior to domestic models of care. Initially, medicalised maternity care did not safeguard against the varied biological disorders of birthing. Regardless of clinical need, institutionalised birth slowly became the norm for all women as a profound marker of social status. Clinical maternity practices were prescribed not only for the prevention of crisis, but as a mere feature of modern life. Indeed, Janet Bogdan describes the path of medicalising birth in the United States as one that started with the prevention of obstetric emergency, but moved rapidly to the treatment of normal delivery.[185] In regards to reproductive health, the place of medicine rapidly expanded, as traditional caring models were replaced by clinical services. The obstetrician and his medical practice were expected to intervene not just in states of physiological distress, but also in the natural progression of labour and delivery. Medicalised maternity was a matter of sociology, not biology. And as nations modernised, women and their birth practices followed suit.

The role of the WHO

By 1950, most of Europe and North America had sufficiently institutionalised birthing practices, so that nearly all births either took place in hospital, or at the

[184] M. Tew and S. Kitzinger, *Safer Childbirth?: A Critical History of Maternity Care* (London, 1998).

[185] In her words: 'At first, physicians claimed superiority over midwives in deliveries involving complications. Soon, however, they claimed their attendance was called for in all deliveries.' J. Bogdan, 'Care or Cure? Childbirth Practices in Nineteenth Century America', *Feminist Studies*, vol. 4, no. 2 (1978), pp. 92–99.

hands of a modern medical practitioner. Having nearly eradicated local reproductive cultures in developed nations, attention increasingly turned to the developing world and the need to once again replace indigenous traditions of maternal care with a medicalised model. Just as in Europe before, this new expansion of medical services for conditions of maternity was framed within a specific development discourse of greater social change— clinics were not meant to merely cure ill mothers and children, but also to provide transformative instruction and supportive care. While the explicit goal was a reduction of mortality, there was also an implicit intention to modernise national cultures of maternity and domestic life.

At the helm of the movement to alter indigenous forms of birth in developing nations was the World Health Organisation. At its founding in 1948, the WHO identified four health priorities for global action: malaria, tuberculosis, sexually transmitted infections, and the improvement of maternal and child health. Dr. Cecily Williams, a British paediatrician from Jamaica, was appointed head of the maternal and child health division, and immediately set to work to standardise WHO member states' approach to medical practices for mothers and children. Williams argued that the provision of maternal health should not be limited to doling out medical cures, because the very pathologies of motherhood in developing nations extended into culture itself. When comparing maternal and child health to the other three priorities of the WHO's initial charter, Williams noted that while malaria, tuberculosis, and venereal disease were all physiological disorders to be cured from, the improvement of maternal health demanded a more socially conscious strategy:

> The method of attack on an international basis cannot be approached in the same manner as one of the 'disease' priorities. The existing conditions vary from country to country; diagnosis, pathology, therapy and prognosis do not depend on well-understood or on laboratory controlled factors. Defects exist not on account of a pathological organism that can be identified with an oil immersion or by a serological technique, but on account of social and economic and nutritional conditions, on account of age old prejudices,

> customs and resistances, that will not necessarily respond to injections of this or that, nor to the exhibition of any standardised procedure.[186]

Cultures of reproduction and domesticity were the origin of both maternal and national pathologies, and must be routed out with the advancement of the clinic. Because the provision of maternal health was not targeting a specific disease, Williams argued that newly-designed maternal and child health clinics should operate with no division between preventive and curative services. Well and sick patients should be treated as a group in order to address hazards of the environment and lifestyle of women that led to disease. Maternal health programmes should 'concentrate attention on vulnerable groups' of women, instructing them in advanced domestic management with the goal of preventing cyclical patterns of disease and mortality.[187] Williams explained that maternal and child health services should 'strive to make individuals and families not merely passive recipients of healthcare, but help them to create their own environments, live their own lives, and achieve their potential.'[188] There was to be a transformative aspect at the heart of global maternity services. Mothers were not to be merely cured, but rather made into modernising agents capable of altering their environment in a way that guaranteed a higher degree of social health and advancement.

Williams' socio-economic approach to maternity clinics characterised the next decades of global maternal health service provision. Throughout the 1950s and 60s, both UNICEF and WHO-supported maternal health projects expanded across the

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[186] Wellcome Library Archive, MSS PP/CDW/D.3, The Papers of Cecily D. Williams, Appointment as Medical Officer in Maternal and Child Health Section, with Related Papers and Correspondence Including Report on First Session of Expert Committee on Maternal and Child Health (London, 1948)

[187] Wellcome Library Archive, MSS PP/CDW/D.15, The Papers of Cecily D. Williams, Papers for Maternal and Child Health Seminar, Inter-Regional 34 (London, 1956).

[188] Wellcome Library Archive, MSS PP/CDW/G.2/1, The Papers of Cecily D. Williams, Family Health, Maternal and Child Health, Nutrition, Training and Use of Personnel (London, 1968).

five developing regions of the world: from the Americas to the Eastern Mediterranean, nations were granted funding from UN bodies for maternal and child health projects which worked to modernise community practices for mothers and children. In each instance, it was culture and social custom which were targeted for transformation, all at the behest of national development. In 1967, UNICEF published an 'Appraisal of Maternal and Child Health Programmes' that described their social approach to maternity care, echoing Williams' assertion that the persistence of traditional culture was fully responsible for the advent of maternal and child health crises:

> Problems relating to the health of mothers and children in developing countries in general, and in Africa in particular, are more determined by cultural, social and economic factors than by the geographical location of the countries concerned. Towards the end of the last century, most of the population lived their own mode of life untouched by Western, i.e. industrial civilisation. They had their own culture, religion and social structure. It is important to remember that strong elements of the traditional social and cultural pattern of life and way of thinking have survived three generations despite the profound changes that took place.[189]

That is to say, because developing nation communities were cut off from Western society, their cultures remained backward and dangerous, especially for conditions of maternity and childhood. It was argued that while there had been a slow introduction of modernity into African societies over the last generation, women were still beholden to destructive maternal traditions.

Attracting women to the clinic

Given the common characterisation of African women as obstinate and unwilling to alter cultures of reproduction and child-rearing, the WHO was cognisant of the

[189] WHO Archive, *Appraisal of Maternal and Child Health Programmes for 1967 Session of UNICEF Executive Board: Report by the Regional Office for Africa* (Geneva, 1967).

need to actively advertise the clinic and attract mothers as patients. Cecily Williams noted that the number of alternative domestic traditions for maternal and infant care acted as hurdles in recruiting women to the clinic. Williams argued that in order to overcome the prejudice of indigenous tradition, health workers must first attract mothers with the power of medical cure, then capitalise on their natural astonishment at the benefits of medicine to indoctrinate women into adopting modern standards of preventive care within their homes. Williams explained that 'disease can motivate people to try to understand its causes and to learn simple preventive measures.' Thus when a child falls ill, mothers will attend the clinic and naturally receive further benefits beyond mere curative treatment. 'Everyone is interested in the health and wellbeing of their children,' Williams argued. And the power of medicine in improving the lives of mothers and children could not be overstated: 'children respond dramatically to sound paediatrics— people can see their children recovering under their eyes, instead of either dying or inevitably becoming the pot-bellied and dyspeptic toddler.'[190] With the confidence of mothers secured by the dramatics of curative treatment, preventive health would naturally follow and domestic practices would be re-oriented towards modernity. Williams was thus adamant that maternal health was the most logical entry-point for larger movements towards both social change and medical advancement:

> Maternal and child health services are the channel through which basic medical care and health education can reach the people in need. They provide the most efficient, the most constructive and the most acceptable means of improving the standard of health, of living, and of parental responsibility, as long as they are carefully adapted to the needs and resources of the country in which they operate.[191]

[190] Wellcome Library Archive, MSS PP/CDW/D.32, The Papers of Cecily D. Williams, The Organization and Administration of Maternal and Child Health Services. Fifth Report of the WHO, World Health Organization Technical Report Series, 1969, No 428 (London, 1969).
[191] Wellcome Library Archive, MSS PP/CDW/D.15 (London, 1956).

Treating children for basic tropical diseases was often a simple matter of oral-rehydration therapy or basic antibiotic dispersal. Dramatically transforming the ill child through such simple means meant that maternal and child health clinics were the most efficient recruitment tool in modernising a population. Medicine could modernise a nation, but only if applied strategically. Maternal and child health was the most logical entry point, as it was not only one of the most effective forms of medicine, but it touched on the most intimate cultural practices and beliefs of a given population. As Williams asserted, all families are interested in preserving the health of their children. In targeting medical practice to this vulnerable group, the power of modern medicine would be most clearly demonstrated, and its role in national modernisation campaigns would be secured.

The case against African exceptionalism

The WHO's maternal health policy was not created in a historic vacuum, but was influenced by colonial medicine, which made similar arguments on the need to develop national cultures first through the reformation and education of mothers. As a daughter of a British colonial family in Jamaica, Cecily Williams herself was reared on the rhetoric of imperial medicine which viewed African bodies as especially dangerous in relation to matters of reproduction. Indeed, it is important to note that the 1967 UNICEF pamphlet on maternal and child health programming targeted 'Africa in particular' as dangerously determined by culture. This is a critical distinction, as while nations across the Middle East, Asia, and South America were subjected to similar policy prescriptions on the dangers of indigenous birthing, there was special concern that Africa was especially backward in relation to maternity practices. In the introduction to this thesis, I discussed the lack of statistical or

physiological evidence for the emphasis on African birth pathologies, but the absence of objective science did not deter colonial governments from mounting campaigns against African cultures in the name of medical expansion.

In 1930s British Nigeria, a national campaign to combat maternal and infant mortality relied first on a mass education programme 'to ensure a common sense conduct during the pre-natal period' among pregnant women.[192] British Nursing Sisters conducted 'Health Weeks' which included a baby show where mothers would compete with one another 'to get their babies into good trim.'[193] An English physician toured the British colonies in Africa in 1935 and argued that the primary tool against maternal mortality was the education of African mothers. The physician decried the poor quality of girls' education in schools, arguing that given African women were 'the guardians of native institutions,' it was necessary to re-orient their cultural predilections early on in adolescence. The lack of female education was not only 'seriously retarding medical progress in the colonies,' but actually acting as a 'brake on the wheel of progress.' With appropriate training, the girls could be brought up to lead 'healthier homes and children.'[194]

British officials lamented the persistent 'ignorance' of African women which prevented the appropriate education of mothers. Women were seen as obstinate and unwilling to co-operate with the preventive health advice from the clinic:

> Confidence is very slowly won in this matter, advice being rarely sought for during the puerperium. Mothers are, whenever possible, shown how to care for and feed their infants and told the proper time to wean. They are,

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[192] Power, A.D., 'Health and Education in Nigeria', *Journal of the Royal African Society*, vol. 34 (1935), p. 413.

[193] United Kingdom National Archive, CO 1071/281, UK Foreign Office in Nigeria, Annual Report on the Social and Economic Progress of the People of Nigeria, 1933 (London Kew Gardens, 1934), p. 24.

[194] United Kingdom National Archive, CO 885/67, Dr. Mary G. Blacklock, Certain Aspects of the Welfare of Women and Children in the Colonies (London Kew Gardens, 1935), pp. 220-230.

> however, very indulgent to their children and little attention is as yet paid to the advice given. This apparent apathy is merely the result of ignorance.[195]

The colonial archive is filled with examples of education campaigns mounted at African mothers. I have provided a handful of examples both here and in the introduction to the thesis, but additional volumes could be written if space permitted. While such a survey is beyond the scope of this thesis, it is important to note that the historic precedent for maternal education in colonial Africa shaped the introduction of global health programming in post-colonial nations. This characterisation of the African mother as uninterested, indulgent, and ignorant continued into the global rhetoric codified by the WHO and UNICEF. Global aid organisations mounted education campaigns in the style of colonial predecessors, founded on the belief that African women were the central keepers of both home and cultural traditions. In the introduction to the thesis, I described in greater detail the experience of women in the Congo and Kenya in facing modern maternity campaigns. While women all over the world were subject to education strategies to alter traditions of maternal and child care, African women were especially targeted for the eradication of backward tradition. Such prejudice was a product of the colonial enterprise, and even if Ethiopia was not itself colonised, its geographic proximity to East African colonies ensured that similar prejudices on the problems of African cultures would shape the establishment of maternal health policies.

[195] United Kingdom National Archive, CO 724, Report by His Britannic Majesty's Government to the Council of the League of Nations on the Administration under Mandate of British Togoland for the year (London Kew Gardens, 1924), p. 42.

Re-socialising Ethiopian birth

In Ethiopia, the recruitment of women into modern life often began first with a transformation of social practices surrounding birth. As one American aid official explained, 'the mother will be receptive to help and advice from one who aided her at the time of delivery. In this way, the midwife will be very useful in saving life and promoting health.'[196] Policies in Ethiopia conformed to Williams' prescription at the WHO: maternal and child health was the most natural entry point for larger social change, and it was most prudent to capture women within the vulnerable state of childbirth. In attending the birth, modern medical practitioners would take on a new position of authority within the community, and could help transpose other modern reforms onto the family after the successful delivery of the child.

The modernisation of birth practices did not involve the mere replacement of indigenous customs with biomedical mechanisms for birth management, however. While cures were doled out in urban hospital environments, there was a cultural thrust of the new medicalising rhetoric which worked to inject new social rituals into customary birth practices. As elsewhere in the history of medicalised maternity, birth in modern Ethiopia was not treated as a mere physiological event, but was instead subjected to new cultural signifiers of social advancement and national development. Social markers and practices surrounding birth were altered in this newly medicalised environment, where women were asked to replace indigenous customs of parturient care with modern modes of intervention and support.

[196] United States NARA, RG469 P248, Records of US Foreign Assistance Agencies: Unclassified Central Files Compiled 1951-1961 (College Park, MD, 1961).

Ivy Pearce, a British nurse and instructor at the Gondar Public Health College, explained how best to replace customary systems of care at birth not just with biomedical treatment, but with more modern methods of psycho-social support. Pearce had written that the 'great magnitude' of deaths among mothers in Ethiopia 'could easily be reduced if ignorance could simply be abolished,' and that the loss of a mother's life was largely due to her 'treatment in labour.'[197] For Pearce, women's 'ignorance' related to their mismanagement of the basic mechanisms of labour and delivery. Pearce argued that Ethiopian women did not understand the different stages of labour, and would push in an inappropriate manner, tiring themselves with wasted effort.

Writing for the *Ethiopian Medical Journal*, two physicians joined Pearce's call for a reformation of normal delivery. Their article argues for better preventive care at the time of delivery, explaining that across Ethiopia, women were poorly instructed in their management of labour. Encouraged to bear down during the first stage of labour, before the cervix was fully dilated, these women were prone to complications like early exhaustion of the uterus, a common precursor to the development of birth injuries like obstetric fistula.[198]

In other words, it was the inappropriate methods of supportive care at the time of delivery that caused injury and death in birth, and indigenous support systems must be replaced with more advanced care methods. Pearce lamented the inhumane treatment of labouring women that led to their exhaustion and a plateauing of the labour's progression: 'If someone would give the mother a hot cup of sweet tea and

[197] I. Pearce, *Letters of Health* (Oxford, 1972), p. 2.
[198] H.W. Boldt and Y. Workeneh, 'Urinary and Faecal Fistulae in Women', *Ethiopian Medical Journal*, vol. 2, no. 3 (1964), pp. 201–208.

some fresh air, and wash and cool her body and allow her to rest a little, labour might possibly recommence.' She explained that when she was working in rural areas, she would intervene and manage the births in this manner:

> I sent all the neighbours out, allowing only the mother or grandmother to remain. I then give the labouring mother a small injection to relieve pain and relax her, instruct her how to use each pain to the best advantage so as to ensure a speedier delivery of the baby. I allow fresh air in the room and wash the mother when I see she is becoming hot.[199]

Not only did Pearce bring analgesia to the births she attended, she coached the parturient in proper methods of 'bearing down.' She provided new forms of 'comfort' not typically demanded at the time of delivery, and most importantly, removed all supposedly superfluous members of support from the birthing area, literally replacing the indigenous care structure with her authoritative presence.

Existing support at birth

Customarily, births in Ethiopia were attended by the woman's mother or mother-in-law, and several neighbour women who had a history of assisting deliveries. The 'traditional birth attendant' was not as common in Ethiopia as in neighbouring African nations, although there was the occasional *lemd awalaj* (midwife among the Amhara) who would be called to assist in particularly stressful deliveries, if her reputation as a healer had already been proven. On the whole, however, intervention at the time of delivery was widely frowned upon, and assisting women were mostly present to provide mere supportive care. With one woman supporting the parturient from behind, the delivery was typically performed in a squatting position to ease the proper positioning and descent of the baby. Another woman

[199] Pearce, *Letters of Health*, p. 5.

would crouch below and literally catch the baby as it emerged, but would never touch the perineum or inside of the vagina at the time of labour. Should the birth be prolonged, butter could be rubbed on the parturient's abdomen, or herbs would be ingested, but in the majority of cases, attendants at the birth would simply wait and see how things would progress.

As clinics became more common in Ethiopia, families would increasingly take parturients in a state of prolonged labour to seek medical assistance, but outside the institutional environment, traditions of intervention remain strikingly uncommon. Dr. Mérab, a French physician working in the court of Emperor Menelik II, wrote in his treatise on Ethiopian medicine that 'the Abyssinians have such a great horror of any kind of intervention that they will do anything possible to avoid it.' Indeed, after attending one birth where a European midwife demanded to intervene in a case of malpresentation, the mother preferred to 'let nature, more wise than she [the midwife], run its course.'[200] Writing in 1912, Mérab was actually impressed by this so-called 'natural' approach to birthing, given the significantly lower mortality rates in the Ethiopian communities he visited in comparison to European hospitals. Because birth attendants refused to touch the parturient, the spread of septic infection, while endemic in European lying-in facilities, was exceptionally rare in the Ethiopian countryside.

Given the largely non-interventionary role of birth attendants in Ethiopia, the purpose of such attendants remained much more social and supportive than curative. Ethiopian women sought care at birth, not cure, given the widespread

[200] E. Mérab, *Médecins et médecine en Éthiopie: généralités, pathologie chirurgicale et accouchements, médecins étrangers en Éthiopie* (Paris, 1912), p. 181.

notion that deliveries were a normal physiological event, not a crisis in waiting.[201] The expectation of normality demanded supportive care, and it was this system of support that Ethiopian women were most intent on first securing at the time of delivery.

In describing the rich traditions of birthing songs and prayers among the Oromo, Bartels notes that the 'encouragement, blessings, and felicitations [of birth attendants] are not only an expression of their feelings, but have a beneficial effect in and of themselves.'[202] To endure the ardours of labour, women expected and relied on the care of familiar attendants. They rarely sought after the medical practitioner at the time of delivery because the level and intimacy of care was profoundly different. As Dennis Carlson of Gondar College has explained, 'while many people in the Ethiopian countryside recognised the usefulness of modern medical practitioners, especially for managing acute illnesses and prolonged labour, they believed traditional resources were more trustworthy for nearly everything else.'[203] The purview of the clinic was cure, not care, and it was near universal practice among labouring women in Ethiopia to first seek out the caring environment of trusted birthing companions from within their community, only presenting themselves at the clinic should such crises as acute illness or prolonged labour occur.

In Pearce's description of modernised care, all the trappings of social support in Ethiopian birth were stripped away so that the parturient was left mostly alone. This aligned with modern clinical practices of the time, and was considered both more advanced and preferable for women in developing countries. Tabitha Kanogo has explained that in Kenya, the British worked to 'civilise' maternity by medicalising it,

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[201] The description of birth as either a "normal physiological event" or a "crisis in waiting" is taken from Andrew Symon. A. Symon, *Risk and Choice in Maternity Care: An International Perspective* (Edinburgh, 2006).

[202] Bartels, *Birth Songs*, p. 407.

[203] A.J. Carlson and D.M.Carlson., *Kossoye: A Village Life in Ethiopia* (Trenton, 2009), p. 84.

and that a key element of this mission was removing women from their 'mud homes' to give birth under the watchful eye of the nurse-midwife.[204] In removing women from their indigenous birthing environment, the natural advancement and development towards modernity promised by maternal health campaigners would naturally follow. Women first had to be stripped of their social traditions of birthing in order to be re-socialised towards modernity.

Gondar maternity services

The Gondar Public Health College relied on WHO-appointed midwives to train the new cadres of community nurses. These midwives were instrumental in adapting WHO rhetoric on maternal and child health within the Ethiopian context. In their practice as modern birth attendants, Gondar nurses were trained to target traditional customs in birth management. Their training was not overly clinical, but instead focused on the cultures of birthing, and their role as a modern, supporting hand at the site of normal delivery. Community nurses were taught how to avoid what was deemed 'bad midwifery.' Nurses were trained to coach women in the proper management of normal labour as described by Ivy Pearce.[205] Complicated cases were to be referred to the nearest medical institution, while nurses worked within the homes of patients to coach them in proper natural birthing.

The first step in re-orienting Ethiopian birth practices was to change the physical position of the parturient. Nurses demanded women cease birthing in the traditional upright position and adopt a supine posture. In mid-twentieth century obstetric practice, this was considered the most favourable position for a labouring women,

[204] T.M. Kanogo, *African Womanhood in Colonial Kenya, 1900-50* (Oxford, 2005), p. 166.
[205] B.O. Barry and E. Mannheimer, 'The Aims of the Medical Faculty of Addis Ababa', *Ethiopian Medical Journal,* vol. 2, no. 2 (1964), pp. 174–178.

largely because it assisted the midwife or obstetrician in viewing the progression of the foetus in the second stage. Officials admitted, however, that this change in position was often unpopular among women, and even put the new nurses in unfavourable competition with traditional birth attendants. In a report by an American aid official from 1960, it was argued that 'patients like to lie on whatever side they choose during the labour period.' While this is permitted by the 'local midwife,' 'our community nurses, *quite properly*, insist that they lie on their backs.' In addition, the official noted that 'women being in labour do not like to have their bodies "exposed,"' again making them wary to be treated at the hands of community nurses, who '*quite properly*, expose and examine patients at regular intervals, listening to the foetal heartbeat.'[206] Custom dictated that birth attendants did not touch the parturient, especially around the perineum. However, nurses were instructed in the modern ritual of vaginal examination, assessing the progression of the cervix's dilation. This modern intervention ran contrary to traditional predilections for unassisted birth, but in modern medical practice, it was deemed critical to increase the monitoring of a birth's progression.

Intervening in the 'natural course of labour'

Neither of these modern interventions - changing the labour position and increasing the number of vaginal examinations - are medically necessary to ensure the healthy delivery of the child. Beginning in the early 1970s, numerous clinical trials have confirmed that the supine position actually slows down the descent of the foetus in the second stage, while increased practitioner examination during labour does not result in improved birth outcomes, and can heighten the risk of infection.

[206] United States NARA, RG469 P246, Records of US Foreign Assistance Agencies: Unclassified Central Files Compiled 1951-1961 (College Park, MD, 1961).

One study concluded that 'the routine use of the supine position during the second stage of labour can be considered to be an intervention in the natural course of labour,' and that there were higher incidences of further interventions, including instrumental deliveries and episiotomies in the supine position.[207] Older studies, like one from 1979, confirmed that the supine position was associated with prolonged labour, and that 95% of women preferred the upright position as it was less painful.[208] Forty years of medical research have confirmed that the switch from upright to supine position is in fact an impediment to birth progression. As for the results of increased monitoring during labour, conclusions are more mixed, as some studies have shown that increased monitoring has led to poorer foetal outcomes, and that repeated vaginal examinations often result in increased infection.[209] However, maternity units in hospitals often perpetuate the practice of increased and continued monitoring and examination of both mother and foetus, despite the evidence that it

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[207] A. De Jonge, A.M. Teunissen, and A.L.M. Lagro-Janssen, 'Supine Position Compared to Other Positions during the Second Stage of Labor: A Meta-Analytic Review', *Journal of Psychosomatic Obstetrics and Gynecology,* vol. 25, no. 1 (2004), pp. 35–45.

[208] R. Caldeyro-Barcia, 'The Influence of Maternal Position on Time of Spontaneous Rupture of the Membranes, Progress of Labor, and Fetal Head Compression', *Birth: Issues in Perinatal Care,* vol. 6, no. 1 (1979), pp. 7–15. See also: B. Carbonne, et al., 'Maternal position during labor: effects on fetal oxygen saturation measured by pulse oximetry', *Obstetrics & Gynecology,* vol. 88, no. 5 (1996), pp. 797-800; M.M. Abitbol, 'Supine position in labor and associated fetal heart rate changes', *Obstetrics & Gynecology*, vol. 65, no. 4 (1985), pp. 481-486; R.C. Goodlin, 'Importance of the lateral position during labor', *Obstetrics & Gynecology,* vol. 37, no. 5 (1971), pp. 698-701; C. Mendez-Bauer, et al., 'Effects of standing position on spontaneous uterine contractility and other aspects of labor', *Journal of Perinatal Medicine,* vol. 3, no. 2 (1975), pp. 89-100; S.Z. Chen, et al., 'Effects of sitting position on uterine activity during labor', *Obstetrics & Gynecology,* vol. 69, no. 1 (1987), pp. 67-73; C.M. Andrews and M. Chrzanowski, 'Maternal position, labor, and comfort', *Applied Nursing Research*, vol. 3, no. 1 (1990), pp. 7-13.

[209] A.D. Haverkamp et al., 'The evaluation of continuous fetal heart rate monitoring in high-risk pregnancy', *American Journal of Obstetrics and Gynecology*, vol. 125, no. 3 (1976), pp. 310-320; A.D. Haverkamp et al., 'A controlled trial of the differential effects of intrapartum fetal monitoring', *American Journal of Obstetrics and Gynecology,* vol. 134, no. 4 (1979), pp. 399-412; S.B. Thacker, D. Stroup, and M. Chang, 'Continuous electronic heart rate monitoring for fetal assessment during labor', *The Cochrane Library* (2001); S.L. Hillier et al., 'Association between bacterial vaginosis and preterm delivery of a low-birth-weight infant', *New England Journal of Medicine,* vol. 333, no. 26 (1995), pp. 1737-1742; T. Kurki et al., 'Bacterial vaginosis in early pregnancy and pregnancy outcome', *Obstetrics & Gynecology,* vol. 80, no. 2 (1992), pp. 173-177.

increases the chance of additional interventions and has no proven benefit for birth outcomes.

Beyond these initial birth interventions, medical research has also largely disproved the need for over-management of the second stage of labour as prescribed by Ivy Pearce. There are several clinical studies that have proved the benefits of allowing women to spontaneously push, that is, to wait for the command of her body to push rather than be directed by a birth attendant.[210]

Pearce's insistence on directing the parturient's pushing is a symptom of common obstetric practice in the mid-twentieth century. The change of birthing position, increased vaginal examination, and external management of the second stage were all historic phenomena related to the transfer of authoritative knowledge from parturient to medical doctor with the increasing medicalisation of birth across Europe and North America. Brigitte Jordan's work in *Childbirth and Authoritative Knowledge* discusses this shift in authority, where any birth tradition outside of Western medicine was considered backward and dangerous. Jordan cites multiple examples of parallel birth customs that function in equal or even superior ways to biomedical models, including indigenous sanitation practices in South America.[211]

In mid-twentieth century obstetric practice, medical interventions became routine in the management of normal, vaginal delivery. A didactic film reel from 1960 entitled *Normal Delivery* helped instruct British nurses and midwives on the proper handling of childbirth in the modern setting. The term 'normal delivery' is used in

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[210] A.M. Thomson, 'Maternal behaviour during spontaneous and directed pushing in the second stage of labour', *Journal of Advanced Nursing,* vol. 22, no. 6 (1995), pp. 1027-1034; L. Bergstrom, '"I Gotta Push. Please Let Me Push!" Social Interactions During the Change from First to Second Stage Labor', *Birth,* vol. 24, no. 3 (1997), pp. 173-180; C.M. Sampselle, et al., 'Provider support of spontaneous pushing during the second stage of labor', *Journal of Obstetric, Gynecologic, & Neonatal Nursing,* vol. 34, no. 6 (2005), pp. 695-702.

[211] B. Jordan, 'Authoritative knowledge and its construction', in R. Davis-Floyd and C.F. Sargent (eds.), *Childbirth and authoritative knowledge: Cross-cultural perspectives* (Berkeley, 1997), pp. 55-79.

obstetrics to indicate a birth where the first two stages of labour progress without any physiological complication and the baby is delivered vaginally. This film, however, makes explicit the way in which even these seemingly 'natural' births are now to be handled with consistent medical intervention. Upon admittance to the hospital, the parturient's pubic area is shaved, she receives injections of pethidine, catheters are put in place to empty her bladder at regular intervals, self-administered analgesia is given in the form of 'gas-and-air,' and finally, as the delivery ends its second stage, an obstetrician is brought in to perform an episiotomy, or cutting of the vaginal opening to leave greater room for the foetus' head.[212]

The medicalised interventions in this film reel are by no means physiologically necessary to a successful delivery: if anything they represent a tidied up version of a messy and often chaotic biological event, ordering the procedure into a checklist format of steady progression. The clinic has not merely controlled, but actually standardised the handling of birth to the confines of medical procedure.

The rationale behind medical intervention in the early stages of labour is often to prevent a pathological response toward the physiological expression of childbirth, but in this administration of medical treatment, the parturient is automatically placed in the position of ill patient. The birth has already been pathologised without waiting for an actual crisis such as prolonged labour or malpresentation to occur. This conforms with official sentiment on the pathology of traditional Ethiopian birthing. Both US aid officials and Gondar instructors like Ivy Pearce propagated the notion that customs of normal delivery in Ethiopia were dangerous and needed correcting. In the form of altered labour positions and increased examinations, these corrections only served to pathologise a healthy parturient, granting the community nurse an authoritative position as modern birth attendant.

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[212] *Normal Delivery: Dr. Barnes Film*, 16mm film reel, 12 minutes in length (London, 1960).

When I begin to narrate patients' experiences under the care of community nurses the fourth chapter, it becomes evident that while women were pleased with the caring treatment of the new medical assistants, they did not consistently defer to Gondar graduates as new single authority figures in the management of birth. In hospital births, there was a tendency to over-manage the labour and delivery, ensuring that normal deliveries would often become overly complicated. The problems of authoritative knowledge in Ethiopian birthing are obvious when narrating the actual experiences of women undergoing modern maternity care. The benefits of medicalised birthing in Ethiopia were often muted in overt cultural discourses on the supremacy of medicine over indigenous tradition.

Commanding the nurse's [medical] authority

In Gondar, nurses were trained to command authoritative knowledge of birthing when attending to their patients. Gondar instructors were intent on training nurses in the 'proper' management of normal delivery, not the mere provision of curative treatment in the case of complicated labour. This was a deliberate effort to assert not only the authority of community nurses over all aspects of maternity care, but also the superiority of both medicine and modernity in securing a higher degree of safety and health in domestic life.

Nurses discouraged families from performing basic birth-preparation rituals, including the advanced cooking of food, preparation of a birth 'corner' in the home, and collecting of clean rags and a blade for cutting the cord. As head midwifery instructor at Gondar college, Margaret Mitchell explained that 'this decision was made to avoid any expenses for the mother which might prevent her calling skilled

help.'[213] Aside from economic concerns, Mitchell argued that if the family and mother were too involved in pre-birth preparations, they would see no need to call on the community nurses once labour began. After each birth, the community nurses were trained to sterilise all their equipment immediately in preparation for the next delivery so that she could arrive at an unprepared home in a minute's notice, 'without asking the family to provide anything except water for hand-washing.' Even after the birth occurred, 'the only service asked of the relatives was to wash the plastic square [over which the woman gave birth] in clean water.'[214] This restriction of the family's role in caring for a woman in birth was, once more, deliberate in its symbolism of the supremacy of the community nurse and her modernity in managing the stages of labour.

Given her new status as chief birth attendant, the community nurse was not only responsible for coaching the physical stages of labour, but was also required to take on the role of caring companion, previously performed by the parturient's neighbours and family. In training the nurses to provide supportive care to labouring women, the Gondar college was not only reacting to local predilections in birth management, but also following official WHO policy. In 1949, the WHO Expert Committee on Midwifery had emphasised that the very purpose of the midwife is 'to assist in providing emotional security' to women throughout their cycle of reproduction, recommending that nurses and midwives not be trained solely in the hospital, lest the midwife believe that delivery assistance is the 'be-all and end-all of her work.'[215]

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[213] WHO Archive, M. Mitchell, *EM/Ed.Tr./42 Assignment Report: Haile Selassie I University Public Health College and Training Centre, Gondar: Midwifery Department, 15 September 1958-30 June 1962* (Geneva, 1962).
[214] Ibid.
[215] Wellcome Library Archive, MSS PP/CDW/D.3 (London, 1948).

A note on the 'safety' of non-intervention

The transfer of authoritative knowledge in Ethiopian birthing from customary attendants to trained nurses signified the need of state medical policies to correct indigenous traditions, not necessarily prevent mortality. Indigenous traditions of birthing in Ethiopia differed from those in neighbouring African countries, where interventions of midwives were much more common. While non-intervention can be especially dangerous in times of obstetric crisis, especially with prolonged and obstructed labour, there is evident wisdom in letting a normal labour progress unassisted. Dr. Mérab was correct in praising Ethiopian traditions as they helped prevent the spread of puerperal sepsis, a common condition in Europe at the time.

As will become increasingly evident throughout this thesis, the modernisation of Ethiopian birthing traditions almost always related to the ways in which the cultural support mechanisms around normal delivery could be changed. State policies made no significant effort to improve curative services in more complicated labours, convinced that if the culture of birth would change, mortality figures would diminish. The cultural thrust to birth's medicalisation in Ethiopia is troubling given medical evidence that non-intervention in normal delivery is in fact the most healthful course of action for labouring women. The instinct to not intervene is only problematic when obstetric emergencies arise, and it was in these cases where death among Ethiopian women was all too common. Had maternal health policies in Ethiopia put greater emphasis on assisting complicated deliveries rather than re-orienting the culture of normal delivery, perhaps medical birthing systems would have been more successful in penetrating indigenous maternity cultures.

The implications of incorrect forms of birth in traditional Ethiopia extended beyond the mother's health and into the rearing of children themselves. Gondar instructors emphasised that the role of the community nurse was primarily to prevent 'acute emotional crises of birthing.'[216] Ordering the labour into medicalised stages through increased examination and supine positioning helped ensure that the

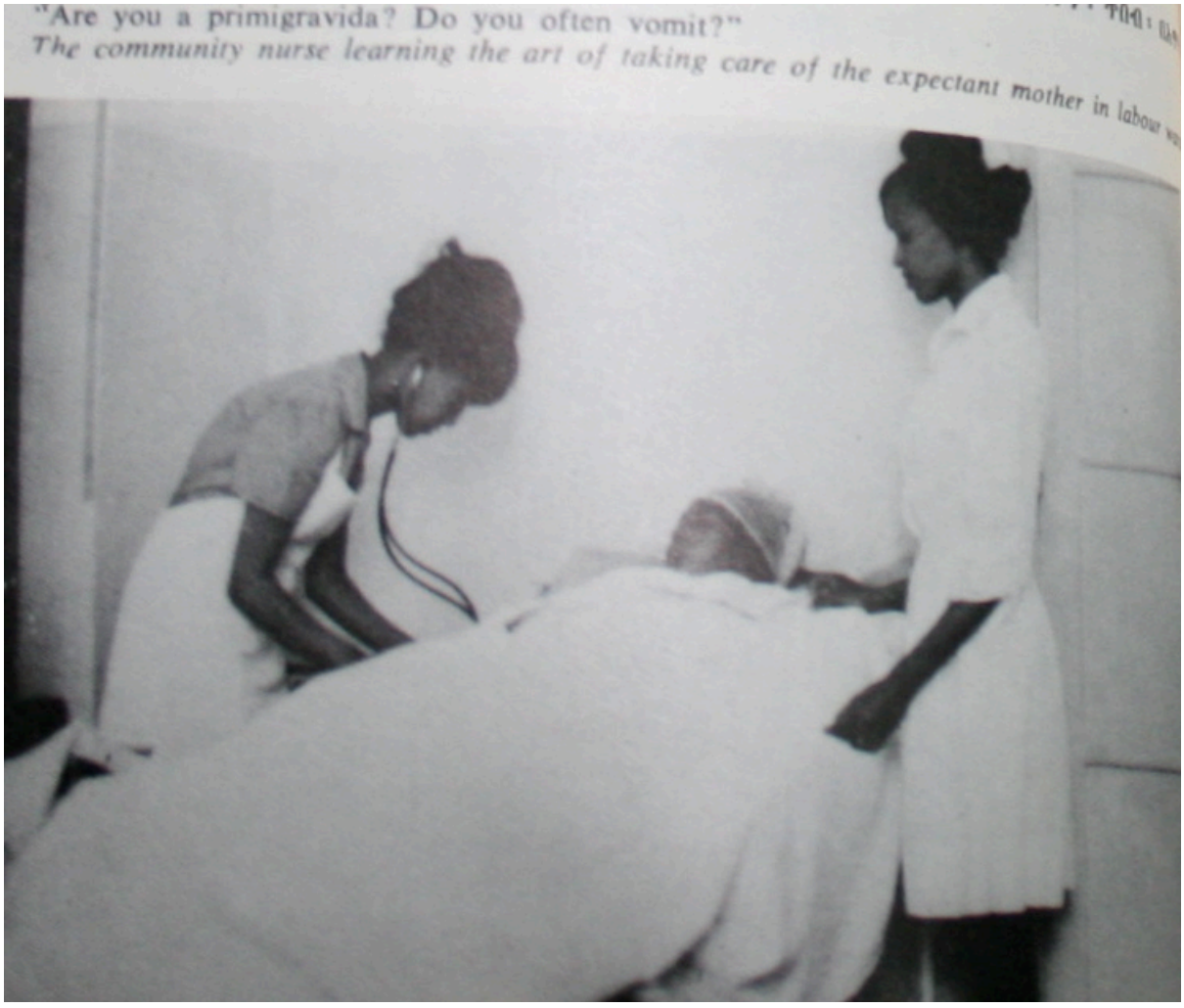

Figure 4: '"Are you a primigravida? Do you often vomit?" The community nurse learning the art of taking care of the expectant mother in labour ward.' Reproduced from the Gondar College Yearbook (Gondar, 1962).

[216] N. Tafari and S. Ross, 'On the Need for Organized Perinatal Care', *Ethiopian Medical Journal*, vol. 11, no. 1 (January 1973), p. 93.

potential chaos of labour was controlled. Preserving the serenity of the parturient was deemed critical by officials concerned that if a woman was overly stressed at the time of delivery, her capacity to adequately rear her child would be constrained. Having delivered her children in the safe and supportive environment created by the community nurse, mothers could then avoid emotional illnesses in the immediate post-partum, including 'grief and a profound sense of failure that could result from the failure to establish an affectional bond between the mother and her baby in the neonatal period.' The community nurse's care of women at the time of birth and the immediate post-partum was thus not merely to safeguard a healthy delivery, but also 'to provide opportunities for promoting the health of the future citizen by encouraging the mother to acquire the right attitudes towards child-rearing.'[217]

While attending births was deemed a critical entry point for modern medical services in the lives of Ethiopian women, as nurse-directed birthing services continued to grow in Gondar town, there was growing concern that more opportunities for health instruction were being missed by women who did not attend ante-natal and post-natal services. Within a few years of Gondar College's opening, it became routine for labouring women in town to call on community nurses should an obstetric emergency arise. Gondar trainees, alongside midwifery instructors, would arrive at the delivery and attend to the crisis either at the home or by transferring the patient to the college's teaching hospital. Margaret Mitchell attempted to put an end to this emergency service by requiring all women who wanted a community nurse present at the delivery to attend ante-natal services during pregnancy. Gondar nurses were not to be the last medical resort for labouring women: nursing staff were working to reshape all conditions of maternity

[217] Ibid.

and domestic life in Ethiopia, beginning at conception and continuing into the period of child-rearing. The community nurse would not only care for mothers during pregnancy and delivery, but also 'help them raise their children in a more healthful way, and to form hygiene habits in the family.'[218] It was critical to extend the services of the new trainees beyond mere birth management.

Policies dictated that while re-socialising birth practices in Ethiopia was a crucial step towards national modernity, it was in the accompanying maternal health clinics that the active reformation of family life would occur. Ante-natal and post-natal services were installed in both urban hospitals and rural health centres with a dual mission. While clinics granted medical staff the opportunity to assess the health of the mother, they also allowed for careful observation of other children in the family. Franz Rosa, an instructor at the Gondar college, explained that in attending ante-natal clinics, most all women would bring additional young children with them, and that this was often the only chance clinic staff would be granted to treat the child.[219] A Swedish physician who operated mobile ante-natal clinics in Addis Ababa also argued that the ante-natal consultation was the ideal opportunity to encourage women to deliver the baby at the hospital. The physician conceded that again, this was 'partly for safe procedure, partly as an opportunity for health education.'[220] Birthing care was insufficient if it was not accompanied by a strong dose of health education for both mother and child.

In both the health centre and hospital, maternal and child health clinics were conducted typically once or twice each week, for pregnant women and all children up to six years of age. There would be between 10-40 women per session, and

[218] Rosa, 'Project of the Haile Selassie I Public Health College', p. 74.
[219] F. Rosa, 'Some Practical Approaches in the Child Health Clinics of Gondar, Ethiopia', *Journal of Tropical Pediatrics,* vol. 9, no. 4 (1964), pp. 113–17.
[220] O. Jäger, 'Data from a Maternal and Child Health Project in Gondar, Ethiopia', *Courrier*, vol. 11 (February 1961), p. 70.

nursing staff would use the clinic as an opportunity to both assess the individual health needs of the women and children present, and also instruct the group on critical matters of home-making and child-rearing. The maternal health clinics in Ethiopia aligned perfectly with the WHO's ethos of preventive, community care above individual medical treatment, and helped the community nurse extend her services beyond mere birthing care. In a description of maternal health clinics in Addis Ababa, one obstetrician noted how, especially in matters of maternity care, it was critical to see beyond individual diagnoses:

> It is all too easy for the student or doctor, seeing a patient in the hospital, to classify him or her as a 'case' and to forget that patients are people and that particularly in obstetrics, the pattern of community life, how the woman lives as regards marriage, her level of hygiene, her education and income, and her happiness as a mother, greatly influences her child-bearing and child-rearing capacity.[221]

This quotation directly mirrors the policies of the WHO in encouraging community solutions for maternal and child health pathologies. Maternity clinics in Ethiopia encouraged healthy living, treating the environmental conditions surrounding the mother and child instead of merely curing the presentation of disease.

Clinic operations

Per Cecily Williams' prescription, clinics were designed to treat both 'sick' and 'well' children alongside one another. Otto Jäger, the head of Addis Ababa's Ethio-Swedish Paediatric Clinic, argued that 'mothers, of course, are not able to distinguish [healthy or sick children] anyway.' Jäger also noted that nearly all

[221] C. Rendel-Short, 'Study of the Social Background of Mothers Attending an MCH Centre in Addis Ababa', *Ethiopian Medical Journal*, vol. 6, no. 2 (1968), p. 47.

Ethiopian children were only partially 'healthy,' as nutritional disturbances, diarrhoea, and parasites were exceptionally common. In their descriptions of maternal health services, it is evident that both Jäger and other health officials at the time played off the perception of the backward mother, easily convinced of the superiority of medical cure. Not only did the Ethiopian mother need clinical staff to tell her whether her child was ill, but officials noted that the high level of ignorance of the women meant they could easily be persuaded by the modern practitioner and his sophisticated treatments. Franz Rosa wrote that 'carrying out laboratory work [at the clinic] while the mother is being interviewed often has educational impact as well as diagnostic value.'[222] Jäger also explained that treating sick children in the presence of other mothers was also deeply effective in demonstrating the power of modern medicine and its accompanying lifestyle prescriptions: 'it was felt that through curative services, confidence and personal relationships could be

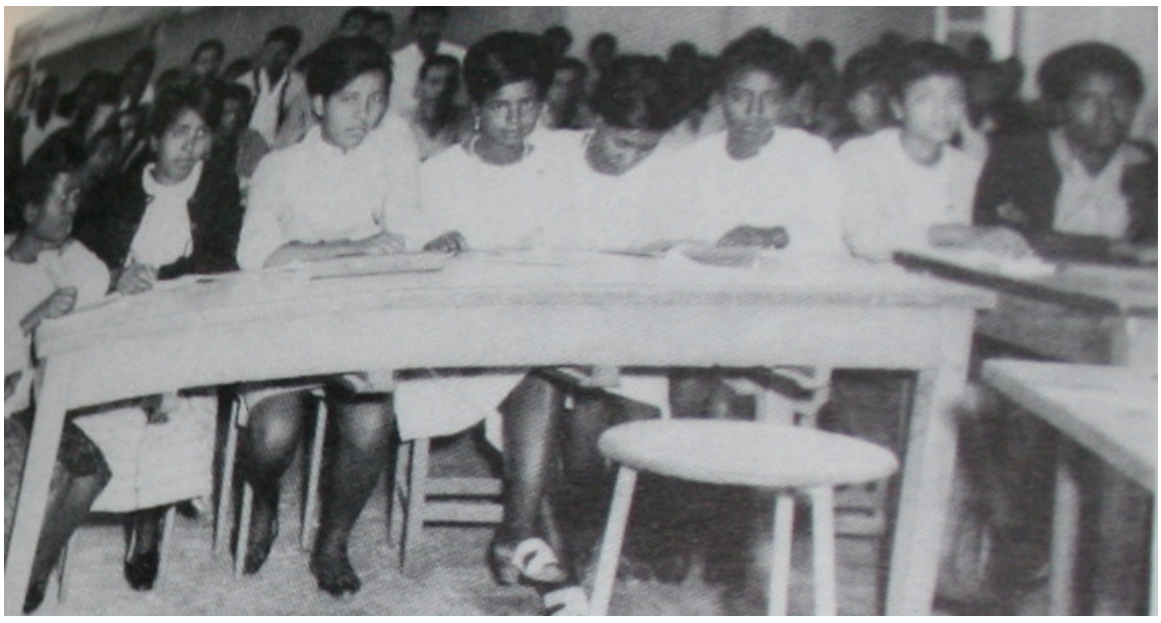

Figure 5: Community nurses attend a lecture, reproduced from the Gondar College Yearbook (Gondar, 1962).

[222] Rosa, 'Practical Approaches to Child Health Clinics', p. 116.

established between mothers and health personnel and through this confidence the mothers were prepared to accept also preventive and educational advice.'[223]

In a Gondar College newsletter, one graduate health officer proudly described his health centre's maternal health patients as 'a group of people who are eager to learn,' and 'open to suggestion.' The health officer was confident that his elite status as a medical practitioner not only helped encourage mothers to attend the clinic, but would also ensure their willingness to adopt the modern living practices prescribed in education sessions. He wrote that 'all mothers like to have their children inspected and praised by the "experts" and to be given encouragement and help to proceed with the good work.' Relying on his position as trusted 'expert,' the health officer concluded that 'by skilled manoeuvres, the group of mothers will be brought to realise their need for various aspects of health education.'[224]Jäger similarly argued that the mothers at the Ethio-Swedish clinic 'were interested to learn, were open to any advice, and were not reluctant to give information in reply to medical personnel questions.'[225] The dynamic between patient and practitioner within the maternity clinic was clear: mothers were there to learn, and clinic staff were eager to instruct.

Franz Rosa gave pragmatic instruction to students at Gondar to ensure this educational thrust of the clinic remained most effective. First, it was essential to preserve the clinic's emphasis on preventive medicine by avoiding leading questions to mothers about any illness in the child. Health centre staff were not to begin consultations with the question 'what is the matter,' or even 'how is the child doing,' as both obliged the mother to have a complaint ready. For Rosa, this 'diverts attention from more critical health concerns,' including the environment in which the child is being raised. He suggested asking general questions about the

[223] Jäger, 'Data from a Maternal and Child Health Project', p. 70.
[224] 'Who Needs Health Education?', *Public Health Letter*, Vol. 2, No. 3 (Gondar, June 1971).
[225] Jäger, 'Data from a Maternal and Child Health Project', p. 70.

environment of the home: what is the child eating? Does the child have teeth? Has s/he been immunised? Is s/he crawling or standing yet? These developmental questions all helped alert nursing staff to potential problems in the rearing of the child that could be corrected through clinical instruction. This helped retain the clinic's purpose of modern reformation of living standards, not mere curative treatment.[226]

The design of maternal and child health clinics meant that there was often a long line of mothers waiting for their consultation with health centre staff. Rosa stated that it was important to combat the boredom in this period by publicly demonstrating the clinical work of curing ill children, while also engaging the women in open discussion about living practices like food preparation, child-rearing, and sanitation. Such discussions allowed for 'group mother pressure' to influence women to alter domestic practices along modern lines. Rosa explained that health centre staff should use creative education methods, including easily-understood metaphors and direct demonstration. In encouraging mothers to cease the traditional practice of covering their infants from the sun, Rosa encouraged nurses to 'compare the infant to a flower, and remind the mother that a flower needs sunshine to blossom.'[227] Demonstrating correct behaviour was also critical: every health centre was meant to have both a working latrine and bathing facility as demonstration tools, while Rosa asserted that children must leave the clinic in the proper state of health and dress. He wrote that nurses should not expect the mothers

[226] Rosa, 'Practical Approaches to Child Health Clinics', p. 113.

[227] Ibid., p. 115. Rickets was a common problem among Ethiopian children at the time, caused from Vitamin D deficiency. Increasing exposure to sunlight was the easiest way to ensure children had an adequate source of Vitamin D. However, mothers were often reluctant to expose their infants as it was believed that this left them in danger of the 'evil eye.'

to leave their infants uncovered in the future unless they left the clinic in this manner.

Given the supposed degree of ignorance to be combatted, the educational task before clinic staff seemed daunting. However, Rosa assured community nurses in particular that their 'female status [would] give her better contact with the mother.' In contrast to the male health officer, the female nurse would be 'more likely to have instinctive sympathy for maternal and child health problems.' Nurses were to sit next to the mother and child throughout consultations, not behind a traditional doctor's desk.[228] Jäger also noted that if clinic staff showed 'love, sympathy and sincerity, then work will always be a success.'[229]



Figure 6: Community nurses demonstrate how to make porridge for infants at a Well-Baby Clinic, reproduced from the Gondar College Yearbook (Gondar, 1962).

[228] Rosa, 'Practical Approaches to Child Health Clinics', p. 116.
[229] Jäger, 'Data from a Maternal and Child Health Project', p. 81.

In these descriptions of the relationship between clinic staff and patients, the deep prejudice against the 'traditional' Ethiopian mother is obvious. Staff were asked to pander to the mother, instructing her as they would a small child. Officials were cognisant of the need for staff to instil some degree of confidence in the mothers, as it is acknowledged that they may be resistant to modern reforms. Gondar graduates were trained to use 'skilful manoeuvres,' and rely on the demonstrative power of medical technology to convince women to alter living practices. Her own knowledge was entirely ignored, as every aspect of her experience in raising children and running a home were subjected to staff scrutiny.

The utter lack of confidence in Ethiopian mothers extended to their experiences within hospital institutions as well. There were often cases presented at maternity clinics that required more rigorous medical treatment. Especially in the city, short-term hospitalisations of mothers and children were commonly prescribed, most often in cases of acute malnutrition of a child. Jäger explained that these hospitalisations were necessary not just for the immediate care of the child, but mostly to provide opportunity for the 'intensive supervision of mother.' Jäger expressed the widespread concern that 'if the problem is cared for in the hospital but the mother is not educated, the problem will recur.'[230]

Rosa had lamented that even at the health centre when nurses demonstrated the preparation of supplemental foods for infants, mothers 'often fail[ed]' to adopt the practices within their home. Clinic staff attempted to tailor nutritional prescriptions to locally available foods: *teff*, the indigenous grain in Ethiopia used in the preparation of the staple bread *injera*, would be mixed with milk powder provided

[230] Ibid.

by UNICEF to produce a gruel to feed to infants aged six months and older. Rosa explained that this supplementary feeding of infants was the first priority of clinics, as childhood anaemia and malnutrition were rampant in Ethiopian homes.[231]

Despite the educational efforts of the clinic, children continued to present with high levels of anaemia, and iron medication would be given at the clinic, or the woman and child would be hospitalised together to encourage better care. Hospitalisations of mothers and their children were carefully monitored to ensure sufficient educational opportunities were granted to women from medical staff. In the Ethio-Swedish Paediatric clinic, infants with low birth-weights would be kept for observation for a period of several weeks. While standard medical practice at the time dictated the isolation of critical infants for treatment by nursing staff, the Ethio-Swedish clinic was concerned that 'prolonged isolation of infants in intensive care units, often shrouded in complex electronic equipment, prevents the mother from establishing contact with her newly born baby, leading to severance of the fragile prenatal bond.'[232] The baby would then be placed in their mother's bed to encourage a sufficient connection between mother and child. A nurse would monitor the mother, and once she was confident in the mother's handling of the infant, the two could be discharged. The clinic would then provide follow-up home visits by a social worker, all in an effort to ensure that the education received in the hospital was sustained within the home.[233]

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[231] Rosa, 'Practical Approaches to Child Health Clinics'.
[232] N. Tafari and G. Sterky, '"Early" Discharge of Low Birth-Weight Infants in a Developing Country', *Journal of Tropical Pediatrics*, vol. 20, no. 2 (1974), p. 73.
[233] Ibid.



Figure 7: Gondar graduates pose in front of the Gorgora Training Health Centre as part of their internship year, reproduced from the Gondar College Yearbook (Gondar, 1962).

Conclusion

As this thesis continues, the problems in engaging women in modern reforms through maternal and child health clinics will be explained in detail from both the practitioner and patient perspective. The maternal and child health programming presented here is largely an ideal: in practice, health workers would confront both pressing obstetric pathologies and profound livelihood restrictions to the idyllic policy narrative described above. In policy tracts, the role of poverty in shaping women's domestic practices was largely neglected in favour of a culturally deterministic approach to disease. However, the importance of livelihood constraints and their influence on women's adherence to policy prescriptions was profound. This is especially evident in the case of child nutrition. While clinics across Ethiopia continually instructed mothers on the proper feeding of infants, the question of where the supplemental food should come from was hardly raised. Women were told to exclusively breastfeed for the first six months, but then to begin to introduce

supplemental foods to their babies from six months onwards. In traditional custom, babies were breastfed exclusively up to two years of age, leaving many children chronically under-nourished. In teaching women about supplemental feeding, clinic staff used locally-available goods, including *teff*, but did not account for problems of food shortages and limited incomes within Ethiopian communities.

The tension between preventive health instruction and livelihood restrictions is neatly illustrated in the case of a Swedish-run mobile mother and child health clinic operational in 1960s Addis Ababa. As director of the project, Dr. Ulla Larsson explained that the clinic visited neighbourhoods to give both curative and preventive services to groups of mothers and children, free of charge. In addition to providing immunisations and medical check-ups, group health education courses were run at the clinic on topics of child nutrition, sanitation, and safe motherhood. All attendees of the courses were given a supply of dry milk provided by UNICEF. Larsson explains, however, that once the UNICEF supply of milk ran out and hand-outs ceased, attendance at the courses 'fell dramatically.'[234] It became clear that just as Cecily Williams predicted, mothers were attracted to the clinic because of the promise of curative treatment. The milk was a welcome supplement to the meagre diet mothers could provide their children, but once supplies were wanting, there was little need to attend a lecture which demanded alterations in living standards inaccessible to the majority of attendees. The course taught women to provide better nutrition for their children, but without the accompanying milk supply, the impact of such lectures was muted.

Preventive health was a central pillar of maternal and child health programming, but officials consistently promoted improved standards of living through campaigns

[234] U. Larsson and Y. Larsson, 'Child Health in Developing Countries--the Role of the Expatriate Doctor. Experiences from Ethiopia', *The Medical Journal of Australia*, vol. 2, no. 4 Suppl (5 October 1974), p. 30.

to alter culture. Practitioners often became frustrated by patients' unwillingness to adopt preventive measures in their homes, neglecting to see the connection between material circumstances and domestic practices. While patients continued to seek pragmatic assistance and curative treatments at the clinic, their refusal to alter standards of living was seen as evidence of the persistence of backward culture even in the face of modern innovation. Noting her frustration with the poor efficacy of the mobile health unit in Addis, Dr. Larsson wrote that 'attempts to evaluate the activity showed that the health advice given had made little if any change in the mothers' attitudes or practices, and that the main benefit derived from immunisations.'[235]

While later chapters will discuss the failures of the medicalised maternity model in further detail, this chapter has helped explain the ways in which modernisation campaigns in Ethiopia became conflated with a gendered discourse on the culture of maternal and child health. Officials believed fully that in exposing women to the clinic, mothers 'will wish to practice 'modern' child-rearing methods over and above traditional ways,' leading to a shift in national customs and practices.[236] This quote is taken from the first National Seminar on Ethiopian Social Welfare in 1965, a conference that demonstrated the continued optimism of officials convinced of the power of modern medicine to enact social change. In one speech at the seminar, an official asked what could be done 'to bridge this gap in the interest of the family and the nation?'[237] The answer lay in the clinic and the new practitioners who manned them. Family life would be transformed along the lines of national modern ideals through the expansion of medicalised maternity care. Women were to be pivotal shapers of modern life in Ethiopia, both as the new medical practitioners spreading

[235] Ibid.
[236] 'Ethiopia's First National Seminar on Social Welfare, 1965: Full Text of Speeches and Resolutions', *Ethiopia Observer,* vol. 9 (1966), p. 250.
[237] Ibid.

the gospel of cultural reform, and as mothers, rearing their children and managing their homes along the lines of modernity.

Chapter 3: Narratives of the Practitioner

> *Nursing is a blessing, it is thrilling when you really know how to handle it - but when you see the unfortunate cases that you cannot reach, those that you could have saved but they have not come on time, it is already too late, it is agonising. To me it was - and up to this day I still have the bad memories. I wish I was there from the beginning - but when it comes too late, it is unfortunate. But you are fortunate when you are able to help and save some lives.*
>
> *— Sister Likimyelesh Kassa, Chief Midwife, Empress Zewditu Memorial Hospital, 1960-1990*[238]

Before 1950, practitioners of modern medicine in Ethiopia were all foreign.[239] By 1970, six nursing schools had been opened, in addition to the Gondar Public Health College and the first medical school at Haile Selassie I University. Ethiopian medical manpower was expanded to around 600 Gondar graduates, 90 physicians, and over one thousand nurses. While most of the training of practitioners remained in the hands of foreign personnel, the new cadre of indigenous medical practitioners remained primarily responsible for the daily expansion of modern medicine in Ethiopia. Practitioners internalised official rhetoric on the place of medicine in transforming the empire into a modern state, focusing their efforts on both curing disease, while also re-educating communities on modern living practices.

The space for women in the expanding field of medicine in Ethiopia was complex: while the majority of practitioners of medicine were women, formally, they occupied a secondary position in medical practice. Almost wholly restricted to the position of nurse and midwife, women were asked to be the assistants of male physicians and administrators. At the same time, given the prevailing belief in the necessity of medicine to transform national domestic life, the role of women as proselytisers for medicine was profound. Female practitioners were tasked with the

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[238] Author interview with Sister Likimyelesh Kassa, Addis Ababa, 18 January 2013.

[239] The one exception was Charles Martin, or Workneh Eshete, an Ethiopian-born physician who was raised in British India and trained as a doctor. Martin first came to Ethiopia to work in the 1920s, and died in 1952.

critical duty to re-educate the nation's homes on proper methods of child-rearing, sanitation, and home management. The majority of practitioners gladly appropriated this mission, convinced of the modernising power of medicine for Ethiopia.

Following the previous two chapters' discussion of official policy regarding medicine as a tool for modernisation, this chapter describes the perspectives of practitioners implementing national policies through clinical practice. I have written this chapter with a combination of archival and oral sources. While the first and third sections of the chapter draw heavily from sources written in mid-twentieth century Ethiopia, the second section is entirely descriptive and based on the interviews of seven women: Shewaye Gebre Kirkos, Nardos Giorgis, Tewabech Bishaw, Likimyelesh Kassa, Anqetz Hailemariam, Yewagenesh Mesfin, and Yezabenesh Amsalu.[240] Shewaye and Nardos both trained at the Princess Tsehai Memorial Hospital: Shewaye as a nurse, and Nardos as a physician. Shewaye was previously a student at the Empress Menen School for Girls in Addis, and entered her nursing training in 1960. She became the head surgical nurse for Dr. Asrat Woldeyes, a famous Ethiopian surgeon active in the 1960s and 70s. Nardos finished medical training at the end of Haile Selassie's reign in the mid-1970s, and worked for several years under the Derg regime before fleeing Ethiopia for a life in Geneva.

Tewabech Bishaw was the first female health officer trained at Gondar, and eventually received a PhD in Public Health. Likimyelesh Kassa entered nursing school at the Empress Zewditu Hospital in 1955, eventually becoming Chief Midwife of the hospital. Anqetz Hailemariam was a student of Likimyelesh's at Zewditu in the 1960s, and went on to work as a nurse in a private Swedish clinic in Addis Ababa

[240] Note that in Ethiopian custom, it is polite to refer to persons by their first given name, so for the remainder of the chapter I will refer to each woman by her first name. I have not changed the names of the practitioners interviewed. In my references for the interviews, I include the date and location of the conversation which the quote comes from. In some cases, there are multiple interview dates for an individual informant.

for several decades. Both Yewagenesh Mesfin and Yezabenesh Amsalu trained to be community nurses in Gondar: the former remained a community nurse for the rest of her life, working in five different health centres around Ethiopia. Yezabenesh eventually moved to Addis and became a trained midwife, teaching midwifery at the Addis Ababa University medical school from the 1990s to the present day.

Medical education in Ethiopia has always been in English, so the interviews were conducted without a translator. It was clear from interviewing these ambitious practitioners that medicine had facilitated the expansion of critical opportunities for Ethiopian women in the mid-twentieth century. The growth of modern medical services in Ethiopia helped create an elite class of professional women who were swift to adopt modern lifestyles. In entering medical careers, women were allured by the promise of elite status and improved standards of living. The professionalisation of an elite sector of Ethiopian society was a natural by-product of the nation's initial development, and while practitioners intended to act as role models for the communities in which they worked, the rapid transition of a privileged class of Ethiopians only proved to further distance the practitioners from their patients. Society became more fragmented between arbitrary markers of modernity and traditionalism, as practitioners continued to internalise modernist rhetoric on the backwardness of traditional Ethiopian life, seeing it as their mission to alter national customs first within their own homes.

Spaces for women in medicine

The gendering of professional categories in Ethiopian medicine was patterned off contemporary norms in Europe and North America, and while the role of women in medicine was restricted to the duties of nursing, the professionalisation of Ethiopian

women was itself an innovation for the time. When the prominent women's activist Sylvia Pankhurst opened the Princess Tsehai Memorial Hospital, she admitted that the hospital's nursing school would present a 'challenge to the traditions which surrounded the place of Ethiopian women in national life.'[241] Pankhurst ensured that just as Princess Tsehai had dedicated herself to the selfless task of nursing, so should the new generation of young Ethiopian women assert their own place in the developing nation as professional caregivers.[242] In this way, the hospital would be exceptionally significant for Ethiopian women, not just in providing maternity services, but also assisting in the formation of the first female professionals for the nation.[243]

Faculty of the Itegue Menen School of Nursing in Asmara felt a similar pride that they had made 'great progress in introducing a new profession for young women in Eritrea.'[244] The Menen School had been opened in 1954 by the United States humanitarian aid division as the first elite nurse training institution outside of Addis. Both the Menen and Tsehai facilities were part of a construction boom of nurse training facilities in the early 1950s. The same year that the Tsehai Hospital opened, the American Seventh-Day Adventist Mission began their own nursing school at the Empress Zewditu Hospital in Addis, while just a year before, the

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[241] E.S. Pankhurst, 'The Princess Tsehai Memorial Hospital', *The Scotsman* (January, 1943).

[242] Pankhurst admonished the youth of Ethiopia to 'follow the fine example of public service set by the Princess.' She believed in the long-term impact of the hospital and its newly trained nurses, who, she argued, would 'play their part in promoting the era of better health and higher standards of life and culture for African peoples.' (E.S. Pankhurst, 'Princess Tsahai Memorial Hospital: A Symbol of International Friendship', *New Times and Ethiopia News*, no. 387 (30 March 1943).

[243] In *New Times and Ethiopia News*, Pankhurst wrote that 'to the women of Ethiopia, the Hospital will be of special importance, to the mothers and children who will be treated in the Hospital, and to those who will enter as probational nurses and become the first members of the Ethiopian nursing profession.' (British Library, Add MS 88925/4/11, Pankhurst Papers: Incomplete or unidentified works by Sylvia Pankhurst (London, 1940-50).

[244] United States NARA, RG469 UD756, Records of US Foreign Assistance Agencies: Country Files 1935-1957 (College Park, MD, 1957).

Ethiopian Red Cross had set up a small nursing academy at the Haile Selassie I Hospital (formerly Bet Saida). In addition to the nursing programs, Addis Ababa was also home to three 'dresser' schools, which trained basic medical auxiliaries. The dresser schools were popularised in early twentieth century Ethiopia by short-staffed foreign and diplomatic missions who relied on the - mostly male - dressers to provide basic first aid and patient care.

The sequestering of Ethiopians to the auxiliary role of dresser was viewed poorly by Pankhurst, who characterised existing dressers as 'untrained, poor people who have never been to school.' Pankhurst complained that because of the general medical personnel shortage in Ethiopia, dressers had been unduly overburdened by responsibilities which lay beyond their capacities, reducing the overall quality of medical care.[245] Nursing schools were meant to close this personnel gap, and for Pankhurst, it was essential that at Tsehai, the Ethiopian trainees were considered elite medical practitioners, not mere auxiliaries. Leading up to the Tsehai hospital's opening, British Foreign Office commentators had suggested using the Tsehai hospital as another community midwife training facility, akin to the famed Omdurman Midwifery School in Sudan run by the Wolff sisters.[246] It was even suggested that the Ethiopian government hire Mabel and Gertrude Wolff to come to Addis and set up a similar program to train lay birth attendants. Pankhurst rejected this suggestion outright, stating that she was opposed to the 'briefer and more superficial training for the Ethiopian district nurse and midwife than has been

[245] Pankhurst, 'The Princess Tsehai Memorial Hospital', p. 129.

[246] British Library, FO 371/53458, Report by Dr. E. D. Pridie on the Health Services of Ethiopia. Code 1 File 114 (London Kew Gardens, 1946). Heather Bell wrote an excellent history of the Wolff sisters and Omdurman School, see H. Bell, *Frontiers of Medicine in the Anglo-Egyptian Sudan, 1899-1940* (Oxford, 1999).

established in Britain and Western Europe.'[247] For Pankhurst, this would mean lower standards for Ethiopia, and she was intent on carrying out what she saw as Princess Tsehai's own halted mission to bring 'British standards of nursing into her own country.'[248]

Elite humanitarians

Given the innovative status of the professional Ethiopian woman, it was important that she retain an elite position which distinguished her from the cultural traditions that surrounded her. Whereas the Omdurman school had prided itself in training traditional Sudanese birth attendants, nursing academies in Ethiopia recruited upper-class women with a secondary education. In 1950s Ethiopia, just one per cent of secondary students were female, meaning those women eligible for entry to nursing school were select members of a privileged class.[249] The nurses' careers were therefore shaped by an elite humanitarian identity. These were not lay auxiliaries, but rather the first cadre of highly educated Ethiopian women, ready to appropriate Westernised trappings of modernity through the profession of nursing.

The privilege of working in elite new medical facilities, especially those with royal connections, was part of the appeal for women entering the nursing profession.

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[247] E.S. Pankhurst, 'Report on the Women's Conference for the Princess Tsahai Memorial Hospital', *New Times and Ethiopia News,* no. 445 (11 November 1944).

[248] Before her untimely death, Princess Tsehai had trained as nurse in London and worked at the Great Ormond Street Children's Hospital. She had also founded the Ethiopian Women's Work Association during the Italian occupation to help assist in wartime humanitarian efforts. Tsehai had announced her intention to return to Ethiopia and begin expanding the nursing profession for Ethiopian women. See: R. McKown, *Heroic Nurses* (New York, 1966); E.S. Pankhurst, 'Princess Tsahai Memorial Hospital: Help Us Realise Her Dream', *New Times and Ethiopia News*, no. 352, (30 January 1943); Winster, 'Princess Tsahai Memorial Hospital', *The British Medical Journal,* vol. 1 (April 1951), pp. 813–814.

[249] W.P. Chang, 'Health Manpower Development in an African Country: The Case of Ethiopia', *Journal of Medical Education,* vol. 45, no. 1 (1970), p. 33.

In her interview, Shewaye Gebre Kirkos explained the privileged perception of nurses working at both the Tsehai and Menen facilities throughout Ethiopia:

> In the whole of the country, when you say you were from Princess Tsehai Hospital, you feel elevated a bit. The best school, the best nurses, Princess Tsehai at that time was really a highly regarded place, that and the Menen school. People coming from Menen it was the same thing. A person graduating from Tsehai… it was like a privilege, because it was a royal thing.[250]

Shewaye went on to describe the intimate connection between the Emperor and the hospital named for his daughter, a fact which she felt was 'very motivating' to her work because of how highly the nursing staff was regarded by the Imperial household. She asserts that with the loss of Tsehai, the new nurses who followed the late princess' example of public service 'were like a family to them.' Haile Selassie was a frequent visitor of the hospital, 'suddenly appearing in the hallway' and often given admittance to the nearest surgery ward. Like Emperor Menelik II before him, Haile Selassie enjoyed watching surgical operations take place, and for Shewaye, it was a privilege to work on surgeries with a royal audience: 'at the time, we felt like we were honoured.'[251]

Sylvia Pankhurst had been confident that Ethiopian women would flock to the nursing profession, for as she wrote, 'a princess had been a nurse.'[252] In my interviews with medical professionals from the time, all explained the great appeal of professional life for women. Ato Seifu, a health officer I interviewed alongside his wife, Yewagenesh Mesfin, described the community nurses at Gondar as an 'ambitious group,' and how his own wife abandoned her rural upbringing to train at

[250] Author interview with Sister Shewaye Gebre Kirkos, Addis Ababa, 15 October 2012.
[251] Ibid.
[252] United States NARA, RG469 P248, Records of US Foreign Assistance Agencies: Unclassified Central Files Compiled 1951-1961, (College Park, MD, 1961).

Gondar because she wanted to be a 'city girl.'[253] Both Shewaye and Anqetz Hailemariam listed every member of their graduating secondary school class as having pursued some advanced profession, starting either in secretarial or nursing work, the two professions open to women at the time. Anqetz explained that the ambition of her classmates at the Zewditu school was a factor of this historic moment, stating that her generation 'wanted to do more.' For the first time, women in Ethiopia were able to engage in public, professional life on a large-scale.[254]

This did not mean that modern Ethiopian women would entirely abandon more traditional expectations like motherhood: all the nurses I interviewed had several children at the same time as they built their careers. Shewaye explained the disappointment of her husband each time she returned to work after the births of her four children. Working on call as a surgical nurse, Shewaye would be at the hospital for long and unpredictable hours, leaving her children in the care of household staff. This was a point of contention with her husband who she said was 'always complaining' about her absences from the home. Shewaye's mother also expressed surprise that she would continue to work outside the home once she became a wife and mother, as she herself had only ever worked within the home, looking after her children. Despite the soft criticisms from her family, Shewaye spoke with fondness of this time, explaining that 'the era was just good,' and 'our generation had a very good time.' Even in comparison to her own daughter's experience as both a professional and mother today, Shewaye admits that she was 'lucky,' given the ease of hiring household labour to look after the children and ensure she could continue her nursing duties at the hospital.[255]

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[253] Author interview with Ato Seifu Woldeabraham, Addis Ababa, 25 April 2013.
[254] Author interview with Sister Anqetz Hailemariam, Addis Ababa, 17 January 2013; Author interview with Sister Shewaye Gebre Kirkos, Addis Ababa, 15 October 2012.
[255] Author interview with Sister Shewaye Gebre Kirkos, Addis Ababa, 15 October 2012.

The luxury of hiring additional household help was restricted to the upper class of Ethiopian society, demonstrating again the elite nature of the nurses at the time. These women were privileged to obtain a secondary education, enter the nursing profession, and continue working without the obligation to return to domestic duties. Shewaye and others I interviewed all conceded that the actual salary for the nurse was low ('hardly anything,' Shewaye said), and clearly not sufficient to cover all household costs. The reduced pay was symptomatic of the gendered biases of the time, where professional women were not expected to support anyone but themselves. There was an implicit expectation that once married, the nurse would stop working. Indeed, in many European and North American hospitals at the time, there were strict rules requiring nurses to remain unmarried. In Ethiopia, women often continued to work until a late retirement, buoyed less by their own salary than that of their supportive husbands. Shewaye's husband worked as an entomologist for the government, while other nurses I spoke with had husbands in distinguished careers that allowed them to maintain their own professional life outside the home. Even if husbands expressed a reluctance to see their wives continue working to an old age, their own careers helped facilitate the nurses'. While officials did not expect nurses to support their households, it was clear that in interviewing several women with long and illustrious medical careers, there were many nurses who bypassed official expectation and continued pursuing professional privileges even alongside their duties as wife and mother.

Role restrictions

The position of nurses in society was radical in many ways: working outside the home, domestic duties often fell to hired help. Traditions of Ethiopian womanhood

were beginning to evolve as more women asserted themselves within professional life. Men noticed this rapid shift in the social standing of women, and began viewing the advent of professional women as a symbol of Ethiopia's own burgeoning modernity.

In a Gondar College student newsletter from 1958, one male health officer wrote a laudatory essay for his female classmates, delineating the three new types of women in modern Ethiopia. The first group he described were the 'good housewives.' Rural and uneducated, the beliefs, practices, and identity of these women had not changed in hundreds of years, and they remained largely dependent on their husbands. The second group of women were also uneducated, but despite their 'ignorance,' these women were considered 'smart:' they wear European dresses, use cosmetics, and 'take a good long time over make-up.' These women, even with their traditional upbringing, saw the benefits of modern life, and sought to appropriate symbols of modernity into their own mode of living through the donning of European clothing and cosmetics.

The last group of women were described as educated and truly modern, and while there were not many of these women in Ethiopia at the time, 'those who are in the schools are increasing in number.' Most radically, 'these ladies to some extent participate in most fields, competing with men.' In addition, 'they live in modern buildings, eat balanced food with fat, carbohydrate, protein, and vitamins, for they know more about diet.' Above all, these modern Ethiopian women 'try hard to compete with the Europeans in every respect.'[256] It was in the last group of Ethiopian women that the community nurse belonged, because not only had she adapted to modern life in her home, dress, and behaviour, she also 'competed' with men in professional fields.

[256] United States NARA, RG469 UD394, Records of US Foreign Assistance Agencies: Ethiopia - Health 1958-1960, (College Park, MD, 1960).

The author of the essay is careful in his praise, however. While he lauds community nurses for their orientation towards European standards of modern life, he is quick to remind his readers that the nurses' professional duties are best characterised within 'traditional' feminine qualities of nurture and care. The health officer wrote that entering the nursing profession was 'the most trusted, kindest thing a woman or a girl can do for the well-being of her fellow-men.'[257] Nurses themselves may have sought medical training out of personal ambition, but they were largely pigeonholed into a position of caring service. Nursing was a suitable profession for women because it only enhanced the qualities long viewed as natural to the female gender. The modern Ethiopian woman was radical in her entrance to public life, but not to the degree that she would wholly abandon her essential duties to care and serve. Ethiopian nurses would be engaged in public life through their profession, but this engagement remained restricted to the duties deemed traditional and appropriate for women.[258]

Descriptions of the female community nurse as compared to her male counterparts are highly demonstrative of the gendered perceptions of various cadres of health practitioner. As one student of Gondar explained, while the sanitarians were the 'health soldiers' working under the health officers, themselves tasked with 'killing disease,' the community nurse was to act as 'the health receptionist' of the

[257] Ibid.

[258] This 'widened' role of women in modern Ethiopia was not only restricted to nursing, but encompassed all forms of domestic professionalisation. In 1958, the Women's Vocational Educational School was opened in Addis Ababa, another institution which trained Ethiopian women to expand their innate domestic skills towards professional ends. The school promised to teach women a means of earning their own living through the instruction of 'advanced homemaking techniques.' (United States NARA, RG469 UD756, Records of US Foreign Assistance Agencies: Health Reports Relating to Ethiopia Compiled 1955-1958 (College Park, MD, 1958).)

team, 'holding mankind in a warm embrace.'[259] Male health workers were active combatants and leaders in a war on disease, while the female nurse was the gentle counterpoint to masculine aggression. Nurses were praised for their 'gentle' approach to communities, as it was believed that the female nurse remained the most viable entry point for communities in seeking out health services. The crucial social element of the Gondar approach largely rested on the community nurse and her ability to commune with rural women through a domiciliary-based model of maternal and child care. Dennis Carlson argued that the male members of the health team were to learn from the personal approach of the nurse in working with community members to improve the success of health centre operations: 'Every effort must be made to increase the health worker's impact upon the society. He needs to have a high level of understanding and skills in curative and preventive medicine and at the same time he must be oriented to the social approach exemplified by the community nurse.'[260] It was the sole female member of the team that most exemplified the Gondar ideology of preventive, community-based care. Because her role was considered the least curative and 'technical' of the three health team members, she was believed to be the most effective member of the team in working within the parameters of the public health mission.

Despite the steady praise laid on the community nurses for their capacity to care for communities, the prejudice of gender roles at the time continued to work against these women as they pursued education and careers. Community nurses seemed trapped between social expectations that demanded they become modern, but only insofar as this modernity conformed with a prescribed gendered identity. On a visit

[259] United States NARA, RG469 UD394, Records of US Foreign Assistance Agencies: Ethiopia - Health 1958-1960 (College Park, MD, 1960).
[260] Rockefeller Foundation, RF: 02.1964/701, Ethiopia General Correspondence, (New York, 1964).

to the Gondar college, D.I. Madjaric, a WHO technical officer, observed that community nurses' marks were significantly lower than their male counterparts' while undergoing training. Margaret Mitchell, the WHO-appointed midwifery tutor at Gondar, noted a similar phenomenon, explaining that the discrepancy in results was due to the significant difference in age and educational background between the health officer and community nurse.[261] While the former had finished twelve years of education and was usually 19 or 20 by the time he entered the college, community nurses were expected to have completed just eight years of schooling, and were just 16 or 17 at admittance to the Gondar programme. Their skills in English were limited because of this stunted education, making their instruction at Gondar difficult. Madjaric admitted quite plainly that the performance of the community nurses at the college signified the 'lower cultural standing of women' in Ethiopia.[262] Even if this status was 'changing in the towns,' the Ethiopian countryside still placed men and women within a fixed stratification of gendered roles and expectations. Given most students were raised in these rural environments, it was easy to see how this prejudiced upbringing affected their performance at the college.

However, it was not merely rural expectations of women that were skewed in favour of men— the college administrators and officials themselves often displayed a similar prejudice against the community nurses who, despite the critical role they played on the health team, were still deemed less prominent and capable professionally than their male companions. Madjaric noted that while the community nurses were the most successful members of the health team, this was

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[261] WHO Archive, M. Mitchell, *EM/Ed.Tr./42 Assignment Report: Haile Selassie I University Public Health College and Training Centre, Gondar: Midwifery Department, 15 September 1958-30 June 1962* (Geneva, 1962).

[262] WHO Archive, D.I. Madjaric, *EM/Ed.Tr./240 Assignment Report: Public Health College and Training Centre, Gondar, 3 January - 22 November 1971* (Geneva, 1972).

largely because they 'did not aim at any special career.'[263] While health officers were ambitious in their hope of eventually attaining senior positions in the public health administration of the Ethiopian government, there was no hope of advancement for the community nurse. She was expected to be a community nurse first and last, or instead to eventually marry and quit her career outright. Indeed, when one health official visited a rural health centre in the early 1960s, he described the following scene of the community nurses in action:

> We watched as the community nurses explained step by step to the circle of attentive mothers sitting on the ground, each with a baby on her back. We watched too as the mothers fed their babies samples of the finished porridge and gave full approval as they saw how eagerly the babies ate it. And we listened as one old man who observed the community nurse commented to another: that's the kind of girl our boys should marry![264]

Nurses were praised not for their skills in administering medical services, but because of their caring natures which could eventually help them serve a husband and family.

In evaluating data on the career trajectories of female graduates of Gondar college, it is striking how official gender biases did leave the nurses little opportunity for promotion, and how many women left nursing careers once married. A survey of the employment status of Gondar graduates from 1967 shows that of the 185 community nurses since graduated from the college, a full 48 had already left employment. The remaining graduates were all either employed in a health centre (98), or within the Gondar college hospital network (34). There were no nurses who had advanced to provincial health departments, ministry headquarters, or to medical school for further education. But in the case of health officers, just 74 of 163

[263] Ibid.
[264] J.S. Prince, 'Public Health Practice in New York State and Ethiopia', *Health News (New York State Health Department)* (1963), pp. 41–45.

remained employed in health centres, while 32 had been promoted within national health services, and 26 were studying to be doctors. Even among the 198 sanitarians, despite having the same three years of education as the community nurse, 29 had been promoted to provincial and national health department positions. The employment drop-out rate among the male health workers was also less than half of what it was for women.[265]

The case of a female health officer

The significance of gendered prejudice in the Gondar programme was nowhere more pronounced, however, than in the fact that official policy dictated that only men could apply for the health officer course. Dennis Carlson explained his own challenge to this policy when, in 1965, he met Tewabech Bishaw, a young woman from Jimma, who asked if she could enter Gondar and train to be a health officer rather than a community nurse. Carlson had encountered Tewabech on a national recruitment campaign, and, struck with her talent and tenacity, immediately agreed to admit her to the health officer course the following year. When officials at the Ministry of Public Health heard of this breach of policy, they temporarily fired Carlson from his post as Dean. The vice president to the Minister, Hailu Sebsibie, moved forward to replace Carlson with the current Associate Dean, Dwight Bissell. Bissell refused the position, and after a considerable degree of political wrangling, Carlson was re-instated and Tewabech allowed to enter the College. Carlson admitted that while in theory, the policy was in place to 'protect' women from the trials of leading a remote health centre, it was largely due to the prevailing sexist

[265] Chang, *Health Manpower Development in an African Country*, p. 35.

attitudes of the time that continued to place women in the category of 'nurse' but not 'doctor.'[266]

Tewabech herself explained in an interview that it seems 'like a story' now, not real history, but 'in those days, women were not considered to be managers.' She described her fight for admittance to the health officer course, composing letters to Carlson, the college, and the University Senate in Addis Ababa, which governed the training centre. Even then, Tewabech was only given a conditional admittance— if she failed the course, she would be the last woman to ever enter the college to train as a health officer. She again protested the authorities, stating that 'it's not fair— boys are failing, and you didn't stop the programme. So why would you stop the programme when I as an individual failed? I said, I don't represent Ethiopian women— I am just one person. I will not take this responsibility.' Tewabech's bold stance worked again in her favour and the condition was removed. As she explained, 'I know how firmly I argued. Now thinking back I know my language was not so articulate, but I know I must have impressed them. They were impressed that someone was actually asking, and saying no to what they were saying— saying, why not?'[267]

While undergoing training, Tewabech continued to fight against arbitrary gendered restrictions, including an earlier curfew for female students. Instead of conforming to the curfew, on principle, Tewabech would stay out of her dorm late into the night, only going back in once the later male curfew had passed. This action was again met with considerable censure, but in standing her ground, Tewabech managed to convince administrators to level the curfew between men and women. She explained that the earlier curfew for women was another 'protective' measure to

[266] Phone interview by author with Dr. Dennis Carlson, 23 November 2012.
[267] Author interview with Dr. Tewabech Bishaw, Addis Ababa, 18 April 2013.

ensure nursing students stayed away from the potential dangers of Gondar town. But for Tewabech, this was merely a sexist gesture that restricted her mobility. Protective measures only served to limit Tewabech based on arbitrary definitions of her gender, and she fought against them whenever possible. She explained to me that she was hardly interested in staying out late with the men, but the principle of the restriction was problematic for her. Nursing students even asked her to back off from her fight, afraid of the trouble she would cause, but to Tewabech, she was fighting the restrictions not only for herself, but for all female students at Gondar. If women were to truly be 'modern,' should their opportunities remain so limited?[268]

Tewabech's actions help expose the deep-seated prejudice against women at the time, despite their initial steps towards professional competition with men. In 1956, at the Empress Itegue Menen School of Nursing in Asmara, one instructor wrote that 'women in professional life still are in the minority. Accepting them as co-workers is quite a novel idea. It will take some time to change attitudes and to achieve complete acceptance.'[269] Women themselves were not fully convinced of their ability to be leaders within the medical profession. When I interviewed female patients over the course of my fieldwork, it was common for the women to cite prejudice against female medical practitioners. Female nurses were often viewed as less capable than male doctors: if a woman travelled to the hospital, she expected to see a competent male physician who could cure her with modern medical treatments, not a subsidiary female nurse whose role was primarily to provide supportive care. While the advent of nursing in Ethiopia helped widen the role of women, this new female professionalism was not automatically accepted, either by the patient, or indeed by other medical professionals. Perceptions among patients were gendered in a way

[268] Ibid.
[269] United States NARA, RG469 UD756 (College Park, MD, 1958).

unintended by proponents of modern medicine in Ethiopia: while female nurses were expected to widen their domestic propensities for caring to the hospital setting, patients often rejected female practitioners in favour of men.

Claiming authority: the de facto duties of women

It is evident that there were multiple paradoxes within the identity of the new Ethiopian nurse. While she was praised for her modernity of dress and behaviour, she was restricted to roles befitting more traditional femininity. In official policy, the nurse was not allowed to lead a medical facility, nor would she be able to rise along a career ladder, but in practice, many professional Ethiopian women skirted official expectation and doggedly pursued advanced positions in their careers.

Tewabech is a critical example of this: after finishing her course of training, she moved on to a successful career first as a health officer, then as a medical doctor. However, this does not mean she was not met with a steady stream of official prejudice along the way. In her first posting at a health centre in Bonga, a remote area in the southwest of Ethiopia, the district manager composed a letter to the Gondar College demanding they replace Tewabech with a male health officer, wary of how a woman could actually handle the considerable work of managing such a remote health centre. His request was denied, and once Tewabech arrived in Bonga, her exceptional work and professionalism impressed the local official. She was so successful in her tenure at Bonga that once her two years of service at the health centre were finished and she was asked to move on to another posting in Dire Dawa, the district manager wrote another letter of complaint, this time asking that

Tewabech's posting be extended so she could continue her tenure as leader of the district's health centre.[270]

Once women were allowed positions of leadership and command within their professional life, they largely excelled in their careers. This advancement was never formally encouraged nor condoned, and a female practitioner's rise along a career path would often occur out of either a bold, personal persistence, as with Tewabech, or by mere default and lack of qualified male personnel.

Yezabenesh described in detail her command of a remote health centre in the face of an absent male health officer. After completing her community nurse training in Gondar, Yezabenesh was posted directly to a health centre in Gambella province, near the border with Sudan. She explained that as the nominal head of the centre, the health officer was equipped with a Land Rover that he would use to visit Metu, the nearest town. The vehicle was meant to facilitate district health screenings and supervision, but Yezabenesh said the health officer would take any excuse to go to Metu and then stay on for over a month. In his absence, Yezabenesh and the other community nurse posted to the area would manage the health centre on their own: 'it's not only the labours that we manage, but we also examine [patients]. We also work in the account room. We are the ones to work in the laboratory, as finance people. We give [patients] medicine, injections. We worked in the pharmacy, we are the cleaners, the janitors, we are everything.' Yezabenesh assured me that this really was not a problem, that the nurses and health officers trained alongside one another in Gondar, so 'whatever the health officer knows, the community nurse knows: communicable diseases, malaria, babies sick with convulsions - we can manage. I had no deaths.' The confidence of Yezabenesh is striking. Formally, she was meant to be an auxiliary position within the health centre team, restricted to maternal and

[270] Author interview with Dr. Tewabech Bishaw, Addis Ababa, 18 April 2013.

child health duties. Instead, with an absent health officer, she assumed the entire management of the clinic and its patients.[271]

Yezabenesh's career continued in a series of rural health centres before she landed in Addis Ababa, where she worked for the first time in a hospital. In the urban setting, her confidence in her capacity to lead as a medical practitioner came into conflict with official policy. At the time, community nurses trained at Gondar were considered a separate category from the 'registered nurse' of the urban hospital. Yewagenesh had stated that the difference between the two categories was 'more or less politics,' and that even though Gondar nurses worked in communities and registered nurses in the hospital, 'after so many years, a nurse is a nurse, there is no difference.'[272] Still, Yewagenesh's husband, Seifu, admitted that there was real conflict between the two categories. When Gondar nurses came to the city, the 'registered nurse used to look down at them. They said, you are trained to work in the rural area, why come to the hospital?'[273]

When Yezabenesh came to work in the hospital for the first time, she confronted this formal prejudice directly. While her training had only been three years in Gondar, by the time she came to Addis, Yezabenesh had worked for over fifteen years in the field as a medical practitioner. Officially, however, she would not even be considered a midwife, only a lay community nurse. Her salary was considerably lower than urban-trained nurses, despite her seniority of experience. She organised a group of nurses in similar standing to protest the Ministry of Public Health three

[271] Author interview with Sister Yezabenesh Amsalu, Addis Ababa, 16 January 2013.
[272] Ibid.
[273] Author interview with Ato Seifu Woldeabraham, Addis Ababa, 25 April 2013.

times over the course of the next decade until finally, in the 1990s, she was granted the title of midwife and a salary increase.[274]

Yezabenesh's case is highly instructive in delineating the difference between official definitions of female space within Ethiopian medical practice, and the activities carved out by ambitious women. In my interview with Likimyelesh, she described her own career trajectory as a delicate balance between formal restrictions and pragmatic necessity. Likimyelesh started working as a nurse in Dessie, at a Seventh-Day Adventist-run clinic. She worked under an American physician who was constantly traveling back to the US to complete his studies and exams. In his absence, Likimyelesh took charge of the clinic, including attending women in labour despite not having yet received midwifery training. She asked, 'what choice do you have? When there is nothing, it's better to have something.' Likimyelesh explained the extreme dearth in medical personnel in Ethiopia at the time, especially in provincial towns like Dessie. She repeated that 'in that time, everything we did was acceptable, because there was no choice. Something is better than nothing. That's how it went.'[275]

After working in Dessie for several years, Likimyelesh decided she needed more formal training. She realised that her work would always require more effort than the auxiliary duties of a caring nursing sister, so she enrolled in a midwifery course in England. While in England, Likimyelesh was placed into a more rigid medical hierarchy: despite having run a maternal clinic on her own in Dessie for nearly a decade, she was now heavily supervised by a network of nursing matrons and instructors. Likimyelesh explained that she could not touch a patient without supervision. Likimyelesh stated that in London, the system 'was good, very good,' a

[274] Author interview with Sister Yezabenesh Amsalu, Addis Ababa, 16 January 2013.
[275] Author interview with Sister Likimyelesh Kassa, Addis Ababa, 18 January 2013.

product of the numerous resources at hand. 'When you have plenty, you have choice.' But in Ethiopia, 'when you have nothing, you have no choice. You have to do with what you have.' Likimyelesh returned to Ethiopia in 1963 to work at the Empress Zewditu Hospital as both a midwife and instructor. She was the only midwife at the hospital, either European or Ethiopian, so she ran the obstetrics department. By 1969, she was running a pre-nursing school at the Seventh-Day Adventist's college in Kuyera. She returned to Zewditu in 1974 as Chief Midwife and obstetrics instructor for the nursing students, as well as heading the maternal and child health department at the university's teaching hospital well into the 1990s.[276]

Likimyelesh's career is coloured by an array of demanding leadership positions. She admitted that this was largely because there were so few resources at hand. As Ethiopia was only starting to build an indigenous cadre of medical practitioners, there was considerable need for any person with medical education to step up and take charge of the busy clinics and hospitals. Yezabenesh had done this for years in a rural setting, but was confronted with official prejudice when fighting for the recognition of her skills and experience. Likimyelesh would assume duties not assigned to her in Dessie in place of an absent male superior, only to be reminded when training in England that formally, she was a mere auxiliary. Even in pursuing advanced career positions, Likimyelesh, Yezabenesh, and others interviewed were all reacting counter to formal expectations that they would enter and leave the nursing profession as young, single women. The pragmatic need for medical personnel in the resource limited environment of Ethiopia, combined with the personal ambitions of professional women, meant that official gendered restrictions on medical practice were often flouted. Not only were such restrictions impractical

[276] Ibid.

to the needs at hand, but many women themselves were simply uninterested in conforming to mere auxiliary roles.

A call to serve: correcting traditions and reforming communities

When asked why they entered the profession of nursing, every woman I interviewed was categorical in stating that it was their personal calling to practice medicine and care for patients. The women consistently mentioned the low pay and long hours, stating that to be a nurse was not merely a job, but rather a true vocation. In reminiscing on her own career in nursing, Likimyelesh was effusive in recounting her satisfaction with the profession:

> And I'm happy, and it's rewarding. The pay was nothing, nothing, nothing considering. But considering what I was doing, I was happy. I was rewarded. Job satisfaction is what you call it. If I was to go through eighteen - through the age of eighteen years - I would do it again. I would go through it again. I wouldn't choose any other profession. It's in my blood. There were other fields with more pay, more appealing to society. But like Florence Nightingale, I'd rather be a nurse.[277]

Yewagenesh also explained that even from an early age, nursing was in 'her character.' Her father had been a dresser, trained by a medical mission in the rural countryside. Yewagenesh saw the potential of medical cures from the time she was a child, and stated that 'from the beginning,' in her home, if she saw that someone was sick, she would take them to a clinic. When she started to earn money, she used it to pay for relatives' medical treatments. Yewagenesh learned this behaviour from her parents, who she called 'good persons,' taking in orphans and supporting poor neighbour families. But the gift of medical cure was always paramount in her

[277] Author interview with Sister Likimyelesh Kassa, Addis Ababa, 18 January 2013.

offer.[278] This was not mere humanitarian aid, but active medical proselytisation. Likimyelesh explained that as a nurse, she could use medicine to not only relieve the pain in her patients, but also teach them that 'they are respected, they are loved, they are God's precious creature.'[279]

Even now, in retirement, all the nurses interviewed explained how they actively seek opportunities to help people get medical care. Anqetz described administering triage for strangers on city buses in Addis.[280] Yewagenesh stated that she consistently advises neighbours to go to their health centre, and often pays their fees if they are unable. She explained that convincing people to receive medical care was not straightforward, but because of her own character, she was able to teach people about the necessity of modern medicine. She said that she treats people 'not as a health worker, but as her mother, as her friend, as her daughter.' Using her position as intimate carer strategically, Yewagenesh admitted that it is only for her sake that the patients 'accept' the recommended treatment.[281]

At this point in the interview, Yewagenesh's husband, Seifu, jumped in and stated that his wife was 'really good' at her job, that she 'very much cares for her profession, and became a nurse by her choice.' Seifu recalled their time in training at Gondar, stating that not all the community nurses were as devoted to their patients as Yewagenesh, but that it was difficult to not become enthusiastic about the mission of medicine while a student at the college. He explained:

> The training there, the purpose of the college, was to go and serve deprived people. So our teachers were very much devoted, and there were people who were experienced with serving in the rural area. Our teachers were from the US, but they had vast experience in public health, and they worked in

[278] Author interview with Sister Yewagenesh Mesfin, Addis Ababa, 25 April 2013.
[279] Author interview with Sister Likimyelesh Kassa, Addis Ababa, 18 January 2013.
[280] Author interview with Sister Anqetz Hailemariam, Addis Ababa, 17 January 2013.
[281] Author interview with Sister Yewagenesh Mesfin, Addis Ababa, 25 April 2013.

> different African countries, so they really hammered on us that we have to serve the people. So it changed our attitudes, and of course we were young, but when we went to the rural area, we were working really hard - very devoted. The pay was not high, but it's as I told you - it's the training.[282]

Seifu is careful to mention again that working as a medical auxiliary at the time was formally restrictive, with the low pay and the remote working location. But the mission of medicine in modernising Ethiopia had been drilled into medical students at the time. Medicine and its practitioners were there to serve the people in a holistic way - both curing their illnesses and re-educating them socially towards modern life.

Not only in Gondar, but at the Zewditu and Tsehai schools as well, practitioners described how they were taught to care for patients first before medical treatment would be administered. In an interview, Dr. Nardos Giorgis, a physician who underwent medical training at Tsehai in the late 1960s, explained how when acting as an intern in the obstetrics ward, she was instructed to never leave the labouring patient for one moment, even as the first stages of labour dragged on for over eight hours. Her senior tutor drilled into Nardos that what the patient most needed was 'presence - she needs presence. A smiling face. Hold her hand and calm her, make sure she's ok. I don't want just the heartbeat or blood pressure.'[283]

At the Zewditu school, Anqetz described how her instructors taught that the patient is 'like a glass, a breakable glass,' and that 'when you deal with medicine, you have to *care*,' not only cure. The instructors trained Anqetz in psychology and communication, to understand how to 'get through' to a patient and help them on a social level. Anqetz explained that even for the strangers she meets and provides medical counsel for, she will follow-up repeatedly to ensure they are adequately altering their behaviour along her medical advice and prescriptions. She admits that

[282] Author interview with Ato Seifu Woldeabraham, Addis Ababa, 25 April 2013.
[283] Author interview with Dr. Nardos Giorgis, Addis Ababa, 12 February 2013.

she is 'frank and straightforward' with her patients, telling them, 'I want to teach you, do you have any questions for me?' Anqetz believes that she has a 'sympathetic heart,' and it makes her worry about her patients. She often pleads with her patients to come to the hospital, correct their behaviours, to 'do this, please.' She credits this again on her training, that she was taught to not be 'half-hearted' with nursing. This is a calling, one that she believes comes from God Himself. 'He taught me' to be a nurse, to care for patients and help them improve their lives.[284] Anqetz's training at the Seventh-Day Adventist-run Zewditu facility only reinforced the divine purpose of her career. Even though she was not an Adventist herself, the proselytising thrust of mission work coloured her medical training. With medicine entwined so closely with national development and social modernisation efforts, it was clear to practitioners that their mission extended beyond mere curative treatment.



Figure 8: A community nurse and health officer perform a home visit, reproduced from the Gondar College Yearbook (Gondar, 1962).

[284] Author interview with Sister Anqetz Hailemariam, Addis Ababa, 17 January 2013.

Modern medicine was an innovation for Ethiopia at the time, and practitioners were conscious of the need to adapt its principles to the population at hand. Official policy dictated that female nurses would act as the 'health receptionists,' warmly 'embracing' the population to modern standards of healthy behaviour. In a description of his stay at the Princess Tsehai Hospital in the mid-1950s, one patient was vivid in detailing how the care of the nurses, or 'Nightingales,' helped soften his perception of a potentially frightening medical procedure. Makonnen Iwneta was admitted to the hospital for surgery, but was first given a private room to convalesce before the operation. Admitted to the first class ward, a nurse entered and enquired if he was a patient. Given the spacious accommodation, wide veranda, and general comforts of the hospital, Makonnen said he, too 'had forgotten he was a patient and had to think for a few seconds before replying.' He explains the attentiveness of the nurses who brought him tea and magazines at the mere press of his call button. When admitted for surgery, he 'had expected to see all kinds of slaughtering instruments' in the operating theatre, but was pleasantly surprised by the cleanliness and order of the space. Hours after surgery, visitors came to see him and remarked at how he was alert, smiling, and healthy looking:

> "I just could not believe it. How could you speak, eat and move the first day? I have seen operated people not long ago lying on their backs motionless, dumb and starving for many days. If you recover, this hospital must be miraculous." Indeed it is a miraculous hospital, efficiently equipped with expert doctors and many "Nightingales." I found the surgeon and the matron smiling and humorous, the sisters and the nurses sincere and sympathetic. Every irregularity was immediately reported and promptly corrected. Under such treatment I could leave the hospital on the fifth day of my operation. This motherly treatment reminded me of the virtuous Lady of the Lamp, Florence Nightingale.[285]

[285] E.S. Pankhurst, 'Ethiopian Patient's Tribute to Princess Tsahai Memorial Hospital', *New Times and Ethiopia News*, no. 929 (6 March 1954).

Both Likimyelesh and Makonnen reference Florence Nightingale in relation to nursing practice in Ethiopia, a telling sign of the perception of female medical practitioners at the time. When acting as bedside carers, mediating between the patient's well-being and the medical treatments administered, their role was largely idealised. Their responsibility to care softened their image, as if the purpose of the female practitioner was to merely make medical patients comfortable while undergoing complicated procedures and treatment, not necessarily cure and treat in their own right.

In interviews, it was evident that the nurses themselves had a fraught relationship with the curative aspect of modern medicine. While all expressed little doubt in the potential of medicine as a tool of modernisation, there were undertones of reluctance among the practitioners regarding the universal good of medical practice. Anqetz related a story of her father, who was frequently ill and mostly cared for by her stepmother. At some point, his ailments were beyond the capacity of home treatment, and the family took him to be treated by an Italian doctor resident in Addis Ababa. The doctor performed a botched operation on Anqetz's father and the surgical opening swiftly became infected. He was bedridden for three years as the wound only worsened. Frantic to save his life, Anqetz's stepmother took her father to every hospital then available— first the Russian-run Menelik hospital, then Bet Saida. There was nothing to be done, however, as the sepsis was too far advanced and her father died shortly thereafter.[286]

This occurred in the late 1930s, when Anqetz was only a child, but she said that these events sparked her interest in caring for sick people, and drove her to pursue nursing. I asked her if she had any reservations about medicine, given her father's demise from the iatrogenic effects of surgery. Anqetz paused, and replied that 'the

[286] Author interview with Sister Anqetz Hailemariam, Addis Ababa, 17 January 2013.

Lord helped me understand.' For Anqetz, it was not the Italian doctor's failures that were most memorable, but instead the loving care of her stepmother. She explained that medicine was a caring art as much as it was curative, and she wanted to be in a position in which she could assist ill patients with some degree of authority. Anqetz wanted to help relieve suffering through medical cure, but also understood her primary role was to care for patients in times of crisis.[287]

Likimyelesh described the ways she would mediate the effects of medicine for her obstetric patients. She explained that while she followed up on all the babies she helped deliver, she took particular care of babies born with medical instruments, including vacuum extraction, forceps, and Caesarean section. Likimyelesh admitted that she was not overly confident that there were no lingering effects of instrumental deliveries on the babies born later on in life, stating that it would be preferable if all babies were born naturally, as it is 'God's design that they push.' With medicalised delivery, the descent into the birth canal can be overly forced, leading to a risk of internal bleeding, or head injury. Likimyelesh handled these babies more carefully—ensuring they were not exposed to bright lights or loud noises. She would teach the mothers to handle these babies with special care, lifting and holding them more gently than they would another newborn. Likimyelesh stated that in times of foetal distress, or if an anatomical problem in the mother would prevent the natural delivery, a Caesarean section was necessary, 'thanks to science.' However, she left this praise of science with a caveat, that babies born in this way were to 'be watched carefully the first few hours,' and even later in life.[288]

It is clear that in the experiences of both Anqetz and Likimyelesh, their position in relation to medical science is complex. Both women explained that they used the

[287] Ibid.
[288] Author interview with Sister Likimyelesh Kassa, Addis Ababa, 18 January 2013.

caring art of nursing as a way to assuage potential harmful effects of medical practice. They are not over-zealous about medical science, and argue for the necessity of careful mediation between the patient and their treatment. The belief in medicine is therefore not restricted to its curative potential, but instead to its accompanying symbols of modernity in improving standards of living. In the position of caring nurse, both Likimyelesh and Anqetz felt it necessary to primarily educate the patient. Medical cure was not the final objective of their practice. Instead, the female practitioners would use medicine to convince patients of the need to alter customs of daily life. Just as the Ethiopian Nightingales had safeguarded Makonnen Iwneta from the potential dangers of an invasive medical operation at the Tsehai hospital, female practitioners would act as handmaidens to modernity, gently coaxing their patients and students away from harmful traditions and into the comforts of modern living.

Correcting traditions

While working in Dessie, Likimyelesh stated that she saw 'a lot of unfortunate mothers' who had undergone birth first at home with the assistance of relatives and neighbours. Likimyelesh was mostly compassionate to these attendants, explaining that 'they didn't know, they did their best, but still it wasn't done properly.' She described how, in cases of obstructed and prolonged labour, traditional attendants would attempt to turn the baby inside manually, or cut the cervix open to widen the birth canal. Likimyelesh mentioned one case of a woman who came to the clinic in Dessie after her cervix had been cut by her neighbour. The cut was infected, and Likimyelesh said she was 'mad - I was mad! I cried, I literally cried for that woman.' She took care of the infected wound, washing her and changing the dressings,

administering antibiotics. The woman recovered, but the anger Likimyelesh felt spurred her forward, making her 'who I am now.' Before this incident, she did not realise the gross need for maternal care. Previously, as a nurse, she had concentrated only on infant and child care, but this woman's experience shifted her priorities towards the eradication of harmful birth customs. It was not only the child that needed looking after, but also the mother herself.[289]

While seeing poorly treated obstetric complications drove Likimyelesh to practice midwifery, she did not react by increasing medical intervention at the time of delivery. In line with official rhetoric of the time, Likimyelesh felt that the best method to safeguard mothers was to reform the culture surrounding maternity. In her practice, she began this reformation before conception. Likimyelesh explained that to become pregnant, a woman must be old enough and healthy enough in order to ensure the child is properly developed. Once pregnant, she should attend ante-natal care, wash herself and her surroundings, prepare her nipples for breastfeeding. Likimyelesh stated that 'I loved talking to the mother; I'm interested in teaching the mothers: promoting breastfeeding, and how they should take care of the babies—giving proper nutrition and bringing babies to the clinic, even if they are not sick, for regular check-ups.' She was highly invested in altering the cultures surrounding maternal and child health— not through increased medicalisation, but a mere modernisation of indigenous customs of care.[290]

When asked how best to correct the traditions of birthing in Ethiopia, Likimyelesh stated that it was simply a matter of altering the system of care within the home. She admitted that 'the mother delivering was very well taken care of, the fact is that the way she is taken care of is the wrong way.' Likimyelesh praised the

[289] Author interview with Sister Likimyelesh Kassa, Addis Ababa, 18 January 2013.
[290] Ibid.

traditions of giving better food to a mother before and after delivery, and described the celebratory washing of the woman's clothing and bed linens in the post-partum period by neighbour women.[291] This celebration was typical of Amhara women at the time: a day was appointed after the birth where all women in the community would gather at the nearest water source and wash the linens jointly, returning with the clothing on their heads, dancing and singing.

Likimyelesh said that 'in our understanding, this should be done daily - not even just daily, but frequently.' For her, the 'most important part for me as a nurse, as a qualified midwife, is knowing the risk that women go through [during delivery]. How exhausted she is, how vulnerable she is to infection.' She added that as a mother herself, she knows what women need in labour, and the care given traditionally was simply wrong. The wrong kind of food, the wrong method of washing and cleanliness, and poor methods of psycho-social support to avoid exhaustion in the parturient. Likimyelesh stated that she was 'obliged to teach what is needed, what is *more* needed for the mother at that time' because she 'felt sorry for [the mothers].'[292]

Correcting harmful traditions was one of the main attractions for women entering the nursing profession. Yewagenesh explained how extensive their mandate was in working with mothers at the health centre: 'we were working day and night, we showed the mother how to feed their children, how to make their clothes for children, even food preparation for the family - everything!' The care of the community nurses would often begin with ante-natal services at the maternal and child health clinic, where they would stress the importance of rest and nutrition for the pregnant woman. They would teach the expectant mother how to prepare for

[291] Ibid.
[292] Ibid.

the delivery by cleaning the home and linens, and alerting neighbours that they must tell the community nurse once the labour had begun. Yewagenesh admitted that often the women were afraid, especially primiparous women, and that the nurses would assure the mothers that they were the most qualified attendants available. The nurses would describe their alternative care methods to the pregnant woman, explaining that in modern birthing practice, the woman would be in the 'sleeping position,' rather than the customary 'sitting position.' The nurse would bring gloves, scissors, razor blades, and other equipment that she would boil in water in front of the woman to demonstrate the superiority of the modern, sterile methods in use.[293]

Expectant mothers often reported to Yewagenesh that they felt quite alone in matters of reproduction: husbands, neighbours, or other relatives rarely discussed or forewarned the women in matters of pregnancy and delivery, instead letting circumstances take their course naturally. The community nurses became the confidants of pregnant women, discussing all problems and questions they had regarding the pregnancy, delivery, and rearing of the child. Yewagenesh said that given their openness, extensive knowledge, and kind demeanour, the women respected the nurses greatly. When it came time to transfer from a health centre, Yewagenesh said that the women would cry, asking 'how will I be separated from you?'[294]

In describing her experiences in administering maternity care to women in rural Ethiopia, Yewagenesh was careful to find a space in which she could command a degree of authority over matters of reproduction, but in a way that remained palatable and relatable to the community. Reforming birthing culture was a subtle

[293] Author interview with Sister Yewagenesh Mesfin, Addis Ababa, 25 April 2013.
[294] Ibid.

matter of inserting modern methods of sanitation and support to the parturient, not revolutionising labour and delivery through over-medicalisation. Yewagenesh said that they were careful to retain customs that were innocuous and often unavoidable, including giving birth within the home itself. In the Gondar model, there was never a push to have women deliver at the health centre. Community nurses were meant to attend births at home, and Yewagenesh approved of this policy, stating that the woman was much more comfortable in her own home, and it was frankly 'unrealistic' to expect her to travel long distances at the end of her pregnancy to deliver in a clinic or hospital. Health centres themselves were not equipped for delivery - the community nurses would bring all necessary instruments directly to the home - and the nearest hospital was often several hundred kilometres away.[295]

During her time at the health centre in Gambella, Yezabenesh also explained that she would attend births within the home. This did not prove a problem at all, as nearly all her deliveries were normal and healthy— easily treated within the home environment. In her two years of service in Gambella, she remembers three women who had birth complications beyond the care of the home, and she recommended they be transferred to the nearest hospital in Metu. The health centre had radio communication with which they could call a plane in Metu to come and pick up emergency medical cases. The cost to the family was one Ethiopian dollar, and in only one instance did the family refuse the ambulance service. This woman died, as well as another woman who was transferred by plane to hospital in Jimma and was given an overdose of anaesthesia at the time of her Caesarean section. Only one woman who was transferred to a hospital survived, but Yezabenesh stated that in all her home deliveries in Gambella, she saw 'no deaths.'[296]

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[295] Ibid.

[296] Author interview with Sister Yezabenesh Amsalu, Addis Ababa, 16 January 2013.

Resistance to change

The nurses were careful in their administration of maternal health services in Ethiopia, subtly inserting themselves as authority figures over matters of pregnancy, delivery, and child-rearing, wielding tools of modernity when necessary, but not overly medicalising what remained a natural process. Even when approached in this 'gentle' manner, challenges to the process of altering embedded cultures of reproduction and child-rearing inevitably arose.

Likimyelesh described the persistence of indigenous custom even within the modern clinical setting. Her oldest child was struck with a severe case of diarrhoea when she was two years old, and a colleague at the Zewditu Hospital offered to take the child and care for her. Likimyelesh refused, saying she would care for the child herself, but several hospital workers rallied around her saying she should give the child away for external care, that she was merely being stubborn. The child eventually recovered, and the first hospital employee who had offered to take the child confessed to Likimyelesh that she had intended to have the child's uvula removed by a local medical practitioner. Uvula cutting was a customary operation for young children in cases of illness, ranging from pneumonia to diarrhoea, as it was felt the uvula blocked the proper digestion of food. Likimyelesh expressed shock that a hospital worker would remain beholden to such a custom. She chastised the woman, stating 'how can you do this? This is a hospital! You are supposed to teach the other people not to do these things, and here you work in the hospital and you are encouraging this.'[297]

Anqetz reported similar sentiments of reluctance among patients at the Zewditu Hospital to fully abandon indigenous treatments. She explained that there was an

[297] Author interview with Sister Likimyelesh Kassa, Addis Ababa, 18 January 2013.

obvious appreciation of the care given at the hospital, but patients would have lingering doubts, asking 'does medicine work as much as holy water? As much as native medicine?' Anqetz stated that people would be happy if the medical treatment worked quickly to cure their ailment, but if there were remaining side effects, or the illness was not fully treated, the value of medicine was put in question.[298]

In her work at the Tsehai Hospital, Shewaye, too, saw resistance among patients to change. She admitted that the most important aspect of medical work in Ethiopia was 'behaviour change' and education, stating that 'when people are educated, they can live a different life, they can prevent diseases. That's why we have to teach them.' But this educational thrust was often viewed poorly by patients. Shewaye explained that 'our people are very sensitive to certain things' related to culture, and are very defensive when attacked. When told what they should eat, how to 'adjust their home,' there will naturally follow a degree of scepticism and questioning. Why should we change our behaviour? Especially when healthy? Shewaye said it was impossible to 'force them to do something they don't know.'[299]

At the same time, Shewaye expressed a high degree of confidence in the retroactive power of medical work in Ethiopia. She looked with fondness to the Haile Selassie period, when there was a freedom of exchange and knowledge among so many nations: at Tsehai, she worked beside physicians from a dozen countries, a fact she says was essential for the growth of Ethiopian culture. 'It was really good because we had outside information. It's not good to be locked in— it is good to have shared knowledge from outside for the betterment of the country.' At one point, Shewaye was commissioned to work in a rural area of Ethiopia as part of a

[298] Author interview with Sister Anqetz Hailemariam, Addis Ababa, 17 January 2013.
[299] Author interview with Sister Shewaye Gebre Kirkos, Addis Ababa, 15 October 2012.

humanitarian mission. While there, she helped teach the women better methods of housing construction. She was confronted with initial suspicion in the community, but once she built a home with improved materials and demonstrated the functioning of the new brick fireplace and chimney inside, the women came to her and said 'how come we did not know how to do this before?' Shewaye explained that once she showed the women how to do it, they were convinced and would pass on the knowledge between them.[300]

The demonstrative aspect of modernity was essential in the spread of medicine and cultural reform in Ethiopia. Yewagenesh said that any resistance she saw among women would be quickly rectified once they saw a community-nurse attended delivery. 'When they see, they understand,' she said.[301] Other women who rejected the care of the nurses would often be convinced to start attending the health centre for the next pregnancy after having seen the nurses in action. The nurses agreed that this was especially critical in matters of maternal health, because as Likimyelesh said, this 'is the beginning of everything.' If you 'save the mother's life, she is able to take care of the growing baby.' And this baby is 'the promise of the country later on. Unless you get babies, and help them grow, then later on, there is no nation. That is the foundation of the country.' Everything begins with the mother's health: her nutritional intake, sanitary practices, and domestic behaviours.[302]

Once the nurses could demonstrate superior, modern methods of managing the mother's health and environment, communities would be convinced to alter practices and the nation would naturally advance. The nurses fully adapted this nationalist message within their practices, believing fully in the transformative aspect of medicine for Ethiopia. Even if indigenous customs persisted within

[300] Ibid.
[301] Author interview with Sister Yewagenesh Mesfin, Addis Ababa, 25 April 2013.
[302] Author interview with Sister Likimyelesh Kassa, Addis Ababa, 18 January 2013.

communities, the nurses were optimistic that in the end, the demonstrative power of medicine and modernity would win out overall.

Modern entitlements: using medicine to advance personal status

Having appropriated the modernising message of medicine in Ethiopia, female practitioners set out to lead their compatriots into modern life in a model of caring didacticism. Set with this task of leading the charge to modernity, the practitioners were inevitably set apart from other women and the customary practices of Ethiopian life. In order to lead by example, the nurses themselves would have to retain a wholly modern way of life, an attractive feature of the profession. Nurses adopted Western clothing and hairstyles, lived in modern homes, and altered their diets to fit Western nutritional standards. While the nursing salary was limited, it was still much higher than the income of the typical farming household in Ethiopia, and by virtue of their professional status, nurses were often placed in an elevated social position that meant they attracted husbands with optimistic career prospects. The potential for self-modernisation and personal advancement within medical careers helped expand the burgeoning professional class in Ethiopia, but also proved to further divide society along superficial lines of tradition and modernity. Medical practitioners became more alienated from the communities they were meant to serve, and it became increasingly difficult to relate to the patients they were tasked with educating. These social divisions proved detrimental to the modernisation-through-medicine model, while the benefits of modern living became more narrowly focused on a small group of elite professionals.

When Likimyelesh was 14, she moved to Addis Ababa to live with an uncle who had agreed to pay her secondary school fees. The uncle drove Likimyelesh around the city in his own car, and showed her his 'fabulous, very big house.' He told his niece that if she did well in her studies, she could 'have a house better than mine.' Likimyelesh explained that this 'did it' for her: 'all the time I was in school I was thinking of that.'[303]

Likimyelesh was raised in a remote rural area of Ethiopia, and the allure of a large, modern house is understandable. Her frank description of the motivating nature of modern luxury is echoed in the writings of many early medical practitioners in Ethiopia, especially in Gondar. Like Likimyelesh, most Gondar students originated from the rural environments in which they were eventually meant to serve, but in training for several years in the modern city of Gondar, students would rapidly acclimate to the luxuries of urban life, losing their connection to community customs they had left behind.

When Dennis Carlson became Dean of the Gondar Public Health College in 1963, he was instrumental in bringing more rural residents to the college for training, beginning an empire-wide recruitment mission that shuttled faculty members across Ethiopia's secondary schools to speak on the benefits of a career in public health service. Carlson was concerned that in the first years of the college's operation, the majority of students were from Addis Ababa or Harar, and their experience in rural environments was limited. Carlson was cognisant that given the significant divide between urban and rural communities in Ethiopia, even with an entirely indigenous cohort of trainees, Gondar graduates would be working in 'differing cultural

[303] Ibid.

situations.'[304] An urban health officer would find himself culturally separate from the social customs of a remote rural area, and this constant distinction between 'modern' and 'traditional' Ethiopia was in many ways exacerbated by the students' training. Even those students recruited from rural areas would then spend three or four years in the urban environment of Gondar, indoctrinated into the principles and practices of city life. It was hoped that the Gondar graduate would merely internalise the principles of modernity learnt in Gondar town, then work to integrate the urban lifestyle within the parameters of their more 'traditional' rural upbringing.

In order to bridge this widening gap between the traditional and modern sectors of Ethiopian communities, students were to be the 'right kind' of Ethiopian. That is, they were to be well-versed in the cultures of both the countryside and town, and comfortably able to translate the principles taught at Gondar to their home communities. Internal correspondence among American aid administrators in Ethiopia describes their own penchant to recruit this type of Ethiopian who could both operate seamlessly within the national context, while also working under the 'American philosophy' to 'get things done.' The US gave numerous grants to young men in Ethiopia, including Gondar graduates, to study for advanced degrees in American universities. These men would then return to Ethiopia and work within high positions of government ministries, 'carrying into the Ministry the democratic process idea and the knowledge of American way of life and manner of doing things.'[305] While foreign physicians and administrators were considered largely ineffective when working within Ethiopian ministries and health services, Ethiopians trained in Western-style institutions, including Gondar, could help

[304] Rockefeller Foundation, RF: 02.1964/701 (New York, 1964).
[305] United States NARA, RG469 P246 (College Park, MD, 1958).

bridge this cultural divide between modernity and traditionalism in the 'communities of rapid transition' in Ethiopia.[306]

On the part of Gondar students themselves, they very quickly adopted the role of national modernisers, eager to project their personal levels of modernity in lifestyle and ideology. In students' writings from the mid-century, it is clear that there was a general malaise among young Ethiopians anxious to separate themselves from the negative image of their nation as 'backward' and overtly 'traditional.' Working for the US Embassy in Addis Ababa, anthropologist Edith Lord conducted a survey of Ethiopian students in 1959 to ascertain their own beliefs regarding modernisation and relations between local communities and foreign aid workers. When asked what students would say to a foreigner recently arrived to Ethiopia, the responses included: 'Why must they constantly stress the bad qualities of our country?,' and 'Don't always say how advanced your country is.' Another student argued, 'If they wish to teach us good ways of doing things, let them do it indirectly. It is intolerable to be told you're backward by others.'[307] The new generation of Ethiopian students was fixated on staking their place in modern Ethiopian life, and actively resisted the prejudiced labelling of Ethiopia by foreign commentators at the time.

These students' relationship to traditional Ethiopia was complex, however: while intent on defending the nation against its detractors, students also tended to internalise the very image of Ethiopia as paralysed within centuries of destructive tradition. They propagated themselves as examples of the modern capacity of Ethiopians, while simultaneously using their 'backward' countrymen as a comparative foil to their own superior status. In the *Spring of Health*, a Gondar

[306] The term 'communities of rapid transition' is Dennis Carlson's, meaning that the rural places where graduates worked were steeped in tradition, but would rapidly modernise with the presence of the health centre. (Rockefeller Foundation, RF: 02.1964/701 (New York, 1964).

[307] E. Lord, *Cultural Patterns in Ethiopia* (Addis Ababa, 1959), pp.17-20.

student newsletter, one health officer wrote that 'the people of Ethiopia were fast asleep for about 500 years while the other nations were advancing rapidly with their civilisations. Thanks to His Imperial Majesty, Haile Selassie, we are now waking up to catching up with the other nations.'[308] Students appropriated much of the derogatory language about their nation and its customs, but sought to assert themselves as the antithesis of traditional Ethiopia. While there may have been sectors of Ethiopia that remained backward, it was 'intolerable' for students to be called backward themselves, and especially at Gondar, young Ethiopians were increasingly vocal about their own privileged place as development vanguards, leading the nation's communities away from their traditions and into modern life. In the same 1957 issue of the *Spring of Health*, one student described the Gondar graduates as 'health warriors getting ready this year for war on disease which they are going to abolish from their country, Ethiopia.' This demonstrates a virulent streak among Gondar students who considered themselves active combatants against the multiple plagues of ill health and underdevelopment in Ethiopia.

Over the course of my fieldwork, I interviewed a number of male health officers in addition to the female community nurses. One former health officer, Kinfe Gebreyehu, explained his own contrasting status in relation to the community he left behind:

> When I went back to my hometown on vacations and told everybody, including the neighbours, what the training was about and what life in college looked like, they were delighted at knowing someone from their own community going to be a health officer and heal them from the maladies they have been suffering. I gave them the highest hope. My uncle, in particular, who has some basic education and was the city clerk, very well knew what it means to be a health officer and attain that level of education and skill.[309]

[308] United States NARA, RG469 UD394, (College Park, MD, 1960).
[309] Author interview with Ato Kinfe Gebreyehu, Addis Ababa, 8 October 2012.

By virtue of his training as a health officer, Kinfe was clearly set apart from his home community. In Kinfe's view, his community understood that his training meant that he was granted a new level of prestige, and that his educational status meant he could help lead the community away from previous maladies.

The experience of Kinfe is symptomatic of the larger view of this first generation of medical practitioners who, while Ethiopian in upbringing, had been indoctrinated into a system of learning that distinguished them from the communities in which they were raised. Practitioners were respected for their unique skills in rooting out disease, and they themselves were proud of the 'hope' they brought to Ethiopia. The new generation of trained practitioners believed fully in their capacity to modernise their nation, to not just provide curative treatment to individuals, but to actively transform entire communities through medicine.

The space between patient and practitioner

Distinguished by their modern education and lifestyle, the degree of separation between practitioners and their patients continued to widen in the years that followed medicine's expansion in Ethiopia. This was especially true when the practitioners, who were largely Amhara, set out to man health centres and clinics in border regions of the empire with diverse ethnicities. Yezabenesh explained her experience in Gambella, where there was a complex mix of both Southern Sudanese and West Ethiopian ethnic groups. Yezabenesh is from the Gojjam area, in Northern Ethiopia, and speaks only Amharic and a bit of Tigrinya. She explained the 'bizarre' practices of the people in Gambella, including 'throwing babies into the jungle' for arbitrary reasons including being touched by a menstruating woman. Her understanding of the cultures of the region was incomplete, however, as she never

learned any of the local languages. She said that this was not a problem as she always had a translator nearby who could speak Amharic, but it is clear that given her descriptions of the people and their community customs, much was lost in translation.[310]

In remote health centre postings like Gambella, many graduates of the Gondar college felt intensely isolated. Trained as Ethiopia's 'soldiers of health,' Gondar graduates viewed themselves now as largely separate from traditional Ethiopian society, privileged to undergo rigorous 'scientific training' that would allow them to propagate the principles of modern medicine to communities they viewed as largely backward. Once installed in their respective health centres, however, graduates swiftly realised that not only were communities not immediately deferential to their authority over matters of healing, but also that the ill-equipped facilities in which they worked would not allow them to adequately treat communities in the advanced scientific methods they had anticipated. Graduates expected to advance their social standing through employment in the national public health infrastructure, but were instead left mostly on their own to work in remote outpostings. With no clear career ladder on which to advance, graduates felt lost in their current hardships, confronting uncooperative communities, endless clinical hours, and chronic shortages of supplies.

Several commentators had noted personal reservations about the elite nature of Gondar trainees, sceptical that these young, modern Ethiopians would actually be up to the task of manning remote health facilities. When members of the UK Embassy in Addis Ababa visited Gondar in 1969, one official noted that while 'the majority [of Gondar students] are likeable characters, when one sees them sitting in the bars and cafes in their smart suits ordering espresso coffee and passing round

[310] Author interview with Sister Yezabenesh Amsalu, Addis Ababa, 16 January 2013.

packets of American cigarettes…[knowing their work] means a return to a *tukul*[311] in a compound on some mountainside,' the 'overly sophisticated' nature of the training course became obvious.[312] While the intention of the Gondar college was to advance the modernisation of Ethiopia, critics felt that the lifestyles of students at the college were becoming too far removed from the communities in which they were meant to serve.

In his ethnography of the Amhara, *Wax and Gold*, Donald Levine asserted that with the increasing development of Ethiopia, those 'Ethiopians who are striving to modernise their country have for the most part lost touch with the peasantry.' Either such 'modernisers' had been born and raised with no contact with rural life at all, or they began to willingly ignore personal markers of a rural upbringing.[313] Indeed, students were only too eager to distinguish themselves from the typical customs of Ethiopian life: in a complaints column of the college newsletter, the *Students' Mouthpiece*, one health officer wrote in to say that 'food officers shouldn't wear *gabis* in dining hall,' showing clear disdain for college staff seen to be wearing the customary clothing of Ethiopia. Another health officer wrote, 'at meal times, how can one tolerate the invariable *injera* and *wot*?'[314] Again, the staple dish of Ethiopian cuisine was seen as unsatisfactory to students increasingly exposed to European modes of living, both in the urban area of Gondar, and in the classroom, where Western definitions of nutrition were taught.

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[311] The term for a typical Ethiopian house, meaning 'two-level,' as the home would be constructed to accommodate animals on the lower level, while the family would sleep above.

[312] United Kingdom National Archive, FO 1043/77, UK Foreign Office of Ethiopia, Tours by Embassy Staff, (London Kew Gardens, 1969).

[313] D.N. Levine, *Wax & Gold: Tradition and Innovation in Ethiopian Culture* (Chicago, 1972), p. 55.

[314] 'Enough!', *The Student's Mouthpiece*, Vol. 2 (Gondar,1963).

This increasing division between medical practitioners and 'traditional' Ethiopians was not only a product of their several years of training, however, but also harked back to the largely elite origins of students and their families. As Christopher Clapham has explained, 'development has the effect of making old divisions far more articulate and aware of themselves than they were before.'[315] Having received a secondary education, all medical students were from a distinct class of Ethiopian society, and college officials were perhaps naive in neglecting to consider the importance of social rank in the empire as they worked to train elite youth to work within impoverished rural communities. As one student reported to a US official, 'foreigners should understand something about our class system in Ethiopia, for if they understand the classes of people, they will better be able to deal with them accordingly. There are some who feel superiority and some who feel inferiority, this seems to be something of which foreigners are not aware.'[316] Ato Teso, a high-ranking judge in Haile Selassie's regime, further noted that in Ethiopia, 'we have this tradition of authority and superiority that causes respect to be paid to us and that protects our right.' Teso was referring to the hierarchy of a father over his family, landlord over peasant, and the clergy's spiritual authority over the nation. He argued that this hierarchical structure would secure the prestige of Ethiopia's 'old families,' even if the nation was 'revolutionised' by modern development.[317]

Imbued with an innate feeling of superiority and status, medical practitioners felt confident that their work would be intrinsic to Ethiopia's modernisation. As one health officer wrote, 'If my birth is only to raise the established population of

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[315] C.S. Clapham, *Haile-Selassie's Government* (London, 1969), p. 185.
[316] Lord, *Cultural Patterns in Ethiopia*, p. 15.
[317] R.K. Molvaer, *Tradition and Change in Ethiopia: Social and Cultural Life as Reflected in Amharic Fictional Literature Ca. 1930-1974* (Leiden, 1980), p. 23.

Ethiopia from 21,999,999 to 22 million, then I strongly hate my very existence. But if I am born to contribute something to society, to develop an enthusiastic idealism, and to further join effort in saving my country from impending peril, then my existence is worth something.'[318] Another student explained to his classmates that 'you and I are members of a privileged minority.' But because of this very privileged status, practitioners were to dedicate themselves to elevating the 'underprivileged majority' which 'still creeps under the heavy weight of ignorance, unbearable poverty and poor health.' The duty of the health teams was to use their superior knowledge of objective science and technology to route out the underdevelopment of Ethiopia, for 'upon us the health conditions of our nation depend. We are the foundation stones for future health.' The health officer played to the sympathy of his colleagues, describing a typical scenario of walking down an Ethiopian street: 'Look at the swollen bellies of our little brother. Can't the learned few solve these problems? Have they no sympathy for their brothers and sisters? We must be able to sacrifice both body and heart to help these people in need.'[319]

Possessing unique skills and scientific knowledge on the principles of infection and disease, health workers felt confident that not only were they wholly separate and distinct from the 'underprivileged majority' of the population, but that they would be able to re-educate the masses to abandon backward notions of health and healing. In 1956, one health officer explained:

> If we take the careless fathers with intestinal diseases and tuberculosis, who defecate anywhere and spit tubercle bacilli any place, and the careless mothers who do the same thing, who leave foodstuffs uncovered, we can see how they cause or bring out the diseases of their children… [but they blame God instead]. It is human nature to find an excuse when something goes wrong. This kind of reasoning does not work all the time because disease is not a God-sent punishment and God has no intention of bringing about the

[318] 'Enough!', *The Student's Mouthpiece*, Vol. 2 (Gondar, 1963).
[319] Ibid.

> deaths of children— diseases and deaths are brought about by sheer carelessness and ignorance of sanitation and personal hygiene.[320]

The rhetoric of early medical practitioners in Ethiopia displays a clear understanding of their elevated position in relation to the lowly masses they were to serve. My own interviews with nurses and health officers corroborate the written accounts of Gondar students rallying around both their privileged status and potential to correct the troubling traditions of their nation. The majority of medical practitioners entered their training from an elevated social position, but the dogmatic nature of their medical training only reinforced their belief in their potential to route out the backwardness within Ethiopian society. As one faculty member at Gondar explained to his students, 'your function should be to instruct [communities]… as the teacher you are expected to know the best way for everything.'[321] Such statements only worked to further separate the practitioners from the communities they were to serve, granting health workers a further degree of entitlement.

Rejecting duties to care

In entering the medical profession, young Ethiopian students largely expected a life of modern luxury and social prestige. While all the nurses I interviewed explained their personal convictions regarding the art and profession of nursing, this sentiment was not universal amongst initial medical recruits. Shewaye explained that when she entered the Tsehai nursing school in 1960, twenty-one fellow

[320] United States NARA, RG469 UD756, Records of US Foreign Assistance Agencies: Health Reports Relating to Ethiopia compiled 1955-1958 (College Park, MD, 1956).
[321] F.B. Elder, 'Sanitation and Water Supply Problems in Ethiopia', in E.F. Torrey (ed.), *Introduction to Health and Health Education in Ethiopia* (Addis Ababa, 1967), p. 49.

classmates from her secondary school entered with her. However, the exacting expectations of these vanguard nurses soon clouded the prestigious image cultivated by young entrants to the profession: only three of Shewaye's classmates finished the nursing course four years later. Shewaye explained how challenging the training was: 'if you didn't find satisfaction in nursing, you couldn't do it.' For all its elitist trappings, she argued that nursing is ultimately a 'humble profession… It takes up your time, your energy, your intellect… you have to give totally to the profession.'[322] For the majority of trainees, the modern prestige and attraction of medicine did not make up for the significant amount of labour involved.

Anqetz also described in detail the rigour of her training at the Zewditu Hospital. She said that nurses were like 'soldiers,' waking up at six to wash and dress, attend class until 7:30, and then have fifteen minutes in chapel for prayer. After a short breakfast, the work would begin at 8:30, and would not end until nine in the evening. Nurses who worked in the emergency ward of the hospital would not end their shift until midnight or well into the morning. Anqetz explained that it was a rapid transition between the lab, classroom, and hospital ward throughout the day. Every nurse would rotate between the hospital departments as in standard physician training. In the obstetrics department, each nurse would have to manage fifty deliveries before she could move on to her next rotation.[323]

Shewaye also explained that not only was the training rigorous in its unceasing schedule, but often the work of nursing was brutal, frightening labour. She argued that coming from secondary school, nursing was an entirely new form of education. This was not a mere academic pursuit, but very physical and immediate work. Shewaye explained that in her first week of training, her instructors asked that she

[322] Author interview with Sister Shewaye Gebre Kirkos, Addis Ababa, 15 October 2012.
[323] Author interview with Sister Anqetz Hailemariam, Addis Ababa, 17 January 2013.

watch over a terminally ill patient alone for several hours. She said the man was 'shouting and shouting,' and was bleeding heavily. Left alone to manage the patient, Shewaye admitted she had no idea what she was doing, and was incredibly frightened. This was all part of the training, however: 'they just put you in there and see how you are reacting.' From the beginning, the nurses had to confront pain and suffering. Shewaye said that you have to know how to deal with a lot of pain, and that if 'the nurse sees blood and she cries, that's not good for the patient.' The nurse must control her emotions and work with diligence.[324]

Shewaye explained how when confronted with this shocking environment, the majority of her classmates left to be secretaries and shopkeepers, preferring to 'sit in the office and type,' rather than stick with the 'hardship' of nursing care. Choosing more accessible and visibly modern professions, Shewaye's classmates refused the new roles assigned them as institutionalised care-givers. Expecting to be healers equipped with advanced medical cures, nurse probationers were instead asked to be primarily humanitarian carers, leading patients by example into more modern standards of living.[325]

The task of altering domestic living customs was not restricted to Gondar graduates: there was a repeated demand on urban hospital nurses to demonstrate the benefits of modernity to patients, including promoting sanitation, improved nutrition, and the perceived practicality of Western clothing. Mothers were particular targets of nurse instruction at the Tsehai Hospital. In an article about the hospital four years into operation, Sylvia Pankhurst described the typical scene of a 'humble cottager' come to the hospital for treatment, with the nurse standing beside and admonishing the mother on how to clothe her baby more warmly. Pankhurst

[324] Ibid.
[325] Ibid.

asserts that 'the experienced nurses are needed to guide and advise the mother in the care of her convalescent baby. A great educational work in the rearing of infants is required of hospitals and clinics everywhere.'[326]

Despite Pankhurst's optimistic appraisal, however, the educational work of the city nurse was unappealing to many new recruits. At the Menen School of Nursing, complaints were made about the disappointing performance of graduates in their roles as carers and public health educators. When one Menen graduate was assigned to work in a remote clinic solely to instruct mothers in better preventive care measures, the nurse abandoned her post within a week, returning instead to a more treatment-centred position at Asmara hospital. Four years after the Menen School's founding, instructors began placing probationers on fifteen hour 'continuous care' rounds at the hospital to 'increase students' feeling of responsibility' and improve the expected ministering role of nurse probationers at the patient bedside.[327] It was hoped that the future nurses would fully appropriate the definitions of modern nursing into their practice, which was mainly to care for and educate the patient.

Conclusion

In narrating the practitioner experience, contradictions in her role as moderniser arise. Nurses and midwives were exercising radical new rights as the first generation of female professionals in Ethiopia, but their position in medical practice was nominally limited within gendered expectations. The persistence of traditional gender definitions meant that women were officially unable to lead clinical practices or perform any significant role in curing patients. Such restrictions were consistently

[326] Pankhurst, 'Ethiopian Patient's Tribute to Princess Tsahai Memorial Hospital'.
[327] United States NARA, RG469 P246 (College Park, 1961).

flouted, however, as women assumed responsibilities in clinical practices either out of a sense of personal ambition or in a vacuum of appropriate male staff. Having been asked to primarily care for patients, female practitioners appropriated their official expectation to nurture patients as an effective method to communicate the necessity of altering traditional customs and reforming cultures surrounding health and reproduction.

Practitioners largely agreed with official policies to reform traditional life through medicine, but simultaneously asserted their own authoritative knowledge over questions of medicine and tradition. Concessions between official policy and local practicalities were common, as practitioners themselves viewed medicine with a degree of reluctance for its potential iatrogenic effects, especially in regards to maternity care. Women used their position of trusted carer as a way to mediate between the patient and her medical treatment, allowing certain traditions to persist in order to reform others considered more dangerous. Considering both the foreignness of modern medical treatments and the boldness of the mission to wholly alter indigenous culture, female practitioners understood the significance of this position as mediator.

At the same time, as the expectations on nurses began to mount, some women chose to reject the challenging labours of medical work in favour of more outwardly modern professions. Personal ambitions came in conflict with humanitarian expectations of medical practitioners. Many women pursued medical careers in the hopes of advancing their own status in modern Ethiopia, and when confronted with low salaries, remote working locations, and the arduous labour of nursing care, many initial recruits abandoned their medical ambitions. Even those who continued the training and entered professional nursing careers continued to face challenges to personal ambitions: community nurses would seek employment in the capital, and

bedside sisters would take up more lucrative posts in private clinics. Aside from Yewagenesh, every woman I interviewed pursued an advanced position and salary either in Addis Ababa or abroad, intent on using her medical training to further enhance her own personal status.

By official design, the nursing academies in Ethiopia were meant to craft a cadre of modern Ethiopian women, ready to educate communities on correct living practices through nurturing care and personal example. In practice, women used their nursing careers to advance their personal pursuit of modernity, appropriating the messages of community reformation along the way. Practitioners hoped to use their elite status and personal markers of modernity to demonstrate the benefits of modern living practices to their traditional compatriots, but often merely alienated themselves from the patients they were meant to serve. While officials intended this new class of professionals to lead the charge to advanced living for all Ethiopian communities, the space between practitioner and patient only widened in the decades of imperial rule.

Chapter 4: The patient experience

If a woman suffers strong pain during childbirth, recite the 71st Psalm 78 times with holy oil on her forehead. She will deliver the baby. The birth will occur as she wishes, and it will be painless.

— 18th century Amhara medical manuscript[328]

Women's experiences with medicine in Haile Selassie's Ethiopia varied considerably between practitioner and patient. While nurses were able to advance their modern status in the practice of medicine, such benefits poorly translated to the patient experience. The modernisation of maternal health practices was meant to be a didactic exercise, a vehicle to greater community transformation. When narrating the experiences of patients, however, it is evident that the alteration of lifestyles was rarely preceded by a visit to the clinic. Women who incorporated the lessons of public health were nearly all members of a higher class already exposed to other features of Ethiopia's modernisation, including elite professions with larger incomes. Such women could afford the lifestyle changes requisite to modernity, and were proud to project their status in modern Ethiopia by deliberately choosing hospital births. For the majority of women, however, interactions with modern healthcare were sporadic, often in the case of medical emergency. Most patients were uninterested in being co-opted into state modernisation schemes, unaware that their decisions regarding household management and child-rearing had larger implications for their status in modern Ethiopia.

Like the preceding chapter, this chapter draws heavily from the oral interviews collected during my fieldwork in Ethiopia in 2012-2013. I conducted 150 patient interviews while in Ethiopia at three different sites; Addis Ababa, the capital,

[328] S. Strelcyn, 'Les Mystères Des Psaumes, Traité Éthiopien Sur L'emploi Des Psaumes (Amharique Ancien)', *Bulletin of the School of Oriental and African Studies*, vol. 44, no. 1 (1981), p. 75.

Gondar, a mid-sized town in Northern Ethiopia, and Jinka, a small town in the south of the country. The women I interviewed all gave birth between 1950 and 1980, so were keen observers and participants in Haile Selassie's medicalisation efforts. Further, those women I spoke with who had given birth in the hospital made up the first generation of women to undergo institutionalised birth in Ethiopia. Without exception, the women's mothers gave birth at home, while most of their daughters gave birth in present-day hospitals and clinics. These women represent the link between Ethiopia's shifting practices in birthing.

In citing my interviews, I am careful to demarcate patterns in both geography and periodisation in women's experiences. While the span of birth stories contained in my interviews stretches to three decades, there were marked differences between women who gave birth at the start of Haile Selassie's medical expansion in the early 1950s versus the end of his rule and start of the Derg administration in the 1970s. As the emperor's reign continued, medical services were slowly expanded, with more rural health centres and urban hospital beds. Medical assistance in birth became more common, while other innovations in child health, notably more widespread immunisation campaigns, characterised the early Derg years. During my interviews, I asked the woman her own age and the age of her children to determine when she gave birth, but this was often a challenging process as ages were mostly approximate. Often women could only say they gave birth '*behaileselassiegize*' or '*bederggize*' (in the time or Haile Selassie, or in the time of the Derg). More subtle clues within the interview could indicate a more accurate time frame for delivery, especially if women made statements like 'it was normal at the time to give birth at home' or 'it was normal to receive ante-natal care' - these comments reflected both shifts in conceptions of maternal health practice, and also varied based on the demographic background of the interviewee. Wealthier, urban women were quicker

to state the normality of hospital services, given their greater access to medicalised maternity as compared to rural counterparts.

In addition to including the approximate years of the woman's labours in the patient narratives, I also note the difference in geography within the interview citation. The references to patient interviews in this chapter include the neighbourhood where I conducted my interviews in Addis Ababa and Gondar towns. I categorised interviews by *woreda* in Addis Ababa, a large government unit, and then by *kebele*, a smaller community unit, in Gondar. The population of Gondar is significantly smaller than Addis Ababa, so I was more specific in coding the interview location. In Jinka, given the small population, I interviewed women only in the main town, which comprises just one *kebele*, so will not delineate which neighbourhood the women lived in. Lastly, the names of women interviewed are all pseudonyms. I have coded the informants with their interviews, so they can be cross-referenced with the original transcripts if necessary.

I begin the chapter by discussing the most prominent themes arising in the interviews, organised first along the geographical boundaries of my interview collection. I begin in Addis Ababa, where the prominent connection between class and birth choices was evident. In Gondar, I relate narratives of numerous women from varied social classes, exploring the ways in which the public health college inserted itself into the town's birthing practices. Finally in Jinka, I describe the ways in which a severe paucity of medical services determined patterns of both birthing and childcare.

I end the chapter first with a summation of the narrative themes, and then a discussion of relevant anthropological literature on health behaviours in mid-twentieth century Ethiopia. While much of this literature has come into question for both its relevance and accuracy by contemporary anthropologists of Ethiopia, I

believe that the accounts written in the mid-twentieth century are useful in expanding potential explanations for the health behaviours of my interview subjects. The secondary literature helps expand upon the themes which emerged from my own data collection, contextualising choices related to maternity care within larger social definitions of health and disease.

Choosing the hospital: class and modernity in Addis Ababa

For most women in Haile Selassie's Ethiopia, giving birth in the hospital was not a deliberate choice, but was instead an exception to the normal practice of home delivery. If a woman delivered in the hospital, it was nearly always in times of obstetric crisis. Women arrived at the hospital mid-labour with a condition that could not be treated at home, e.g. malpresentation or uterine rupture. Given that the majority of births continued to be conducted at home even after the expansion of clinical care, it is evident that modern maternity services merely inserted themselves into the cosmology of existing birthing practices. For nearly all women I interviewed, clinical practices did not replace home care, but were simply an additional option in cases of obstetric duress.

The most prominent theme emerging in my interviews was the clear delineation between curative services at the hospital versus normal caring services at home. Women viewed the hospital as a place for emergency cures, and the home as the appropriate site for all other routine maternity care. This theme will recur throughout both this and the next chapter in varying forms, though there are deviations from its pattern.

The most notable exception was found in the ten women I spoke with who deliberately sought out medicalised maternity care from the outset of their

pregnancies. In interviewing these women, it was clear that in choosing the hospital, their perception of modern medicine extended beyond mere curative care. There were additional signifiers guiding their choice of maternity care, most notably one's social ranking. Aster Yonatan explained that 'in my class, no one gave birth at home because I'm from the capital city.' People were different 'in the village,' but given her status as a wealthy, urban Ethiopian, there was no question that the hospital was the only option for maternity care.[329]

Not all of the women I spoke with who chose institutionalised care were exceptionally wealthy, but they were all privileged participants in some aspect of Ethiopia's modernisation. In the case of Helina Mesfin, when asked why she went to the health centre for ante-natal services when she gave birth in the early 1960s, she merely replied, 'I was a teacher.'[330] There was an implicit expectation that the newly professionalised classes of Ethiopian society would automatically replace indigenous healing practices with more modern alternatives.

Social pressures in birth choices

While Helina was unique in being a professional teacher herself, it was more often the case of the husband's profession that dictated a woman's choice of birth location. Lealem Hailemariam said that her husband was a veterinarian, so he 'let me go to the hospital' for both ante-natal care and her six deliveries from 1955-1965. Lealem explained that 'it was not common for others to go to the hospital. It was

[329] Author interview with Aster Yonatan, Addis Ababa, Woreda 1 (Bole Mikael), 16 April 2013. Note: nearly every woman included in this section lives in Woreda 1, Bole Mikael. While nearly every woreda in Addis Ababa has a healthy mix of socio-economic classes, Bole Mikael has a high proportion of wealthy residents. The wealth status of woreda residents was reflected in my interviews.

[330] Author interview with Helina Mesfin, Addis Ababa, Woreda 1 (Bole Mikael), 20 April 2013.

only because my husband was aware - it wasn't even me who was aware - my husband forced me to go.'[331] Given that Lealem began giving birth at the very start of Haile Selassie's medical expansion, it was considered 'normal' for her neighbours and relatives to stay at home to deliver. However, Lealem's husband had secured his prominent status in the modernising state as a veterinarian, and felt it critical that his wife conform to modern expectations of birthing practices. Lealem's husband had inserted himself in the new social structures of the modern state by virtue of his profession, and was intent on extending his status to his wife via medicalised maternity.

This pattern of social pressure regarding birth choices arose often in interviews. When interviewing Elshadai Tewabe, I asked why she attended the hospital for all of her seven births in the 1960s, and her adult son, present at the interview, interrupted to answer for his mother: 'it's because her husband was educated.'[332] This explanation was seen as sufficient— if you had sought out modern education, you would modernise all other aspects of your life, especially healthcare. It was also understood that the husband's status was a critical factor in determining his wife's birthing practices. It was not up to the woman herself to choose the terms of her maternity care, as she was often asked to merely follow the decisions of the authority figures within her larger social network.

Debre Nigussie explained to me that when she first fell pregnant in 1950, her sisters and cousins all convinced her to see a renowned doctor at the Haile Selassie I Hospital in Addis. The physician was considered one of the best in Addis, a '*gobez yeferenjihakim*,' or 'clever foreign doctor.' In 1950, modern medical services were only

[331] Author interview with Lealem Hailemariam, Addis Ababa, Woreda 1 (Bole Mikael), 20 April 2013.
[332] Author interview with Elshadai Tewabe, Addis Ababa, Woreda 1 (Bole Mikael), 16 April 2013.

just expanding in Ethiopia, and Debre and her sisters were the first women in her family to give birth in the hospital: her mother had delivered all ten of her children at home, explaining that 'it was easy' for her to deliver and she did not need any medical assistance. Despite her own history of successful home births, Debre's mother also insisted that Debre attend the hospital because of the reputation of this doctor.

Even though Debre's birth choices were largely dictated by her family, Debre was pleased with the decision, stating that the care at the hospital was exceptional. She paid as a private patient and stayed for two weeks after each of her three deliveries. Debre always returned to the same hospital, and said that she never stepped inside a public health institution. Her family could afford the user fees at the most elite of medical institutions, a privilege extended to only a handful of women in Addis. Debre explained that she knew no one who gave birth at home. She casually stated that 'by that time, everyone was giving birth in the hospital.'[333]

Debre's blanket assertion betrays her position in Addis Ababa's social classes. As part of the wealthiest sector of society, Debre was easily co-opted into the modern symbolism of institutionalised maternity care. Everyone within her own social circle could afford the fees of private hospital care, and was adamant about attending the doctor with the highest reputation possible. Considering only ten out of 150 women I interviewed deliberately chose hospital deliveries over home births, it is clear that in Haile Selassie's time, not 'everyone' was giving birth in the hospital. The class distinctions in birthing practices are clearly evident. With the introduction of the hospital, wealthy families could further entrench themselves in an elite position separate from their compatriots. Even if the woman herself did not actively choose the hospital setting, her social position would heavily determine the manner of her

[333] Author interview with Debre Nigussie, Addis Ababa, Woreda 1 (Bole Mikael), 20 April 2013.

care during pregnancy and delivery. The decision to birth in the hospital was often collective, made by relatives and friends intent on securing their status and prestige. In modern Ethiopia, there was a groundswell movement in professional circles of society towards asserting one's personal modernity. The actions of an entire family combined to determine an individual's status in modern Ethiopia, and there was a group mentality in conforming to the choices of modern peers.

Modern disappointments

Even among the wealthiest sector of Addis society, the pressure to give birth in hospital did not always have a positive outcome. Aster Yonatan said that it was her friend who recommended she attend the Princess Tsehai Hospital when she became pregnant with her first child at age 21. This was 1967, and the friend said that a 'special doctor' worked at Tsehai, Dr. Rose. Aster was told how well the Tsehai staff take care of women in comparison to other hospitals. There was a large private room in which she could deliver for a high fee, a cost her family was happy to pay. Aster went to Dr. Rose for the duration of her pregnancy, and arrived at the hospital at the first onset of labour.

From Aster's description, it is quite clear that her labour was mismanaged by the attendant nurse. After only a short first stage of labour contractions, Aster explained that she was feeling a great deal of pressure, and told the nurse that 'there's something about to come out.' Her body had transitioned to the second, pushing stage of labour, and the baby was shortly on its way to be born. The nurse discouraged Aster from pushing, however, as the doctor was not yet present and they had not completed all the necessary routines for labour care. Given this was Aster's first delivery, the nurse was frank in stating that she did not 'know anything

about labour,' and that the medical staff were the authority in directing the birth's progression.

Aster reached a point of desperation - the pain of her baby's descent into the birth canal was excruciating, and she could not help the sensations to push and assist the delivery. Aster explained that in her large private room, her 'whole family,' both her own and her husband's, were present at the birth, and they were all wailing and crying, convinced that she was dying given the chaos of the second stage. She finally begged the nurse to just examine the position of the baby, and the nurse reluctantly assented. Shocked to see the baby's head fully crowned, the nurse asked Aster to 'try to bring up the baby.' The nurse said that she needed the doctor present to do an episiotomy, or cutting and opening of the vaginal canal, but Aster said that it was impossible to wait and 'bring up the baby.' Her son was born a moment later, and Aster lamented that in the chaos of his unexpected arrival, the nurse ran out to get assistance, leaving Aster and her baby alone, uncovered. She explained hearing people crying, running up and down the stairs. The baby's breathing was stilted at first, but the nurses were unprepared and did not attend to him right away.

In relating this experience, Aster called it a 'trauma.' She said that the friend who had initially recommended the Tsehai Hospital had had a 'nice labour,' and had encouraged Aster in relating how well they cared for her. Given her friend's description of the comforts of the hospital, Aster had not expected the labour to be so traumatic. Aster said that she had arranged to travel to Mombasa shortly after the due date while pregnant, but had to cancel the trip given the long recovery from her painful delivery. Aster's mother reprimanded her daughter, saying 'what are you thinking, that labour is easy?' There was a clear disconnection between Aster's expectations of modern delivery and the reality of birthing's requisite physical exertion. Given the prestige of Tsehai, the order and cleanliness of the ward, Aster

was shocked by the chaos of her delivery and its mismanagement. During her pregnancy, Aster had monthly check-ups and all progressed normally, so she had little idea that the labour would progress with any issue.[334]

In digesting Aster's narrative, I was struck by the fact that her labour was actually entirely normal: she moved from the first to second stage very quickly, especially given that this was her first delivery, but that should not have been such a cause for concern. The attendant nurse was merely intent on following an ordered progression of medical interventions over the course of the labour, not recognising that such interventions were clearly unnecessary. The nurse wanted Aster to stop the baby's natural descent, a feat that is physically impossible for any labouring woman, only to perform a surgical cut that is meant to widen the vaginal opening and ease the baby's delivery. The fact that the nurse would ask Aster to stop the natural delivery of the baby in order to perform a medical intervention meant to assist his arrival is a troubling reminder of the over-medicalisation of maternity services in the mid-twentieth century. Clearly the baby was easing himself into the world without assistance, a fact that upset the nurse who wanted to restore the labour to the medicalised checklist she had been trained to perform.

Aster's first delivery was a normal, quick labour, but was unsuited to the mechanisation of hospital delivery at the time. I asked Aster if, looking back on the experience, she wished she had given birth at home, but she responded that if she had stayed at home, she would not even be talking to me right now: 'I would be underground. If I gave birth in the house, by now I might be in the ground.' To Aster, even with the trauma of the hospital delivery, home birth was still considered unduly dangerous and was equated with death. (Her concern is not unfounded; in times of crisis, unassisted deliveries too often end in mortality.) Even though in

[334] Author interview with Aster Yonatan, Addis Ababa, Woreda 1 (Bole Mikael), 16 April 2013.

Aster's case medical intervention impeded her delivery, she explained that 'the hospital was important,' and that she had succumbed to her family's pressured belief that in modern times, no one gave birth at home. There was a consensus among her relatives that she should give birth in the hospital for all three of her children, even after the harrowing experience with the first. Overall, despite her initial disappointment in the birth of her first child, Aster would not alter anything about the way she handled her pregnancies and births.[335] In her class, women went to the hospital without argument. Giving birth in the late 1960s, Aster was conforming to a pattern now entrenched among the wealthy classes of Ethiopia after nearly two decades of hospital expansion in the empire. This was modern Ethiopia, and there was no question that wealthy, professional families would fail to benefit from the prestige of new hospitals and highly trained physicians.

The influence of class on the hospital experience

Disappointment in modern health services was not limited to the wealthy, however: Haweni Ayalew explained how when she was admitted to Paulos Hospital for prolonged labour in the early 1970s, she was displeased that they discharged her after just one day. Paulos Hospital was established in Addis as a facility for the poor, with no user fees and large, corridor-style wards. The hospital was consistently overcrowded, and the staff explained to Haweni that they needed to free the beds for additional patients. Haweni was concerned that given her complicated delivery, a problem in the post-natal period may arise, but she would no longer be near requisite medical staff to treat the disorder.[336]

[335] Ibid.
[336] Author interview with Haweni Ayalew, Addis Ababa, Woreda 12 (Yeka), 28 April 2013.

Hareg Ghetu also explained to me her frustration with her treatment at the Gandhi Hospital after being admitted in a state of prolonged labour in 1970. Hareg was another poor patient who was sequestered in a crowded open ward with several other labouring women. The chaotic environment meant that Hareg was treated in a rushed manner: to assist the labour's progression, nursing staff performed an episiotomy on Hareg without localised anaesthesia. Like Haweni, Hareg was also discharged within twenty-four hours of her delivery, despite the considerable pain of her freshly sutured episiotomy. She was left with no advice to treat the wound, and it was infected shortly after she arrived at home. Hareg explained feeling the pain and discomfort of the wound for months after the delivery, and vowed never to return to a medical facility for labour care, even if another emergency should occur.[337]

The experiences of Haweni and Hareg are telling of the difference between the classed wards in Ethiopian hospitals. As with Aster, there was medical mismanagement in both Haweni and Hareg's deliveries, but in the former case, Aster's family was allowed to remain with her throughout both the labour and period of recovery in her private room. Hareg explained how her husband was not allowed into the Gandhi maternity ward, and she was alone with the medical staff for the duration of her stay at the hospital. Aster was at least given some degree of comfort in the aftermath of her traumatic birth, but for third-class patients like Haweni and Hareg, there was no gesture of psycho-social support extended by the over-worked medical staff. Emergency labour cases were treated in a rushed manner to compensate for the large number of patients and small number of beds.

While working as an obstetrician at Tsehai Hospital, Dr. Elisabeth Duncan said that she would frequently see third-class patients giving birth on tables in the

[337] Author interview with Hareg Ghetu, Addis Ababa, Woreda 7 (Addis Ketema), 8 May 2013.

corridor or on the floor of the ward's entrance hall. There was simply not enough space to accommodate the emergency cases arriving at the hospitals in Addis, and Dr. Duncan explained how the staff would be overrun by the demands of their patients.[338] Dr. Duncan also noted how rapidly the quality of hospital services declined in the years of imperial rule: considering both Haweni and Hareg gave birth after 1970, their poor experiences are a reflection not only of the class differences between wards, but also the lack of imperial investment in the upkeep of medical infrastructure.

Dr. Catherine Nicholson, another obstetrician who led the Tsehai maternity unit with her husband Reginald Hamlin for over a decade, explained in her memoir the considerable strain on hospital staff forced to juggle the various needs of patients in the numerous labour wards. Dr. Nicholson noted that there were stark differences in the expectations of patients in the first-, second-, and third-class wards: 'While the peasant women bore their illnesses with great stoicism, we found our private patients were more demanding. They all wanted to be looked after personally, so even if a woman was having a perfectly normal delivery she wanted Reg[inald Hamlin] or me to be there.'[339] Dr. Nicholson explains how first-class patients would often bring servants with them to the hospital, and were used to privileged treatment, both at home and in the institutional setting. At one point, the Ministry of Health actually levelled a complaint against Nicholson and Hamlin for 'neglecting these important patients,' to which Dr. Nicholson replied that there was never neglect, they were often merely attending 'a poor woman in far greater need than the private one.' [340]

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[338] Author interview with Dr. Elisabeth Duncan, Addis Ababa, 9 February 2013.
[339] C.N. Hamlin, and J. Little, *The Hospital by the River: A Story of Hope* (Oxford, 2008), p. 59.
[340] Hamlin and Little, *The Hospital by the River*, p. 60.

In the narratives of Haweni and Hareg, it is evident that even though they were classed as 'peasant women' in a third-tier labour ward, they were still expecting a high level of care within the modern medical institution. No doubt Dr. Nicholson saw many first-class patients who felt unduly entitled to constant medical supervision, but the 'stoicism' Dr. Nicholson mentions in relation to her third-class patients was likely an external coping mechanism adopted by women when faced with medical neglect. Haweni and Hareg were vivid in describing their dissatisfaction with modern maternity care at Paulos and Gandhi. But given that they could not afford to pay for preferential treatment, they had little voice in determining the care they received in the facilities. Both were angry at being discharged so soon after traumatic deliveries, but there was no chance that they could reverse the hospital's decisions regarding their care.

Class was a prominent feature in determining the care of labouring women in Ethiopia, not only in the ways in which it drove women to deliberately choose the hospital as a site of delivery, but also in influencing how women were treated within the hospital itself. While all patients of the hospital expected the best care available from such a modern institution, the capacity to complain and rectify medical ill-treatment was a right reserved for the wealthy. From Dr. Nicholson's description of the censure she herself received from the Ministry of Health, it is evident that hospital staff themselves were not callous about the treatment of third-class patients, but were instead forced to divide their attentions unevenly between the classed wards. The pragmatic demands of running a busy hospital with limited staff trumped any humane tendency of the medical staff to care for their patients in an equal manner. From the start, such equanimity was rendered impossible by the immediate division of patients into three separate wards based solely on their ability to pay the necessary fee.

Home birthing in Gondar town

The experiences of women in Gondar were more varied than those interviewed in Addis. While medical deliveries were largely the purview of the wealthy and emergency cases in the capital, Gondar was unique in Ethiopia for housing a fully-fledged community health service attached to the Public Health College and Training Centre. As part of their training, the community nurses were expected to conduct home visitations to pregnant and labouring women in Gondar town, and there were few women who did not come into contact with the college's extensive public health network. If there was anywhere in Ethiopia where the preventive health message of modern maternity care would be transferred to the home environment, it was Gondar. Here was a town filled with medical students eager to project the message of domestic modernisation to their fellow countrymen. Community nurses were in constant contact with women for the duration of their pregnancy and into the post-partum period, ensuring that there was ample opportunity for didactic instruction.

In Gondar, normal deliveries were always attended within the home, with only emergency cases transferred to the college's teaching hospital. In this way, the Gondar model conformed to customary expectations that normal births should remain within the home setting. There was a key difference, of course, in that the attendants at home births in Gondar were often trained medical staff, not the traditional lay assistants. In interviewing women in Gondar town, I was struck by how ubiquitous the college-run health service was among all social classes. Each of the thirty women interviewed remembered the community nurses, either as a patient themselves or as attending a neighbour. Women became patients almost by

accident, few deliberately sought out the medical services offered, but no one outright refused the nurses' entry to their homes.

Solyana Tesfalem delivered her first child at home in the early 1950s because the labour was easy and fast, and besides 'it was considered normal at the time to deliver at home rather than going to the hospital.' When she was pregnant with her second child several years later, student nurses arrived at her house as part of their community rounds, and began regular visits for ante-natal care. At the time of delivery, a trained midwife arrived with a community nurse, performing an episiotomy within the home and returning everyday for a week after to ensure Solyana was properly healed and her baby was healthy. This difference in birth experiences over a span of a few years speaks to the rapid increase of medical services in Gondar town with the establishment of the college: Solyana went from stating the 'normal' nature of giving birth at home, to receiving the assistance of medical assistance from the college. Solyana said that she was in pain because of the episiotomy, but otherwise there were no other problems. She was happy with the care offered, speaking highly of the nurses and the great respect they showed her over the course of their treatment.[341]

Variations on Solyana's experience were repeated several times in my interviews with women in Gondar: while most women did not actively seek out modern medical services, by virtue of the well-established network of college students and staff in the community, it was easy to be co-opted into the modern maternity care on offer. And because the Gondar system emphasised home-based care, women explained that there was no need to search for assistance in labour— nurses would come directly to them. Neghist Gezahegn described how in her third delivery in the early 1960s, a midwife and community nurse were called to her home because the

[341] Author interview with Solyana Tesfalem, Gondar, Kebele 3 (Medhane Alem), 10 April 2013.

labour was prolonged. She had never had ante-natal care, and had no other contact with the health-workers apart from this emergency intervention. Their swift arrival at her delivery speaks to the extensive nature of the college's community services.[342]

While in Gondar, I also interviewed Ato Melke Tesfa, a health officer who was first hired at the college as a driver before entering as a student. Melke explained that while working as a driver, nearly all his duties related to community midwifery. He would be called at all hours of the day and night to drive a nurse and supervising midwife to the homes of women around Gondar town to attend deliveries. The work was arduous and unceasing: Melke said he would only be able to manage a few hours of sleep in the car during the day.[343]

Seeking psycho-social support

While it was exceptionally common for women in Gondar to be assisted by college staff and students during both pregnancy and delivery, especially if they gave birth in the late 1950s and 1960s, I did not find any evidence that the repeated contact and ubiquity of the medical personnel had any long-term or lasting impact on the lifestyle of the women treated. Given the extensive network of Gondar's public health programme, I was persistent in my interviews in searching for some recollection of the public health instruction of the nurses. And while everyone who had been treated by Gondar staff were effusive in their praise of the nurses' respect, knowledge, and careful treatment, no one mentioned altering their practices of child-rearing or home management after receiving regular ante-natal and post-natal instruction.

[342] Author interview with Neghist Gezahegn, Gondar, Kebele 14 (Adebabai Yesus), 8 April 2013.
[343] Author interview with Ato Melke Tesfa, Gondar, 11 April 2013.

There were just two women I interviewed who chose to give birth with Gondar staff, contacting the community nurses during pregnancy and both delivering within the hospital. The stories of these women help explain the problematic expectation that modern maternity services would pave the way for a full domestic re-orientation.

When Selam Abraham became pregnant in the 1960s, the choice to contact the nurses was obvious, as she had challenging pregnancies and frequently fell ill during the nine months' gestation. Her pattern of complicated pregnancies was not the only reason Selam forewent the custom of home birth, however: Selam stated that because of her impoverished status, she qualified for free hospital care. She explained that if she had stayed at home and given birth with the assistance of her neighbours, she would have had to 'negotiate' a fee for the birth attendants, likely an 'in-kind' contribution of food or drink. Given her meagre household income and limited resources, this was an uncomfortable prospect for Selam. The hospital was therefore a welcome alternative, even though in contrast to her pregnancies, Selam's actual labours progressed with little complication.

Selam remembered how carefully the nurses took care of her in the hospital, and mentioned the new clothes they gave both her and the baby before she was discharged.[344] Selam worked her whole life as a casual labourer, and was still living in a state of material poverty when I interviewed her. Her interactions with modern medical staff were a welcome relief from her challenging circumstances, but were not sufficient to overcome the reality of her meagre income. Livelihood restrictions could not be changed by mere public health instruction, and while Selam benefited greatly from the dedicated care of Gondar nursing staff, given the practical restrictions of her limited income, she was not able to alter her lifestyle as prescribed

[344] Author interview with Selam Abraham, Gondar, Kebele 4 (Gabriel Akebabi), 9 April 2013.

by the idealistic policy constructs within the Gondar model of preventive maternal health. She was not able to improve sanitation and water provision within her home, or radically alter her food intake to incorporate more diverse nutrients.

In examining the case of Selam, another element in the use of modern maternity services in Ethiopia arose: the clinic became a de facto refuge for women who were not comfortable with the community model of home birthing. This discomfort was commonly rooted in issues of socio-economic status. The other woman I interviewed who deliberately sought out the care of Gondar staff was Nardos Girma. Nardos went to the hospital to deliver both of her children because, as she explained, 'I am poor, so I preferred to have support from the facility because there was no one at the time giving me support.'

Nardos was orphaned at a young age in a village in Begimdir province, and came to Gondar as a teenager, looking for work. Nardos found employment as a house girl in the mid-1960s, and became pregnant soon after from a man in the home where she worked. She had no support network to assist her in the pregnancy or delivery, and turned in desperation to the hospital care. When asked if she was happy with the services offered her at the hospital, Nardos answered by saying that yes, the hospital was comfortable. She qualified this statement, however, in repeating that because she was poor, she had no one else to care for her.[345] Nardos was clearly grateful for the assistance of the Gondar facility, especially when they waived her delivery fee because she arrived at the hospital alone without relatives. Still, she was careful to mention that she was only content with the hospital's care because it was the only alternative available to her.

I interviewed Nardos in her small, makeshift room on the outskirts of Gondar town. She spoke in a low voice and the interview was shorter than others. I could tell

[345] Author interview with Nardos Girma, Gondar, Kebele 4 (Gabriel Akebabi), 9 April 2013.

Nardos was reluctant to tell her story, and repeated several times that the circumstances were largely outside her control. She had little choice in where she gave birth, and it was evident that she would have preferred the more traditional, supportive environment of a home at the time of her pregnancies. This was simply not an option for her.

In my interview with Hirut Gebrekristos, she was forthright in delineating the pattern of birth choices in Gondar at the time: if a woman had no relatives, she would go straight to the facility at the onset of delivery to get necessary support. If the woman had relatives, it was best to stay at home and wait for a complication to arise. The relatives would be there to support the woman, and call the facility if an ambulance was needed. Hirut herself had given birth to her children at home with a large support network of family and neighbours. She related this pattern of birth choices to explain why she had not sought out medical care: she was sufficiently supported at home, and was certain that if a complication had arisen in her delivery, her family could have easily called for medical staff.[346]

Hirut's declarative attitude demonstrated how at the time, modern medicine in Gondar was widely considered a welcome centre of support for women in need. This need could be physiological, in the case of obstetric distress, but also social. As a large town surrounded by hundreds of smaller settlements, Gondar attracted many single women who took employment as domestic servants or as sellers of *tej*, a sweet honey wine. For these women, the hospital provided a support network unavailable at home.

There were other women, however, who even if on the fringes of society, were determined to return to a supportive community at the time of delivery. Lidet Tilahun explained how she escaped a forced marriage in her village when she was a

[346] Author interview with Hirut Gebrekristos, Gondar, Kebele 3 (Medhane Alem), 10 April 2013.

young teenager, fleeing to Gondar in the late 1960s where she soon found employment in a *tej* house. Pregnant within the year, Lidet returned to her home village to be cared for by her mother. Lidet knew of the community nurses working in Gondar town and their connection to the hospital, but she said she preferred the care of her mother. Lidet said that it was difficult to have a baby outside marriage, and the neighbours in Gondar openly criticised and ostracised her.[347] While Nardos had faced a similar situation and found an outlet in the hospital's care, Lidet's mother was still living, and even though she admitted it was challenging to return to her home, she was more comfortable facing criticism from her own family than the potential prejudice of strange health workers at the hospital.

Lessons learned

The interviews in Gondar opened new fields of enquiry to me, including the critical importance of supportive care at the time of delivery. While I had anticipated hearing descriptions of mothercraft lessons and preventive health instruction, it was obvious that the varied circumstances of women's lives overwhelmed the tidy policy prescriptions of the state. Officials relied on the interactions with modern medical staff to alter women's patterns of living, but the influence of existing customs, combined with community pressure and livelihood restrictions resulted in much more varied trajectories of maternity patients.

Meron Tessema's narrative is indicative of the common experience of women in Gondar town who returned to community birthing practices even after steady contact with college midwifery personnel. Meron's first delivery in 1960 was transferred to the hospital because the labour was prolonged. Meron was highly

[347] Author interview with Lidet Tilahun, Gondar, Kebele 4 (Gabriel Akebabi), 8 April 2013.

complimentary of the care both she and her baby received in hospital. The facility was clean, the staff knowledgeable and helpful, but for the five deliveries which followed her first, Meron stayed at home, attended by her mother. The nurses had visited Meron early into her first pregnancy, and she had attended ante-natal care with them. For the remaining pregnancies, however, she did not even seek out ante-natal care: she asserted that she was healthy, there were no problems, and no reason to see the nurses during this time. As for the delivery, she explained that she had paid just fifty cents to deliver the first baby at the hospital, so cost 'wasn't an issue.' The care was extensive, with a free ambulance picking her up from her home, and medications for newborns with no fee. But, Meron explained, she had no complications in pregnancy or delivery after the first baby. Her children were all healthy, and she had complete confidence in the capacity of her mother and neighbours in assisting normal deliveries. Meron admitted that her attendants at home did not have 'full knowledge,' but their care was sufficient to deal with the normal progression of labour. The attendants supported Meron from behind as she squatted on her knees during the labour, received the baby, and cut the cord. Meron stated that such support required hardly any skill, but what skill was needed given her complication-free deliveries?

Meron explained that health facilities were important in dealing with complications, and she was pleased she had delivered her first baby at the hospital in town. But she was afraid that arriving at a health facility or calling the community nurses before a complication arose would in itself cause the labour to be prolonged. Meron only wanted to deliver in front of women, and was wary of the male medical staff she had seen at the hospital. The stress of the clinical environment would only impede her labour's progression, and she preferred the comfort of her home, where

her neighbours could make coffee and food and she was surrounded by close, female friends and relatives.[348]

Yodit Belestie further explained that she attended the hospital for her deliveries simply because 'if you are in the hospital and a complication arises, it's easy to handle.' Yodit mentioned several potential complications: high blood pressure, low iron levels, obstructed labour, all of which require hospital assistance. Yodit had learned these things from her own experience delivering in the hospital between 1958-1970. Her knowledge of obstetrics was considerable, and she recalled in detail her own six hospital deliveries, each with varied complications from malpresentation to mild haemorrhaging.[349]

When asked if she remembered any additional instruction taught by the nurses regarding child-rearing, food preparation, or water sanitation, Yodit only continued to discuss the physiology of obstetric complications. Yodit's interactions with medical staff were lengthy and highly instructive, but only insofar as they related to her own initial expectations of modern hospital care. For Yodit, there was little relation between public health measures and medicalised delivery care. She accessed the Gondar medical staff for their extensive knowledge of obstetrics, not lifestyle reformation.

Giving birth on the periphery in Jinka

The final location of my interviews was Jinka, a small town in the Southern Omo Valley, on the periphery of Haile Selassie's empire. Jinka was founded around 1957 as an administrative outpost of the expanding Ethiopian empire. Amhara officials

[348] Author interview with Meron Tessema, Gondar, Kebele 3 (Medhane Alem), 10 April 2013.
[349] Author interview with Yodit Belestie, Gondar, Kebele 14 (Adebabai Yesus), 8 April 2013.

moved to the region to extend control over the numerous ethnic groups resident in the Omo Valley. A health centre was built in Jinka in 1962, staffed by Gondar graduates, while the Norwegian Lutheran Mission also had a significant presence in the region with clinics, schools, and a hospital. I interviewed women in Jinka from both the Amhara and local Ari ethnic groups, hoping to explore the participation of 'peripheral' women within the state's medical project. This was also a way for me to interview patients of a Gondar health centre far from the college grounds. I had seen first-hand in Gondar town what the college's model of community health could look like in its ideal form, but was curious if the pattern of embedded community nurses was actually transplanted into a remote health centre.

In Addis Ababa, the importance of class in dictating birth choices was obvious, while in Gondar, the need for psycho-social support at the time of delivery was a prominent theme. In both locations, the underlying conception of modern medicine as a necessary outlet for obstetric cures was evident. While meeting with women in Jinka, further dimensions on the restricted access to modern medicine arose in my interviews. In comparison to Addis and Gondar, the women in Jinka had few opportunities to visit the clinic. Throughout the 1960s, the population of Jinka hovered around 3,000 people, and the majority of women I interviewed lived in remote communities, up to several days' journey from either Jinka or Arba Minch, a larger town 100 kilometres to the northeast. Given the remoteness of the clinic, there were few choices regarding birthing care. One woman explained that she lived several days' walk from a *ferenji*-run clinic in Gofa, and that she would try to go to the clinic for treatment if her children were ill. Otherwise, she never saw a health worker, especially during her deliveries, given their sudden and unpredictable arrival. She and her neighbours would attend the facility only if transport was

readily available, which was 'very rare.' Instead, the community cared for the sick amongst themselves, within the home.[350]

Meklit Abebe's experience was typical for women in the country surrounding Jinka. Meklit's first birth was in 1970 at age 25, but she explained that there was simply no possibility to see a doctor during the pregnancy or delivery, so she gave birth at home with the help of her neighbours. Meklit said that they assisted her 'by the help of God.' When asked what her neighbours did to assist her in the delivery, Meklit explained that they gave 'only care:' making food, washing her clothes. Her birth was prolonged, stretching to four days, and Meklit said the pain was excruciating. She was not entirely confident in the way her mother and neighbours assisted her, grateful for the porridge they prepared, and the social support of their prayers and well-wishes, but Meklit understood that this was all they were expected to do for her. She explained that given the remoteness of the clinic, Meklit could see no 'educated person,' and that she was only able to get better 'with the help of God.'[351]

Meklit's description of the birth conforms with customs at the time, where attendants provided care to the parturient, but largely left the course of the labour to progress naturally without intervention. Meklit was largely undisturbed by these circumstances, accepting that this was how it was to give birth in the countryside at the time.

[350] Author interview with Broukinet Mesfin, Jinka, 14 May 2013.
[351] Author interview with Meklit Abebe, Jinka, 14 May 2013.

The benefits of home care

Some women were more effusive in praising the care they received at home, and were clearly uninterested in seeking any alternative medical solution to the management of labour. I first introduced the experience of Helina Petros at the start of this thesis. Helina gave birth for the first time around 1960 in the Hamer region. Her husband was a police officer, and while ethnically Amhara, her family was frequently shuttled around the southern region of Ethiopia to help administer state police services. Helina explained that in some postings, there would be a state-run clinic for police officers and their families, manned by an auxiliary dresser. At the time of her first delivery, however, Helina and her husband were alone with no access to a health centre. Helina delivered twins, but one of the babies died shortly after birth. She haemorrhaged during the third stage of labour, and described the delivery as 'very difficult.' Helina had felt pain for weeks leading up to the delivery, so knew labour was imminent. Even so, given the remoteness of their home, there was little point to travel to the dresser-run clinic. Helina said that while the clinics were useful for minor illnesses, the dresser knew little about assisting in childbirth.

Instead, Helina relied fully on the care of her husband. New to the area, there were no neighbours Helina trusted to assist her, but she said she was happy anyway being cared for by the loving partner she described as 'not just my husband, but my brother.' Helina's husband did all the household work in the last weeks of her pregnancy, prepared a birthing spot within the home, washed all of her clothes, and fed her the customary porridge after the delivery. Helina described how during the long and difficult labour, her husband held her, saying repeatedly the Amharic word for comfort, *ayzosh, ayzosh*. Her husband did not cower from touching her or her clothes, even though they became covered in blood from the post-partum

haemorrhaging. This was exceptional, given the widespread taboo against touching women's blood during menstruation and labour.

For her remaining nine deliveries, the last occurring in 1978, even once Helina had moved to other areas closer to health clinics and near relatives, she continued to rely solely on her husband's care. He proved to be a remarkable birth companion, providing both physical and psycho-social support for Helina throughout her difficult labours. Even if other options were later available, Helina felt that medical staff would not be able to provide anything further than what her husband offered. The clinics were merely remote out-postings: another woman interviewed even said that they were staffed 'only by nurses, not educated people.'[352] There was little confidence in the ability of peripheral auxiliaries, especially in times of labour and delivery, where supportive care was considered the most critical asset to the parturient.[353]

Kenene Tilahun was actually living in Jinka when she gave birth to her last child in 1965. She had already had several children in the country, and even though she now lived less than one kilometre from the health centre, she said she continued to rely on her neighbours for assistance in delivery. Kenene was frank in stating that the neighbour was 'more experienced even than the doctors and the nurses:' she could palpate the abdomen and tell the position of the baby, predicting accurately when she would give birth. For her first births, she delivered at home out of default, because there were 'no educated persons around.' But having successfully delivered without the assistance of medical staff, Kenene saw no point in going to the health centre in Jinka for her final delivery. She was able to stay home for forty days after the birth, cared for by her relatives who brought food and coffee, washing her

[352] Author interview with Hirut Binyam, Jinka, 15 May 2013.
[353] Author interview with Helina Petros, Jinka, 15 May 2013.

clothes and taking care of her other children. Kenene spoke with great confidence in the care she received, and did not regret the lack of medical support.[354]

Remote health services

While home births were the norm in Jinka and the surrounding areas, there were occasions when the lack of medical assistance was problematic. Kiddist Assefa related her experience of birthing five children in the village of Senegal in the 1970s, a four-hour walk from Jinka. Kiddist explained that while she had no complications in delivering her children, there were problems afterwards, especially in caring for sick infants. Food was always in short supply, especially once Kiddist's husband died after the birth of her fifth child. The child was born with several health problems - Kiddist was not able to name the illnesses, only stating that he was constantly unwell. She tried the community remedy to feed the infant butter, but he did not get better. Kiddist said that her other children had all recovered from their illnesses after being treated with butter, but the last baby was only worsening. She decided to put the infant on her back and walked to Jinka to seek treatment at the health centre. With her husband now deceased and no family in the immediate vicinity, Kiddist had to bring her two youngest children with her to Jinka in addition to the baby. It was an arduous journey - already a four hour walk, notwithstanding carrying two small children and one infant. The baby was cured from the medication given at the Jinka health centre, but Kiddist described the situation as a string of hardships. The effort to ensure her children remained fit and healthy was immense given her distance from health facilities.[355]

[354] Author interview with Kenene Tilahun, Jinka, 15 May 2013.
[355] Author interview with Kiddist Assefa, Jinka, 14 May 2013.

Milet Mersha also explained her frustration with the care she received at home in Jinka town during her third delivery in 1965. Milet's first births occurred without complication, but during the third delivery of twins, the second baby was obstructed and would not be delivered. Milet complained to me that her neighbours gave her no help - they knew nothing, and the problem was 'beyond the scope' of an experienced birth attendant called in by her family. Milet said that she left the home of her own will and went to the health centre in town to deliver the second twin. She had no encouragement, as everyone said they should help her within the home. Milet was frustrated by the experience, claiming that 'no one supported her,' and it was her own initiative to seek out emergency medical assistance.[356]

Ethnic divisions

Women who expressed dissatisfaction with the home delivery customs in Jinka were not limited to those with untreatable complications and illnesses. As in Addis Ababa, ethnicity and class were prominent factors in determining a woman's choices regarding healthcare. Considering Jinka was a modern town, founded only in the late 1950s as an administrative seat of the empire, there was a large influx of northern Amhara stationed in the town along with their wives and families. Pat Turton, an anthropologist and nurse who lived in the South Omo Valley in the early 1970s, made detailed observations of Jinka's health centre, noting that the majority of female patients were middle-class Amhara, wives of civil servants stationed in town.[357] In an assessment of health centre activities in rural Ethiopia, Simon Messing

[356] Author interview with Milet Mersha, Jinka, 14 May 2013.
[357] Author interview with Dr. Pat Turton, Oxford, UK, 3 March 2012.

noted similarly that in peripheral areas, it was most often 'young salaried officials [who] are the vanguard of modern health attitudes' in Ethiopian communities.[358]

Franz Perabo, a WHO official who visited Gondar-run health centres in Ethiopia in 1972, wrote that after observing numerous 'Well-Baby Clinics,' he was disappointed to see that it was 'largely wives of salaried employees, clerks, or white-collar workers' who came to the clinic to receive public health instruction.[359] Perabo lamented that these were not the target audience for the clinics, but admitted that the poverty of the majority of rural Ethiopians was a prohibitive factor to their attendance at public health ventures. Perabo wrote that 'the less fortunate have in their daily struggle for existence no comprehension of the meaning of a Well-Baby Clinic. It has to be accepted that for a long time to come, maternal and child health sessions in rural areas will essentially be sessions for sick children and pregnant mothers.' Perabo asserted that such preventive health clinics would only 'get a foothold' when 'a certain standard of living and education has been reached.'[360]

While conducting my interviews in Jinka, I came across one woman who had chosen to give birth in the hospital in Arba Minch in 1965. She travelled to town at the end of her pregnancy, awaiting the start of her labour. When the children were older after the transition to the Derg regime in the late 1970s, she also took them to be vaccinated, and for regular check-ups at the health centre in Jinka.[361] After the woman explained her pattern of behaviour in searching out modern medical care for herself and her children, my research assistant, Dagne, intervened, explaining to me that the woman's husband was highly educated, so the decision to bring the woman

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[358] S.D. Messing, J.S. Prince, and Y. Tseghe, 'Baseline Health Culture Research in Ethiopia', *Journal of Health (Gondar),* vol. 5, no. 1 (April 1965), p. 11.

[359] WHO Archive, F. Perabo, *EM/MCH/90 Assignment Report: Maternal and Child Health Services 1 November 1971-28 January 1972* (Geneva, 1972), p. 5.

[360] Perabo, *Assignment Report,* p. 6.

[361] Author interview with Alpha Mesfin, Jinka, 15 May 2013.

to Arba Minch was made by him. Dagne was a lifelong resident of Jinka and knew the woman and her family. He was careful to annotate the interviews with his own knowledge of the women's circumstances. Jinka is a small town, where people's personal histories are well-known. Dagne was intent on explaining to me who in town was educated and thus prone to seek medical services, versus those poorer women who were restricted to care within the home. All of the women who remained outside the network of medical services were ethnically Ari. A handful were also Amhara, but every Amhara woman we spoke with had at some point come into contact with a health centre, either in Jinka or within the wider missionary network. This was a critical distinction, and signifies the rooted nature of not only class, but also ethnicity, in determining a woman's access to Haile Selassie's modernisation campaigns.

Summarising the narratives

After reviewing the experiences of women and childbirth described above, several interwoven themes emerge. Degrees of risk perception regarding the requisite level of care at the time of delivery connected with issues of trust of varying birthing assistants available. Within town environments, class and ethnicity compounded with familial pressures to help determine women's choices of birth practices, whereas in more remote areas, women were left with few options regarding obstetric care. Given the urban-bias of medical services, women in the country gave birth within the home because this was simply the only option available. Choosing between systems of maternity care was a luxury reserved for women in more urban areas, but even in cases of geographical proximity to a health

facility, communities did not automatically replace indigenous customs with modern practices.

State policies painted a tidy image of the modern medical facility and its ideal patient: surrounding communities would immediately value the modernity of the medical practice and conform to the lifestyle prescriptions of the educated staff. Such idealism was thwarted by the varied lived experiences of women and their families. Existing beliefs regarding health, risk, and disease combined with practical questions of transport and livelihood to shape the birthing practices of individual women. There was no universal pattern or upheaval in birthing practices with the introduction of modern medical alternatives. Instead, decisions were made based on the highly variable circumstances at hand. The choices laid before a wealthy, upper-class resident of Addis Ababa differed considerably from those of a rural tenant farmer. While the influence of class and geography on access to health services may seem obvious, state policies at the time ignored this pressing reality, confident that the attraction of modern medicine would trump any inconvenient social distinctions and class rankings it encountered.

'We just give birth.'

At the time, women's reactions to the inadequate state policies were largely divided into two camps: for the majority of women, they saw no problem with the birthing practices as they existed. At the same time, a second, smaller camp were dissatisfied with home birth traditions, a dissatisfaction often rooted in a negative experience with obstetric complications. In the former group, women understood that there may be a degree of risk associated with childbirth, but for the most part, did not believe that the potential dangers of pregnancy and delivery were beyond

the scope of home treatment. These women largely gave birth normally, without complication, and they believed that the act of giving birth was simply not risky enough to warrant modern medical care.

In Addis, Rahel Hailu explained that despite living less than a kilometre from Paulos hospital, she did not want to go there for maternity care when she was pregnant in the 1970s. Rahel said that yes, there were doctors, but she did not want them: 'Maryam will help us, so there's no need to go to the hospital.'[362] Nabayet Kebede explained that while she took her children later to a health centre in the Piazza neighbourhood of Addis when they were ill, it was not common to give birth outside the home in the early 1960s. Besides, 'we wanted to give birth at home, and the care was very good.'[363] In the northeast of Addis, Medhanit Binyam told me that 'we didn't worry about anything' at the time of delivery. The labour begins and 'we just give birth.' 'We don't care, we don't know' about medicalised modes of maternity care.[364] Sewit Henok said that she 'just slept and then gave birth.'[365] The ease with which dozens of women described the birthing process was telling, and stretched across the time span of my interviews, even into the late 1970s when medical services were more widespread. So often the women would respond to my questions with their own, a variation of one Addis resident's query: 'there are no complications, we give birth in a short time, so why should we go to health facilities?'[366]

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[362] Author interview with Rahel Hailu, Addis Ababa, Woreda 7 (Addis Ketema), 1 May 2013.
[363] Author interview with Nabayet Kebede, Addis Ababa, Woreda 7 (Addis Ketema), 1 May 2013.
[364] Author interview with Medhanit Binyam, Addis Ababa, Woreda 13 (Yeka), 28 April 2013.
[365] Author interview with Sewit Henok, Addis Ababa, Woreda 1 (Bole Mikael), 16 April 2013.
[366] Author interview with Lealem Giorgis, Addis Ababa, Woreda 13 (Yeka), 28 April 2013.

There was another element commonly repeated in these women's interviews—so often I was told that in former times, the population was much healthier than today. With the current ubiquity of public health campaigns warning the population about issues like the spread of HIV, the dangers of unassisted childbirth, and the importance of child immunisations, it is not difficult to see why women would believe that contemporary Ethiopia is riddled with health problems little discussed in the past. Yigebashal Haileselassie even blamed the lazy, urbanised lifestyle for the ill-health of current Ethiopia, stating that people now eat too much sugar, whereas before she and her family were farmers, working long days in the fields with a healthy, whole-grain diet. Yigebashal said that because of her hardy lifestyle, she was able to carry her pregnancies and deliver with no problems at all.[367]

Luwam Workneh lamented the abandonment of former health remedies, including the use of butter and fenugreek seeds for the baby in times of illness. She explained to me how they would grind the fenugreek into a powder, mix it with butter and feed this to the baby for the first five months. Luwam described other herbal remedies she used for her children, and said that they were essential for 'cleaning the insides' of a baby. Nowadays, everyone is 'too afraid' of infectious diseases like HIV. In former times, 'there were no diseases,' so we were confident in the remedies we had. Despite having had three late-term miscarriages, Luwam said she had no trouble with her other pregnancies and deliveries throughout the 1960s. 'I was a farmer, I was healthy, so I gave birth healthfully.'[368]

[367] Author interview with Yigebashal Haileselassie, Addis Ababa, Woreda 1 (Bole Mikael), 20 April 2013.
[368] Author interview with Luwam Workneh, Addis Ababa, Woreda 1 (Bole Mikael), 16 April 2013.

'They do nothing.'

Ethiopian women are hardly unique in expressing such casual attitudes towards birthing. In Kenya, Tabitha Kanogo has described how it was a challenge for the colonial state to convince women to give birth in hospital because of the 'prevailing belief that maternity is a natural condition that does not call for hospitalisation.'[369] For Ethiopian women, such permissiveness extended to the perceived role of the birth attendants themselves. In neighbouring countries, traditional birth attendants often occupied a distinct category of healer, and interventions throughout the labour were more common. Sudanese midwives would cut open the labouring woman's infibulated labia at the start of the delivery, and directed the woman in her standing posture as she bore down with the support of a rope hanging from the ceiling. The midwife would then re-infibulate the woman after the labour ended.[370] In Uganda, there is even evidence of caesarean sections being performed within the home to alleviate obstructed labours.[371]

In contrast to this inclination for midwives to intervene at the time of delivery, Ethiopian women expected birthing attendants to do nothing beyond catching the baby and cutting the umbilical cord. Spiritual interventions were invoked in times of distress, but otherwise, birth attendants in Ethiopia were expected to leave the parturient alone. When queried on the role of their home-birth assistants, several women said that they merely 'receive the child,' and 'nothing else.' Frehiwot Sebsbie said that her birth attendants were good given the circumstances at hand: 'they don't

[369] T.M. Kanogo, *African Womanhood in Colonial Kenya, 1900-50* (Oxford, 2005), p. 168.
[370] J. Boddy, 'Barbaric Custom and Colonial Science: Teaching the Female Body in the Anglo-Egyptian Sudan', *Social Analysis*, vol. 47, no. 2 (2003), pp. 60–81.
[371] D. Trolle, *The History of Caesarean Section* (Copenhagen, 1982).

do anything, they just pray, calling Maryam, Maryam, and so for the time, the care was good.'[372]

Muna Mehari explained to me that the traditional attendants do not even direct the parturient to push during the second stage, allowing the mother to follow the physiological cues of the labour's progression on her own. Muna said that she had given birth to one baby in hospital following a prolonged labour in 1969, and complained that the nurses were overbearing in directing the second stage. She preferred the hands-off approach of her neighbours at home.[373] In a separate interview, Meheret Bitew in Addis stated that it was the very fear of intervention at the hospital that kept her from going to the clinic at the time of her labours. She was afraid that at the hospital she would have to undergo a caesarean section or instrumental delivery, when she would prefer to let the baby come unassisted. Meheret gave birth in the 1970s, and explained that because all of her neighbours at that time went to receive ante-natal care at the clinic, she too attended the local health centre with each of her pregnancies. She said, however, that when the nurses would instruct her to go to the hospital at the time the labour began, she would nod and respond with the affirmative Amharic word *'ishi, ishi*,' all the while knowing that she would actually remain at home to deliver her child.[374]

It was evident that these women who chose to give birth at home even with other clinical options available had a high degree of confidence and trust in their neighbours and relatives as competent labour assistants. After giving birth in both the clinic and at home, Brukinet Belete explained to me the contrast of the care

[372] Author interview with Frehiwot Sebsbie, Gondar, Kebele 4 (Gabriel Akebabi), 9 April 2013.
[373] Author interview with Muna Mehari, Addis Ababa, Woreda 1 (Bole Mikael), 16 April 2013.
[374] Author interview with Meheret Bitew, Addis Ababa, Woreda 7 (Addis Ketema), 8 May 2013.

medical nurses gave to women as compared to the customary attendants: in the clinic, the nurse immediately weighed her baby, while at home, the baby would be given butter after delivery. Brukinet saw little point in placing the baby on the scale, and was troubled by the medical custom to forego giving butter to the infant. She was confident that butter was necessary to assist the baby's digestion, and felt that this difference in care demonstrated the superior understanding of traditional attendants over clinic staff.[375]

Levels of trust and scepticism of various degrees of carers would therefore determine a woman's choice of birth attendant at the time of delivery. Women were often uncertain that clinical staff would manage their births in a manner suitable to local predilections for non-intervention. When faced with uncomplicated labour, women had a higher level of trust in indigenous carers over medicalised staff, given the propensity of hospital births to end in some form of medicalised mediation in the physiological ordeal of birthing.

'Hakim yellem': frustration with customs of the home

While the prevailing attitude towards birth was permissive, a second, smaller group of women interviewed were very vocal about their dissatisfaction with the customs of home birth at the time. According to conventional medical wisdom, one in ten births will require some form of assistance to alleviate a complication for either the mother or newborn. Statistical probability dictates that some of the women I interviewed would have faced such a complication, and it was this group of women who fell into the opposite camp of those described in the section above: for these women, undergoing a complicated labour without access to medical assistance

[375] Author interview with Brukinet Belete, Addis Ababa, Woreda 1 (Bole Mikael), 16 April 2013.

was a source of frustration and anger. In contrast to the majority of women who had normal deliveries at home with traditional assistants, these respondents were largely dissatisfied with the traditional lack of intervention within home delivery care. Such expressions of frustration were especially prominent in my interviews in Jinka, and also among women in Addis Ababa who had lived earlier in more rural areas, giving birth far from medical facilities.

Many women contrasted the time of Haile Selassie with later regimes, stating that under the Derg, the number of facilities increased and maternity care improved. Mekdes Shiferaw explained that even though she lived in Addis, she was too poor to use the hospitals during Haile Selassie's time. Mekdes gave birth at home in the 1950s and 1960s because in her understanding, the hospitals were reserved for those who could pay. She was angry in relating the '*betam chiger*' - many problems - facing her and her poor neighbours. Her births were all prolonged, and Mekdes stated openly that 'rather than suffering, I wish I could go there [to the hospital], but I didn't have the money.'[376]

Meskerem Idriss explained that her first labour in 1960 was prolonged to an excruciating six day ordeal, and then the placenta was further retained for another three days after. In an exasperated tone, she told me there was no doctor (*'hakim yellem!'*), so her family just prayed to Maryam for assistance. They gave her herbal purgatives to help expel the placenta, but otherwise there was nothing to be done. Meskerem said that while they 'did nothing' for her, 'at the time, we were forced to do that.' Now, with more health facilities throughout the country, she felt the situation was much improved.[377]

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[376] Author interview with Mekdes Shiferaw, Addis Ababa, Woreda 1 (Bole Mikael), 16 April 2013.

[377] Author interview with Meskerem Idriss, Addis Ababa, Woreda 7 (Addis Ketema), 1 May 2013.

My most challenging interview was with Gelila Shimelis. Gelila had given birth to eight children entirely unassisted from between 1960-1980. Her husband was a casual labourer, traveling across the rural countryside looking for employment before eventually settling in Addis. This meant that Gelila was never able to give birth near her family, and the neighbours were usually only casual acquaintances, given the frequency of their relocations. She began crying as she related the pain of labouring on her own. Even though Gelila had had no complications during the deliveries themselves, she described the acuteness of her isolation. She felt forced into the circumstances of her reproduction: 'it was my loneliness— I don't have a mother, sisters, relatives, or close family.'[378]

In my interviews in Gondar, I was struck by the lengths to which women would go to secure psycho-social support at the time of delivery. Given Gelila's circumstances, it was not surprising that she was so emotional about her enforced isolation at the time of delivery. This was highly uncommon, and Gelila expressed clear disappointment at having missed the opportunity to be cared for in any manner at the time of her birth, either by traditional assistants or medical personnel.

Problems in child health

The isolation for women was problematic not only in relation to birthing care, but was brought up repeatedly in discussions of children's health. When discussing the lack of medical services for the treatment of childhood illnesses, a large number of women became acutely upset. Even among those women who had given birth without complication and felt confident in home delivery care, the lack of reliable treatments for their children was a subject of real contention.

[378] Author interview with Gelila Shimelis, Addis Ababa, Woreda 12 (Yeka), 24 April 2013.

Most respondents explained that they were forced to treat their children's ailments at home, meaning that many children died from infectious diseases untreatable with the herbal remedies practiced in Ethiopian communities. The women I interviewed were nearly all grand multipara— it was not uncommon for a woman to have borne between twelve and fourteen children. But after querying how many children the woman delivered, I was always forced to ask how many were still living. A handful of women had had no child deaths, but 140 respondents out of 150 had at least one child die before the age of five, the majority seeing around half of their children perish in their first years of life.

The ubiquity of child mortality did not lessen its tragedy: Liyou Yohannis became so animated in discussing her lack of medical resources for her children that she stood up and began pacing the room. She said over and over, '*hakim yellem,*' explaining that while she took all eleven of her children to the local healer in her village for treatment in the 1960s-70s, eight died from common infectious diseases. Liyou was angry, stating that the care of the community was not good: 'they don't have the skill, and they do nothing. They don't know anything.' She further lamented that there was a defeatist pessimism among the healers who just 'waited for her children's deaths.'[379]

Such experiences are troubling, and must be digested alongside the repeated assertions of women that the lack of intervention in manners of maternal and child health were suitable to the culture and custom of the time. The limitations of the state's health infrastructure were noted by women who could have benefitted from the supportive care and medical cures available in the clinic. There were incidents of birth complications and childhood diseases that could not be treated in the home. For the women who underwent such challenges, the absence of the clinic was acute.

[379] Author interview with Liyou Yohannis, Addis Ababa, Woreda 1 (Bole Mikael), 20 April 2013.

The anthropology of health choices in Haile Selassie's Ethiopia

At the time that my informants were giving birth, numerous anthropological studies were completed on the health behaviours and beliefs of highland Ethiopians. It is worth reviewing these studies, many of which corroborate and expand upon the narratives of women collected here. The field of medical anthropology was burgeoning in the 1960s, and several foreign anthropologists and physicians working in Ethiopia began studying the health practices of the Amhara and Oromo communities, assessing the ways in which Ethiopians practiced multiple, overlapping medical systems.

In 1967, E. Fuller Torrey, a US Peace Corps physician working in rural Ethiopia, described his interaction with a man suffering from pneumonia in the area of the Blue Nile Gorge. The man approached Torrey for treatment, knowing his expertise as a medical doctor, and was given a full round of antibiotics. The following day, the same man attended the home of a local woman known for her skill in herbal treatment. She gave him a poultice of herbs and roots to ingest. Finally, on the third day, the village elders conducted a ceremony for the man to assure his return to health. The ceremony involved passing a sheep over the man's body and having him kiss the tail, while also placing a chicken on the man's head to see which direction it would fly off. Happily, the chicken flew in a direction auspicious to a return of health. The man recovered from the illness, and when Torrey enquired what process had made him well, the response from community members was unanimous: '*everything* had made him well.'[380]

[380] E.F. Torrey, 'Health Services in Ethiopia', *The Milbank Memorial Fund Quarterly*, vol. 45, no. 3 (1 July 1967), pp. 278-9.

Torrey used this experience to illustrate the ways in which Ethiopian communities relied on overlapping systems of medical cure and social care in times of illness and crisis. The pneumonic man's three distinct treatments all accounted for separate aspects of the illness. Both the antibiotics and herb poultice were ingested, signifying the need to right a biological or bodily disorder. The last treatment, the village ceremony, was meant to control and harness forces outside the body. Using specified rituals to invoke unseen powers which determined the man's health in the future, this ceremony was necessary for both the patient and community to believe that the unpredictability and recurrence of illness would be prevented.

Because there was not a singular force behind the man's pneumonia, multiple causes for the illness had to be treated. It was this combination of treatments that effected a complete healing. Had the man relied solely on the antibiotics, herbs, or village ceremony, one feature of his disordered state which caused the pneumonia could linger and prevent recovery. This multiplicity of cures for a single disease signifies the rootedness of overlapping medical systems in Ethiopian society. The usefulness of modern medicine was not doubted, and indeed the pneumonic patient sought out Torrey's expertise deliberately. But the antibiotic was not sufficient to cure the man fully, and alternative cures were sought out in parallel to the physician's treatment.

Allan Young, a medical anthropologist working in mid-century Ethiopia, explained this overlapping conception of disease causation and cure as a way in which Ethiopian communities bridged traditional 'externalising' and 'internalising' medical systems. Per Young's definition, an externalising medical system relies on anthropomorphised, aetiological explanations for illness. Such explanations define toxic pathogens as individual agents and actors that deliberately target a person and cause the disease. In internalising systems, however, physiological examinations are

required, and diagnoses are made based on symptoms, not aetiology. In this instance, healers are tasked with restoring a physical equilibrium, as compared to appeasing the aetiological agent identified in an externalising model.[381] As Torrey's narrative above illustrates, both internal and external forces were targeted for treatment, exposing the ways in which customary medicine in Ethiopia relied on biological and supernatural conceptions of health and healing, both in the understanding of disease and in its prescribed treatment.

Categories of practitioner

The complex conception of disease necessitated a varied cosmology of trained practitioners capable of treating both internally- and externally-driven pathologies. In order to restore a physical equilibrium, pragmatic and secular healers were sought, including among the Amhara, bone-setters (*T'egagn*), uvula cutters (*anqar*), circumcisers (*geraz*), cuppers (*aggami*), and teeth-pullers (*T'irs awlaqi*).[382] In the removal or replacement of a specified body part, each of these practitioners manipulated the physiological causes of a disease as it worked through the patient's body. Uvula cutting and teeth pulling were exceptionally widespread practices in the hopes of curing intestinal diseases, a common ailment across Ethiopia. The removal of parts of the mouth and throat was thought to ease the process of mastication and digestion, therefore restoring proper intestinal processes. Cupping was the act of removing excess blood from the head by making incisions in the scalp, and using the concentrated pressure of small cups, the *aggami* would then 'suck'

[381] A. Young, 'Internalizing and Externalizing Medical Belief Systems: An Ethiopian Example', *Social Science & Medicine,* vol. 10, no. 3–4 (March 1976), pp. 147–156.
[382] A. Young, 'Medical Beliefs and Practices of Begemder Amhara' (Univ. of Pennsylvania Ph.D thesis, 1970), pp. 24-32.

blood from the incision point. This removal of bodily material was again meant to restore the balance within the patient's physiognomy, and was used to treat a number of illnesses.[383]

Aside from these specified medical tradesmen, general practitioners of secular medicine (*ogaissa* in the Oromo and *wogesha* in the Amhara) were the most commonly consulted healers within Ethiopian communities.[384] Because of their wide range of knowledge in diagnosis and manipulative treatment, patients would seek the expertise of *ogaissa/wogesha* for the multitude of physical ailments common in Ethiopian communities, including venereal diseases, eye infections, and gastrointestinal complaints. These practitioners often performed simple surgeries - in the case of eye infections, small slits would be placed in the skin on either side of the eyes to promote the removal of excess, toxic fluids. The trade of *ogaissa/wogesha* would often be passed from father to son, and practitioners were famously secretive about their training methods in order to protect both the mystique of their practice, and also their own livelihood as trusted community healers.

Beyond secular healers, the *debtara* in Amhara tradition were common practitioners of spiritual healing and sorcery. Initially trained as a cleric, a *debtara* was a literate healer who utilised a combination of religious practice with herbal treatment. In addition to these priestly diviners, there were multiple categories of metaphysical healers across Ethiopia, including *galu*, *meshaf gelach*, *Zar doctor*, and *tangway*.[385]

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[383] R. Pankhurst, 'An Historical Examination of Traditional Ethiopian Medicine and Surgery', *Ethiopian Medical Journal*, vol. 3, no. 4 (1965), pp. 151–76.
[384] S.D. Messing, 'The Highland-Plateau Amhara of Ethiopia' (Univ. of Pennsylvania Ph.D thesis, 1957), p. 580.
[385] L.J. Slikkerveer, 'Rural Health Development in Ethiopia: Problems of Utilization of Traditional Healers', *Social Science & Medicine*, vol. 16 (1982), pp. 1868-1869.

For each of these practitioners, their focus remained on the unseen, externalising agents that caused physiological disorder among patients. At this time, serious illnesses were remarkably common in Ethiopia, and while some persons could live long after the onset of disease, deaths of others were both commonplace and sudden. This seeming randomness and selectivity of disease and death was explained by communities as evidence of such metaphysical agents at work. Belief in the evil eye, *buda*, or *tôlca* (Oromo), is nearly universal in Ethiopia, a form of kharmic retribution on persons for both positive and negative personality features and behaviours. Spirits, both *Zar* and *ayana* (Oromo), were also commonly invoked and blamed for both fortune and misfortune, including disease. Women were most prone to act out spirit possession in order to control the forces of *Zar* in Ethiopia, similar to neighbouring practices in Sudan and Somalia. By entering this world of unseen agents, women typically used *Zar* ritual to escape their somewhat restrictive domestic spheres, engaging with higher forces and determining a fate for themselves beyond what had been prescribed by marriage and motherhood.[386]

Metaphysical causations of disorders in the mother and child

Because women more frequently accessed external spirits and agents in this deterministic manner, their susceptibility to spirit-driven misfortune was also believed to be heightened. At the time of pregnancy and birth, women were deemed especially prone to attack by such metaphysical forces, and specific precautions were taken in order to prevent impending calamity for both the mother and child. Among

[386] There is some disagreement among current anthropologists whether this deterministic reading of Zar possession in mid-century sources is accurate. For further reading, see the following: A. Young, 'Why Amhara Get Kureynya: Sickness and Possession in an Ethiopian Zar Cult', *American Ethnologist,* vol. 2, no. 3 (1975), pp. 567–584; W. Leslau, 'An Ethiopian Argot of People Possessed by a Spirit', *Africa: Journal of the International African Institute,* vol. 3, no. 19 (1 July 1949), pp. 204–212.

the Oromo, it was seen as dangerous to wake a sleeping pregnant woman, disturbing her unconscious journey to the unseen world. Giving birth to the first and often second child at the home of the woman's parents was also a fundamental necessity: if the birth occurred in the wrong location, a *tôlca* would enter that place and the child would die, or the woman would be made forever after infertile.[387] For both the Oromo and Amhara, pregnant women were not meant to be seen alone, nor should their swollen bellies be highly visible to wandering spirits. Women would therefore mask their pregnancy by wrapping their bellies with a long piece of cotton fabric (*nägärat*) as a protection from the gaze of the evil eye.[388]

The danger of these forces was very real for Ethiopian communities familiar with high rates of death, especially among mothers and infants. One woman I interviewed from the north of Gondar, Zewditu Tesfa, explained that while she had given birth to ten children, four died soon after birth after being struck by the evil eye. Zewditu had commonly assisted births in her community, and explained to me the precautions she took both in her own births and those she attended as lay midwife. For Zewditu, the last month of pregnancy was critical in assessing the survival rate of both mother and child. Palpating the abdomen, Zewditu would determine the position of the baby in utero. She explained that if the baby's body did not lay vertical with the head down, there would be danger and the mother should seek medical assistance. Living not far from a German mission clinic, Zewditu sent two of her own daughters to the mission doctors for deliveries after determining the positions of their babies were inauspicious.

The physicality of birth and the biological origins of delivery crises were readily acknowledged by Zewditu, and she was forthwith in diagnosing disorders in

[387] L. Bartels, 'Birth Customs and Birth Songs of the Macha Galla', *Ethnology*, vol. 8, no. 4 (1 October 1969), pp. 406–422.
[388] Messing, 'The highland-plateau Amhara of Ethiopia', p. 428.

maternity of both bodily and spiritual origin. For her own children that died, she had taken each infant to the German clinic at the onset of distressing symptoms. The children each had varied physical manifestations of disorder: poor suckling, wasting, diarrhoea, and elevated temperature. Given that Zewditu had sought out physiological cures from the attendant doctors, after each child's eventual death, her only explanation for the outcome was that the evil eye had been inexorably fixed on the infants from birth. Biomedical cures were insufficient to save the children, and while Zewditu did not describe any other metaphysical remedies sought from local practitioners, she felt resigned to the fact that their fates had been written by unseen forces outside her own control. Zewditu had tried what biological cures were available, but the fickle nature of life and death ultimately took her children from her.

When asked her impression of the foreign physicians who had failed to save her children's lives, Zewditu animatedly proclaimed that 'they cared for us like a mother,' explaining that she had 'never seen such a level of care.' When the Derg regime removed medical missionaries from the country, including the Germans who ran the clinic in Zewditu's town, she described the community's anger at their removal. These medical practitioners were renowned and appreciated for their specified expertise in providing biological cures. For Zewditu, it was not within their capacity to save her children suffering the throes of the fated evil eye. Their skills were better served in situations of physiological distress, including malpresentation at the time of birth.[389]

A variety of practitioners were acknowledged for the spheres in which they were most relevant. Communities approached multiple healers in order to confront the multiple causes of illness and distress. In the case of Torrey's pneumonic patient, the

[389] Author interview with Zewditu Tesfa, Addis Ababa, Woreda 1 (Bole Mikael), 16 April 2013.

overlapping treatments were successful in routing out the disease, whereas for Zewditu, there was not sufficient treatment to combat the true cause of her children's illness, and they therefore succumbed to death.

'Interdigitation' and the physicality of spiritual healing

In one study of spiritual healers in Ethiopia from the 1960s, Wolde Tinsaye Gezaw, an Orthodox priest believed to have for having cured one million people in just 14 years, was interviewed regarding this multiplicity of healers and treatments operational in modern Ethiopia, and how patients chose which practitioner to attend. When asked, 'should the sick go to a priest instead of a doctor,' Wolde explained that 'it depends upon the type of disease. If it is due to the devil, the patient goes to the priest and holy water. For any other type of disease, the church advises the people to go to the doctor.'[390]

The patients at Wolde's practice had often arrived at his healing compound after seeking care first at a medical clinic. Wolde found no conflict in this plurality of treatment, because of the acute need to treat both physical and spiritual aspects of disease. The priest was adamant about the power of prayer and faith in healing illness, but admitted that cures were complex processes that often required a combination of treatments, including a visit to the clinic. Because of this complexity of cure, delineating which diseases required which treatment was rarely a simple deductive process, and no standard definition of physical versus spiritual disorders existed in the customary medical canon.

Simon Messing, an anthropologist active in Ethiopia throughout the 1960s and early 70s, explained that particularly among the Amhara, 'no line is sharply drawn

[390] R. Giel, Y. Gezahegn, and J. N. Van Luijk, 'Faith-healing and Spirit-possession in Ghion, Ethiopia', *Social Science & Medicine*, vol. 2, no. 1 (1968), p. 68.

between body and spirit in the healing arts.' Messing explained therefore that 'there is considerable ambivalence in the choice of physical or spiritual healers in traditional medicine for any given symptom of disease.' Even within the treatments themselves, Messing defined Amhara communities as practicing an 'interdigitation' between physical and spiritual healing practices: 'when spiritual formulas have to be ingested physically, when herbal remedies have to be gathered with proper spiritual ceremony, or when herbal masks are employed to prevent incubation of sorcery.'[391]

There is a clear connection between spiritual treatments and the physical body, exposing the ways in which Ethiopian communities understood the biological responsibility for disease. While spiritual healers and healing practices are replete in Ethiopian tradition, as Messing demonstrates, such treatments are rarely without some physical manifestation. Another example of this interdigitation are the numerous prayer books that list medical incantations for a variety of both biological and spiritual disorders. In Stefan Strelcyn's tireless translations and annotations of surviving Orthodox prayer books dating back to the eighteenth century, it is evident that in the traditional medico-spiritual canon, one of the most oft-repeated prayers was a plea to protect birthing women from vaginal haemorrhage.[392] As an exceptionally common cause of maternal mortality worldwide, it is not difficult to see why such a prayer would be repeated with such regularity across the three hundred years of Ethiopian medical practices. What is striking about its presence,

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[391] S.D. Messing, *The Target of Health in Ethiopia: A Holistic Reader in Applied Anthropology* (New York, 1972), p. 257.

[392] S. Strelcyn, 'Les Traités Médicaux Éthiopiens', *Cahiers d'Études Africaines,* vol. 2, no. 5 (1 January 1961), pp. 148–159; S. Strelcyn, 'Les Écrits Médicaux Éthiopiens', *Journal of Ethiopian Studies,* vol. 3, no. 1 (1965), pp. 82–103; S. Strelcyn, *Catalogue of Ethiopic Manuscripts in the John Rylands University Library of Manchester* (Manchester, 1974); S. Strelcyn, 'Catalogue of Ethiopian Manuscripts of the Wellcome Institute of the History of Medicine in London', *Bulletin of the School of Oriental and African Studies,* vol. 35, no. 1 (1972), pp. 27–55; S. Strelcyn, *Catalogue of Ethiopian Manuscripts in the British Library Acquired Since the Year 1877* (London, 1978); S. Strelcyn, *Catalogue Des Manuscrits Éthiopiens de l'Accademia Nazionale Dei Lincei: Fonds Conti Rossini et Fonds Caetani 209, 375, 376, 377, 378*, (Rome, 1976).

however, is the way in which such a prayer encapsulates the interdigitation between body and spirit in Amhara medicine defined by Messing. By invoking prayer, the means of treatment is ultimately a metaphysical call to unseen forces. However, the demand itself - to prevent vaginal haemorrhage - is deeply biological. This is not a blind demand for spiritual healing, but a pragmatic invocation of unseen forces to prevent a highly specified physiological symptom of impending maternal death.

Ethiopia is by no means unique in its overlapping care systems: such negotiations between the 'internal' and 'external' worlds of healing are recorded across Africa and Asia. Studies of Chinese, Thai, and South Indian medicine have exposed the ways in which healers use physical prescriptions for social disorders, while notable anthropological studies of medicine in Africa have long explored the interactions between the body and spiritual worlds in local healing.[393] Janice Boddy's work in Sudan is especially instructive in highlighting the ways in which women's health concerns are addressed with physical remedies like infibulation, a physiological procedure meant to safeguard both physiological problems of gynaecology, while also ensuring the woman's spiritual and moral selves remain intact.[394] Ethiopian medicine is therefore easily inserted into a global pattern of multiple cures for both internal and external disorders.

[393] See especially: P. Huard and M. Wong, *Chinese Medicine* (New York, 1968); S.J. Tambiah, 'The ideology of merit and the social correlates of Buddhism in a Thai village', in E.R. Leach (ed.), *Dialectic in Practical Religion* (Cambridge, 1968), pp. 41-121; B.E.F. Beck, 'Colour and heat in South Indian ritual', *Man*, vol. 4, no. 553 (1969), pp. 533-572; V. Turner, *The Drums of Affliction: A Study of Religious Processes Among the Ndembu of Zambia* (Oxford, 1968); E.E. Evans-Pritchard, *Nuer Religion* (Oxford, 1956).

[394] J. Boddy, 'Womb as oasis: the symbolic context of pharaonic circumcision in rural Northern Sudan', *American Ethnologist*, vol. 9, no. 4 (1982), pp. 682-698.

As this chapter's description of women's health choices at the time of childbirth clearly demonstrates, Ethiopian communities were not resistant to modern medicine, but were willing to utilise its treatments should they be deemed appropriate to the disease at hand. However, because communities did not cease all home health remedies with the construction of a modern clinic - including the continuation of home birthing - policy-makers often lamented that Western-style medical campaigns were considered wholly unsuitable by target populations.

In his late study of health-seeking behaviours in Eastern Ethiopia, Leendert Slikkerveer notes that in the mid-twentieth century, academic trends in the study of medicine in developing nations helped exacerbate these conceptions of traditional societies fixated on timeless custom. Slikkerveer argues that similar to policy-makers and government officials, the majority of scholars of medicine and anthropology consistently misinterpreted indigenous patterns of health into a superficial model of tradition versus modernity.[395] In the 1950s and 60s, there was a considerable increase in medical anthropologists interested in 'traditional medicine' in developing countries. By narrowing the focus to local healing practices 'untouched' by modernity, anthropologists played into the fears of policy-makers keen to erase all signifiers of backward custom in emerging nations. It was believed that if communities were only invested in such traditional forms of cure, nations would stagnate in underdevelopment.

In contrast to the false dichotomy of traditional practices pitted against the modern, Slikkerveer was one of the first anthropologists of Ethiopia to argue for a 'systems' approach to understanding health behaviours. Communities were not

[395] L.J. Slikkerveer, *Plural Medical Systems in the Horn of Africa: The Legacy of 'Sheikh' Hippocrates* (London, 1990).

pitting *wogesha* against health officers, but instead moved lithely between multiple systems of healthcare, seeking out the most appropriate treatment for their current ailment.

Beginning in the early 1800s, foreign travelogues of Ethiopia are replete with tales of Ethiopians 'clamouring for cures' from foreign medical workers and travellers. These accounts demonstrate the strong tradition of overlapping health systems in the country: A.B. Wylde wrote in his 1901 travelogue, *Modern Abyssinia*, 'I do not believe there is any nation that are more willing to put themselves under the doctors [sic] care than these Abyssinians.'[396] In the late 1930s, British resident of Ethiopia, Christine Sandford, described Amhara patients she treated with basic first aid as 'confident' and 'submissive to treatment,' repaying the service with 'a humble gratitude.'[397] Members of a French scientific mission in Adowa in the mid-nineteenth century described the population as possessing a 'blind confidence' and 'good will' towards foreign medical treatments - even those that were proved ineffective.[398]

Richard Pankhurst has explained that local interest in modern medicine had less to do with superstitious belief in the 'magic of the foreigner,' but was rather a pragmatic search for cure in the face of acute illness. Indeed, one French traveller explained that after several years of doling out ineffective medicaments among the Tigre, the population's belief in foreign medicine waned and they returned to indigenous treatments.[399] Belief in modern medicine extended insofar as the treatment could be effective in restoring physical equilibrium. Given the large

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[396] A.B. Wylde, *Modern Abyssinia* (London, 1901), p. 417.
[397] C.L. Sandford, *Ethiopia Under Haile Selassie* (London, 1946), p. 66.
[398] R. Pankhurst, 'The Beginnings of Modern Medicine in Ethiopia', *Ethiopia Observer,* vol. 9, no. 2 (1965), p. 117.
[399] Ibid.

number of foreign physicians and travellers actively distributing modern medical treatments in Ethiopian communities from 1800 onward, the population had a long history of exposure to foreign medicine before the mid-twentieth century expansion of national health services. There was widespread awareness that certain foreign treatments were profoundly effective in curing common diseases, while still others had proved useless in the face of illnesses believed to be determined by external, metaphysical agents. Ethiopians approached the multiple systems of treatment in a pragmatic manner, making sound use of modern medicine when both accessible and appropriate for the crisis at hand.

While policy-makers feared local resistance to the clinic, especially in regards to maternal health practices, it is difficult to locate an active reluctance to effective treatment among the population after both re-reading accounts of health workers active in Ethiopia from 1800 up to the late twentieth century, and also listening to patient narratives from the time. By 1950, modern medicine was not an exotic innovation for the population to adopt without question. Western medicine had already begun to penetrate Ethiopia, either in practice or mere rumour, and local communities were only too willing to add relevant modern treatments to their cosmology of healing. Modern medicine never dominated or replaced traditional cures, but Ethiopian communities had never subscribed to a single theory of health and healing, and were not willing to abandon alternative forms of care still requisite for complete well-being.

As Haile Selassie began expanding his modern medical network in Ethiopia, numerous detractors argued that the fact that the population did not abandon indigenous healing practices was evidence of an Ethiopian reluctance to embrace modernity. John Macfie, a British physician who served in Ethiopia during the years of the Italian occupation, was particularly vocal in his doubt of Ethiopians to

develop out of their national healing traditions: 'Theirs was an African's country without a doubt. Clearly they had no desire to be "Europeanised," and were not impressed by the benefits of what we regarded as "civilisation." They were firmly convinced that their own ways were best, and apparently did not entertain the possibility that in some respects they might be bettered.'[400]

This dominant narrative ignored not only the pragmatism of community responses to disease, but also the limited reach of modern medical practitioners at the time. Sporadic in nature, medical campaigns had never penetrated Ethiopian communities to a degree that would allow for their full replacement of indigenous treatments. Further, there were agents of disease that could not be treated by modern medicine, so local healers had to endure alongside the clinic. As the following chapter of this thesis will make more clear, the continuation of indigenous healing practices in Ethiopian society in the twentieth century was not a factor of the population's obstinate refusal to innovate, but is rather symptomatic of community needs to rely on multiple systems of treatment given both the plurality of diseases and the pragmatic limitations of the clinic's accessibility.

Conclusion

The women I interviewed over the course of my fieldwork made pragmatic decisions regarding care during pregnancy and childbirth within a larger cosmology of health behaviours. The persistence of permissive attitudes towards low-intervention home birthing was not a symptom of anti-medical beliefs, but instead related to pre-existing categories of health and disease. Pregnancy was exceptionally

[400] J.W.S. MacFie, *An Ethiopian Diary: a Record of the British Ambulance Service in Ethiopia* (London, 1936), p. x.

common for women in Ethiopia, a condition they would enter multiple times over their lifetime, and it made little sense to undergo multiple routines of ante-natal care in remote health facilities given the actual rarity of pregnancy disorders. Deliveries were usually complication free, and women trusted that the caring support of neighbours and relatives was sufficient for the normal progression of labour.

At the same time, when medical assistance was necessary, women were careful to discern the quality of care on offer. In most instances, women expressed gratitude for the curative services they received at the clinic. Lijitwa Gebru gave birth to her third child at the Norwegian Lutheran Hospital in Gidole, a small settlement roughly halfway between Jinka and Arba Minch. The first two deliveries had been uncomplicated, but Lijitwa began leaking fluid near the end of her third pregnancy and decided to seek out assistance with the missionary doctors. Lijitwa explained how kindly the hospital staff cared for her in her third trimester: 'the care was so good, I wanted to return to the hospital for the delivery too.' She arrived at the hospital in the midst of her labour, and remembers vividly how the nurses ran from their living quarters to greet her at the hospital's entrance and assist her in delivery. Lijitwa told me how impressed she was that the nurse would run with such urgency to care for her. The hospital was able to care for her challenging pregnancy and delivery in a way that combined both biomedical cure and psycho-social support. In relating the experience, Lijitwa was overwhelmed with gratitude for the services she received. She was confident that her problems related to fluid retention could only have been treated in the medical facility, and was enthusiastic about the quality of care she received from clinical staff.[401]

The case of the birth attendant Zewditu Tesfa, related above, is especially demonstrative of the common recognition among Ethiopian communities of

[401] Author interview with Lijitwa Gebru, Jinka, 15 May 2013.

practitioner limitations. Zewditu was careful in identifying which conditions of maternity care required physiological assistance outside her own expertise, referring patients to medical clinics if necessary. Birth could be treated by varied means: in the case of normal delivery, evocative prayers to Maryam and social support were sufficient. For obstetric emergency, biomedical intervention to correct physiological disorders was necessary.

In mid-twentieth century Ethiopia, women actively discerned which healing practices best suited their individual circumstances in times of pregnancy and delivery. Numerous external factors would determine the choice of care made, including familial pressure, ethnicity, and geographic location. Influenced by the WHO rhetoric on perpetuating preventive education programming at maternal health clinics, the state intended to educate maternity patients on the principles of modernity, but the prevailing interest in medicine rested on its mere curative potential. Most of the women I interviewed had few interactions with medical facilities over the course of their reproductive lives, and any lasting impact on their lifestyles or status in relation to modernity was predicated by external factors like income and class. Women who did arrive at medical facilities for emergency obstetric services were greatly affected by the advent of medicalised birthing insofar as the clinic prevented undue mortality and morbidity, but such cursory visits did little to re-orient domestic practices or indigenous traditions towards modernity as prescribed by WHO policy. For the majority of women, the pragmatics of living interrupted the state's intentions for patients' re-socialisation.

Chapter 5: Medical failings at the end of the imperial age

There is no space for snobbery in a poor country as ours… Medical care is becoming more and more a luxury that people cannot afford.

— Yacob Wolde Mariam, 1974[402]

The last two chapters have focussed on the ways in which women participated in state medical enterprises both as practitioners and patients. In both narratives, obvious tensions arose between the perceived role of women within official policy, and the actual priorities and predilections of women within medical practice. All women were deliberate in identifying the ways in which modern medicine could be of most benefit within their individual circumstances, and it was obvious that policy prescriptions on the use of medicine to further modernise Ethiopian communities were vastly restricted by conditions of class, geography, and livelihood.

In this final chapter, I want to return to the official narrative to describe the ways in which Haile Selassie's medical mission failed to achieve its intended transformation of Ethiopian society. Given the framework of the previous two chapters, the gaps in modernisation policies are obvious. I will expand on the narratives above and coalesce the 'failings' of the imperial regime into three main themes: the poor quality of medical services due to lack of government investment; the disconnected philosophies of officials and patients along lines of prevention versus cure; and lastly the neglect of officials to consider livelihood restrictions in modernist policies for medicine's expansion.

I begin the chapter by describing the declining quality of medical services in Haile Selassie's Ethiopia. Met with budgetary crises and crumbling institutions, officials began to doubt the capacity of medicine to adequately modernise Ethiopia.

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[402] F. Hylander, 'A Revolutionary Layman Takes a Look at Ethiopian Healthcare', *Lakartidningen*, vol. 73 (1976), p. 3187.

American aid officials were especially pessimistic about the prospects of Ethiopian medicine, especially after the imperial government began reneging on promises to fund the expansion of the rural health centre network. In describing the failures of the state to adequately finance and support the nation's burgeoning health system, the conflict between modernist ideology and practice is made evident. The incapacity of the state demonstrates once more how medicine continued to be a prestige enterprise for Haile Selassie, as the imperial regime seemed fixated on the mere image and initial construction of an elite medical network without the requisite long-term investment of money, manpower, and supplies.

After this discussion of the system-wide failures of Haile Selassie's medical enterprises, I return to issues of maternal health when describing the conflict between preventive and curative services within the rural health centre. The previous chapter exposed the prevailing interest of maternity patients in the curative potential of modern medical facilities, and given the poor capacity of health centres described below, there is special concern about the inability of rural facilities to adequately treat patients in need of obstetric cures. Designed to prevent, not treat, maternal morbidities, health centres became inundated with emergency cases that too often ended in death. Women arrived at their local facilities in states of obstetric distress, but state policy dictated that emergency cases must be referred to district hospitals. This referral system was wholly impractical given the geographic isolation of most Ethiopian communities, and exposed once more the inadequate consideration of national medical policies for the actual needs of intended patients.

Beyond untreatable obstetric emergencies, there was another underlying problem with the rural health network as related to women. Preventive medicine rested on the capacity of women to alter their domestic environments and therefore modernise the community. However, as first introduced in chapter two, livelihood restrictions

greatly limited the capacity of public health education from adequately transforming Ethiopian life. I expand upon this theme at the end of this chapter, before discussing the final maternal health issue of reproductive health and family planning. I have not discussed the issue of family planning up to this point in the thesis, but use this chapter to explain in detail the protracted history of family planning policy and practice in Ethiopia. The issue of reproductive health was largely ignored by the state under both Haile Selassie and his successor, the Derg. The neglect to provide women with contraceptive care is troubling given the high mortality figures related to unsafe abortion at the time, and speaks to glaring gaps in state medical policies. The persistence of poverty in Ethiopia under Haile Selassie meant that preventive health education was largely fruitless, while the inevitable high fertility of women only compounded existing issues of malnutrition, poor sanitation, and susceptibility to infectious disease. In neglecting reproductive health, the state further demonstrated its superficial understanding of the health needs of the population. The prestige of medicine was paramount in Haile Selassie's Ethiopia, at the expense of actual community reformation and improved health.

Deteriorating quality of services: urban and rural disparities

In the twilight years of Haile Selassie's reign, it was hard for officials to ignore the gross inadequacies of the health model that had been constructed over the previous three decades. Despite considerable planning and foreign investment in medical projects, less than one in six Ethiopians lived within an accessible distance to a health facility. Medicine had been propagated as a tool for national development, but the rural areas of the nation remained largely unchanged. As one visiting member of the Economic Commission for Africa asserted, 'there are classes of the

rural population in Ethiopia which are almost untouched by the impact of development programmes. The disparity of the urban and rural standard of living appears to be appalling.'[403]

While Haile Selassie had expressed a repeated interest in building a health network for his empire, the figures for government investment in health remained dismal, especially in the underdeveloped rural regions. In the last year of the emperor's rule, just 1.3% of Ethiopia's GDP was devoted to medical projects, but 30% of that spending was concentrated on hospital services in Addis Ababa.[404] Rural health centres were also constructed disproportionate to regional populations, evincing clear favouritism for highland Amhara provinces. Shewa province, home to Addis Ababa, had 3.3 million inhabitants in 1974, and 34 health centres. In contrast, Harar province in eastern Ethiopia, despite having the same population, had only five health centres; while Wellega, a highland province west of Shewa, had 33 health centres to serve a population of only 1.4 million.[405]

In terms of sheer statistical distribution of facilities, the inadequacies of the public health network in Ethiopia were striking. This section of the chapter describes in further detail how despite the considerable promise of modern medicine's introduction in Ethiopia, the state's neglect of health infrastructures led to a largely dysfunctional national service. I will begin by explaining the deteriorating quality of hospital services in urban areas of Ethiopia, and then move on to the troubles of the rural health network.

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[403] J. Krishnaswamy, *Paper to the Economic Commission for Africa by Dr. J Krishnaswamy, Regional Planning Adviser in Ethiopia for UNDP* (Addis Ababa, 1967).
[404] E. Cross and N. Holly, *Review of the Health Sector of the Ethiopian Fourth Five Year Plan: An Analysis for the USAID Mission to Ethiopia* (Addis Ababa, 1973), p. 5.
[405] Ethiopian Nutrition Institute, *Directory of Christian Missions and Health Services in Ethiopia* (Addis Ababa, 1971).

The deterioration of the hospital

When Haile Selassie opened the first medical faculty's teaching hospital, the Duke of Harar, in 1967, he intended the facility to be a capstone of imperial power and national modernity. After soliciting donors for the adequate funds to open a teaching hospital and medical faculty for twenty years, the emperor finally had the massive symbol of imperial prestige he had intended. Foreign physicians reluctantly turned over their support to the project, attempting to assuage the critics of this impractical 'white elephant' of a hospital.

Unfortunately, the optimism of the emperor and his supporters was swiftly dismantled in the first years of the hospital's operation. Almost immediately upon opening, the facility proved impossible to manage with the meagre budget allotted from the Ministry of Public Health. As one obstetrician noted, 'the new hospital had been planned to be run by a larger staff, medical, nursing and paramedical, than was available.'[406] The quality of the services was dismal, despite the prestigious hopes of hospital planners.

This regression in quality of care at the teaching hospital was mirrored across Addis Ababa: large hospitals like the Duke of Harar and Paulos continued to be built in the capital throughout Haile Selassie's reign, despite little change in budgetary allotments for the expansive institutions. The infrastructure of older facilities, including the Princess Tsehai Hospital, began crumbling under decades of strained budgeting, and the initial glamour and prestige of Addis medical institutions quickly faded. Dr. Duncan explained how 'filthy' both the Tsehai and Harar facilities were at the start of the 1970s, with widespread flea infestations and bed mattresses

[406] Medical Faculty Obstetrics Department, *Clinical Report of the Princess Tsahai Memorial Hospital and the Black Lion Hospital Obstetrics Department, Addis Ababa, Ethiopia* (Addis Ababa, 1974-75), p. 6.

that had been left hardened by patients' blood. Chronic supply shortages meant that basic equipment, including beds and linens, were never replaced or even properly cleaned, resulting in significant over-use.

The poor quality of hospital services led to a number of unnecessary deaths of patients, especially in instances of obstetric emergency. In a two-year survey of maternal mortality in Addis Ababa, Barbara Kwast noted that of 100 maternal deaths recorded in the city's hospitals, a full quarter had occurred because of inadequate blood supply.[407] While the average maternal death rate at hospitals in Addis Ababa was 4.78 per 1,000 births, at the Duke of Harar Hospital, this figure climbed to 12.68.[408]

Dr. Duncan explained how both Tsehai and Harar obstetrics teams attempted to assuage the poor quality of services, especially in relation to chronic blood shortages. The obstetrics department was always in need of a steady supply of blood to treat the high numbers of haemorrhaging women, and began soliciting blood donations from family members who accompanied parturients to the facilities. All hospital medical staff were also recruited to give regular blood donations, ensuring the blood supply remained largely consistent with the needs of patients. However, Duncan explained that because obstetrics was the only department actively soliciting blood donations, other hospital departments began relying on the obstetrics stores for their own blood needs. The mismanagement of supplies led to continued shortages and numerous preventable maternal deaths.

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[407] B.E. Kwast, W. Kidane-Mariam, E.M. Saed, and F.G.R. Fowkes, *Report on Maternal Health in Addis Ababa: September 1981 - September 1983; A Community-Based Survey on the Incidence and Aetiology of Maternal Mortality and the Use of Maternity Services and Confidential Enquiries into Maternal Deaths in Addis Ababa, Ethiopia* (Addis Ababa, 1984).

[408] Note this is just the hospital mortality rate in Addis Ababa- nationwide, the rate rose to an estimated 20 per 1,000 live births. B.E. Kwast, *Report on Maternal Health in Addis Ababa September 1981- September 1983: A Community-Based Survey on the Incidence and Aetiology of Maternal Mortality and the Use of Maternity Services and Confidential Enquiries Into Maternal Deaths in Addis Ababa, Ethiopia* (Addis Ababa, 1984), p. 116.

In Duncan's clinical report from the obstetrics wards of both the Duke of Harar and Tsehai Hospitals from 1975, she wrote that 'for those accustomed to working in countries where full ante-natal care, facilities for admission to ante-natal beds, delivery suites with foetal monitoring during labour, 24 hour obstetrical anaesthetic service, blood transfusion and adequate lying in beds are available, the following report must read like fiction.'[409]

Patient discontent

As evident from the previous chapter, Addis Ababa patients were cognisant of the gross inadequacies of the capital's medical network, and while attendance at facilities continued to grow with the number of hospital beds, frustration at the poor quality of services was widespread. The case of Elfenish Isayus is especially indicative of the challenges in receiving adequate medical care in Addis, especially for lower class residents and migrants to the capital. Urbanisation may have provided Ethiopian migrants with better access to jobs and social services, but the dysfunction and inequity inherent in urban social networks left residents bereft of the benefits promised by modern city life.

Elfenish migrated to Addis Ababa in 1967 from the rural countryside with her mother to look for employment. She had graduated from sixth grade, and while confident that this would help her secure a job, upon arriving in the capital, Elfenish's hopes were soon dashed in seeing cousins with tenth and twelfth grade educations still unemployed. Moving through various methods of employment, including selling *tej* and harvesting coffee at a nearby plantation, Elfenish settled into a position at a textile factory on the outskirts of the city. Elfenish explained that

[409] Medical Faculty Obstetrics Department, *Clinical Report*, p. 8.

while there was a trained dresser employed by the factory to treat employees' basic health needs, he 'gave the same pill for all our problems.' In the case of acute illness, workers would be referred to the Duke of Harar Hospital, where the company had a contract agreement. Elfenish explained the reluctance of workers to go to hospital, however, because of the considerable amount of time it took to be treated:

> The hospital is always very crowded, so unless a patient reaches there very early in the morning, they tell you to come back the next day. If you are lucky, you get to see the doctor the next day or else you have to go back yet another day. Unless the doctor acknowledges all these wasted work days on the doctor's certificate, the workers do not get paid for those days which were 'wasted' through no fault of their own.

The daily wage at the factory was $1.50, but employees typically paid up to 60 cents each day for transport to work, even more to travel into the centre of town to seek treatment at the teaching hospital. The inaccessibility of the hospital, compounded with over-crowding and poor numbers of medical staff on hand, left many factory employees, including Elfenish, reluctant to seek treatment except in the case of absolute necessity. At the same time, Elfenish was aware that auxiliary services, including the factory's dresser, were largely unskilled and incapable of adequately treating her in time of illness.[410]

Officials had long acknowledged that with exposure to modern modes of living, urban populations in Ethiopia were 'always likely to demand medical services,' and that 'this demand is usually for hospitals.'[411] At the same time, the urban demand was met by poor quality, over-crowded services that remained inadequate to the

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[410] The story of Elfenish Isayus is taken from a comprehensive survey of the 'Condition of Women in Ethiopia,' conducted in 1976 by Zenebework Tadesse and published with assistance from Sweden's International Development Agency. Zenebework's study was written as part of her involvement in the Derg revolution, and is a valuable exploration of the disjunctures between Haile Selassie's policies towards women and their precarious role in society. (Z. Tadesse, *The Condition of Women in Ethiopia* (Addis Ababa, 1976)).

[411] Imperial Ethiopian Government, *Third Five Year Development Plan, 1961-1965 E.C. (1968/69-1972/73 G.C.)* (Addis Ababa, 1968), p. 312.

curative needs of patients. Hospitals had been built in Addis Ababa to secure Ethiopian prestige, and while the early years of their operation had proved successful in developing first- and second-class wards for the urban elite, the swelling numbers of patients, in conjunction with limited budgets and poor numbers of staff, led to the rapid deterioration of the institutions' status as prestigious markers of Ethiopian modernity. Each time an elaborate hospital was built in Addis Ababa, from Princess Tsehai to Duke of Harar, commentators remained hopeful that the elite trappings of the institution could be reoriented to treating the acute needs of the city's growing population. However, in each instance, the intentions for the facility were not met with sufficient budget support, and with declining quality of care, there was little prestige left in the hospitals of Addis Ababa.

Countering the 'political pressure for curative medicine'

The failure of the imperial medical project in Ethiopia was even more apparent in the gross underdevelopment of health services in rural areas. The fundamental lack of economic capacity in the countryside meant that the state's intention to use medicine to develop Ethiopia at the community level failed in the same way as the prestigious institutions in the capital. Haile Selassie had concentrated on superficial mechanisms for rural development, including the construction of health centres, while ignoring the larger structural and social issues that not only perpetuated widespread poverty in the countryside, but wholly prevented populations from adhering to the public health rhetoric propagated at the health centre. Whether it was official budgetary constraints in Addis Ababa hospitals or limitations on livelihood among rural residents, the fundamental mission of Haile Selassie to

modernise Ethiopia through medicine was constrained by the nation's continued economic deprivation.

By the end of the emperor's rule, Ethiopia's rural health service remained underdeveloped and largely inaccessible to the majority of the population. In 1973, existing health centres were working at just 50% capacity, and as one critic plainly asserted, 'it has been realised that the healthcare delivery system was neither functioning as intended nor efficient in terms of numbers of people served, that it provided mostly curative services rather than preventive services, and that it lacked coordination.'[412] The first sign of distress in the rural health network was the budgetary crisis of 1958. When US aid officials signed the agreement to open the Gondar Public Health College and Training Centre with the WHO and Haile Selassie's regime, there was an explicit expectation that while the American and Ethiopian governments would equally split all operating costs for the college itself, the Ethiopian administration had sole responsibility to construct a network of rural health centres and employ Gondar graduates as they began their tenure of national public health service. While operations to train students and administer town health services in Gondar continued with little interruption from the college's opening in 1954, by 1958 - a mere four years into the Gondar College's opening - the imperial Ethiopian government slashed its health budget, leaving virtually no funds for either the construction of the health centres or the hiring of health teams to man them.

The budgetary crisis left American aid administrators frustrated and confused - had this project been doomed from the start? Did Ethiopians even want a public health service? One official lamented that the Americans had been 'hoist on their own petard,' and could go 'neither forward or backward,' having already invested too heavily in Gondar to abandon the project completely, but lacking sufficient local

[412] Cross and Holly, *Review of the Health Sector*, p. 19.

support to continue as initially planned. Officials argued that while the main purpose of America's investment in the project had been 'to win friends for the United States and our way of life,' the back-pedalling of the Ethiopian Government suggested that perhaps the US had 'moved too rapidly for the culture in which we are working.' Arguments on the discrepancy between Ethiopian cultural predilections and foreign medical standards arose, as Americans contended that the Gondar model of preventive medicine was 'extremely difficult to get across' in Ethiopia, since 'political pressure is all for curative medicine.' An internal report at the US aid mission lamented that 'certainly, the greatest emphasis in Ethiopia is on hospitals,' and foreign officials struggled to convince the Ethiopian government of the unquantifiable benefits of public health. Having lobbied local officials for the construction of a public health training centre and administrative network in the nation, Americans were concerned that they had 'caused ill-feeling on the part of some Ethiopian officials who feel we have forced health programs on them which they did not want in the first place, and which they never felt they could adequately support from a financial standpoint.'[413]

Julius Prince, long advocate for the Gondar project, defended the American effort to instil a culture of public health in Ethiopia, arguing that the local regime was ultimately composed of 'men of good will,' that merely 'need our help, but not our dictation.' Prince maintained that with an estimated 75% of the Ethiopian population suffering from serious intestinal diseases, 50% from trachoma, and 40% from syphilis, there was 'no other country in the world' that would benefit so wholly from the provision of basic, preventive health. Further, because of the crippling effect of such widespread communicable disease, Ethiopia was an exemplary case of a

[413] United States NARA, RG469 P246, Records of US Foreign Assistance Agencies: Public Health 1957-1958 (College Park, MD, 1958).

country 'in which economic improvement could not occur without health improvement.'[414]

Prince continued to argue that the hope of Ethiopia's national development rested on the Gondar project, and that Ethiopian officials, while seemingly resistant to over-bearing foreign 'dictation,' were still eager to develop their nation with the assistance of American allies. Similar to earlier arguments of another Ethiopian advocate, Sylvia Pankhurst, Prince emphasised that foreign allies to the Ethiopian health project must remain 'disinterested,' wholly invested in the modernisation of Ethiopia on the country's own terms, encouraging communities and officials in their own roles as the nation's development vanguard.

The question of indigenous will: co-opting local communities into a public health infrastructure

In Prince's estimation, the problem with medical policy thus far was an over-reliance on foreign dictation. There needed to be a significant re-orientation towards indigenous will and desires in regard to national health infrastructure. The joint agreement which founded the Gondar Public Health College in 1954 had intended to privilege this co-option of indigenous efforts in the nation's medicalisation. The agreement not only established the college, but also called for the formation of both municipal and provincial health administration networks for the nation. From the outset, partners agreed that the purpose of the Gondar project would not be restricted to the mere training of health workers, but also include plans for expanding medical services across the empire.

[414] Ibid.

The WHO and US aid mission took on the majority of responsibility for health activities within Gondar town and surrounding areas, not only in the building and operation of the Public Health College itself, but also in administering the Begemedir province's municipal and provincial health services. As described in the previous chapter, Gondar town's health service was highly functional throughout the 1950s and 60s as it relied on a steady flow of funding, staff, and technical support from foreign partners. Beyond the town services, college administrators and WHO technical staff also provided considerable support in the form of funding and manpower to the construction and administration of health facilities and personnel throughout Begemidir. The college's budget supported the construction of three health centres in the province from 1957-1959, and UNICEF set up environmental sanitation programmes in the Dembia, Dabat, and Gondar areas.[415]

While foreign partners invested heavily in the health infrastructure of Gondar town and its surrounding province, the administrative services set up in these areas were intended to be mere models for the Ethiopian government to replicate throughout the empire. Similar municipal and provincial health networks were to be developed in each of the fourteen provinces of Haile Selassie's Ethiopia, and it was up to the nation's Ministry of Public Health to direct the construction of rural health centres. In addition, while international aid would support Gondar health teams in their training and initial practical year, the Ethiopian government was solely responsible for the employment and supervision of students post-graduation. The foundation of the Gondar project rested on the hope that this would ultimately be a local effort on the part of Ethiopians to self-modernise through medicine, enhancing the role of Ethiopian officials and communities in constructing their own national public health network.

[415] The three principal towns in the Begemidir province.

In a 1954 newsletter produced by the US aid mission, this ideal of local ownership and participation in the Gondar mission was clearly narrated in the tale of the construction of the Kolladuba health centre in the Begemidir province. As one of the model health centres used by students in their internship year, the Kolladuba facility was built as part of the college construction effort, with direct funding and supervision by the Americans. Deliberately downplaying the role of the foreign aid mission in Kolladuba's construction, the newsletter proudly proclaimed that the health centre was 'built entirely by the villagers themselves,' and would not only provide the community with 'expert medical attention,' but also 'an education in an improved method of housing construction.'[416]

This careful emphasis on the primacy of local residents in constructing the health centre made it seem as if this was a spontaneous community effort to both equip themselves for the instruction of medical experts, and also improve domestic living standards. What the newsletter fails to mention, however, was the way in which community members were merely co-opted into the project as a free source of local labour, and how the foundation of the health centre and its materials for construction all originated from the US aid mission. Co-opting Kolladuba residents was a strategic move on the part of officials keen to emphasise the ways in which the Gondar project would activate Ethiopia's capacities for self-modernisation and development.

Stalled progress: the budgetary crisis of 1958-60

US officials were hopeful that given they had created a project that was so reliant on local direction and leadership, the Gondar model of national health and

[416] United Kingdom National Archive, FO 371/108227, Copies of Monthly Issues of 'Point 4 News' Published by the USA Operations Mission to Ethiopia (London Kew Gardens, 1954).

development could be easily replicated across the empire. However, at the time of the 1958-60 Ethiopian budgetary crisis, it became clear that not only were Ethiopian officials incapable of contributing their share of funding for public health projects in rural areas, but without a significant top-down mandate or support, communities would not be able to construct health centres for themselves. The scarce resources of rural livelihoods would prohibit the seemingly spontaneous alteration of living standards and practices described at Kolladuba in the American newsletter. While the success of the Gondar project relied heavily on local cooperation, clear limitations in the capacity and willingness to institute the Gondar ideal were evident once the US aid mission or WHO technical team removed their support. In the last years of the 1950s, the considerable delay on the part of the Ethiopian government to fund public health projects as initially agreed threatened to unravel the core principle of local ownership of medicine's advancement in the nation.

At the time of the budgetary crisis, foreign officials debated whether the funding shortfall was due to actual financial limitations of the Ethiopian government, or an active disinterest on the part of local officials to engage with public health work. By 1959, the state's Council of Ministers had still not approved any budget items for the construction of health centres, and the morale of students at Gondar College plummeted. Half of all health officer students quit the course in June of 1959, wary of not being employed upon graduation. American officials scrambled to reassure the student body, and the Dean of the college asked the Minister of Public Health himself to compose individual letters to students making it clear 'that it was an actual lack of funds, rather than a lack of interest which caused the uncertainty with relation to Gondar graduates.'[417]

[417] United States NARA, RG469 P246 (College Park, MD, 1958).

That same year, a quarterly report from the American aid office demonstrated a greater degree of pessimism among US officials that the Ethiopian government was in fact unwilling to go forward with the Gondar project. The report argued that while students had been told throughout their training that they would be sent to health centres to work, 'the health centres exist only on paper.' Even beyond the actual provision of health centre structures, there remained 'no mechanism for providing the health centres with even the minimum of administrative supervision or technical guidance for functioning.' Further, 'no one in the Ministry [of Public Health] appears to understand the need for planning for health centres, and no one is responsible for implementing the very few tentative plans that do exist.'[418]

Officials emphasised that the Ministry's incapacity to act on agreements previously made to construct health centres and employ graduates had an increasingly negative effect on both students and staff: 'graduates have no job security and are not applying the knowledge they struggled to acquire.' The report explains that the first two groups of Gondar graduates had been left with no employment, and are now seen 'wandering up and down the streets of Addis' looking for work. College staff had become similarly disillusioned with what was seen as a 'dark future' for public health in Ethiopia. Because students were not able to utilise the training they were given in a practical health centre setting, faculty began 'to feel [their] work is without real value. . . . The degrees alone are the final goal, not actually providing a national health service.'[419]

Throughout the budgetary crisis years, US officials continued to argue that they had been repeatedly reassured that their responsibility for the Gondar project would end with the internship year. But given the lack of movement on the side of the

[418] Ibid.
[419] Ibid.

Ministry of Public Health, US officials began to contend that while they 'abided by this decision in the past,' the time may have come to 'appeal it.' There was real concern that unless such reforms were made, all American aid efforts thus far would have been in vain. As Julius Prince argued, 'if something is not done about this situation in the very near future, the entire Gondar operation may collapse,' proving to be a 'major catastrophe for public health in Ethiopia.'[420] Beyond national concerns, the international reputation of US aid was also at stake, for as one official warned, 'health officials from many governments are watching this training programme with great interest.'[421]

It was unanimously agreed that while the 'entire success of Gondar' depended on the 'adequate employ and supervision of graduates,' these were the two areas of responsibility in which the Ethiopian government had failed. It was suggested that an alternative support agreement was to be drawn up between responsible parties, but American officials were wary that the 'US cannot singlehandedly meet all of the Ethiopian government's needs.' If budgetary shortfalls were the principal issue, alternative sources of funding were to be scouted, potentially from additional United Nations bodies outside the WHO and UNICEF.

American officials were consistent in the belief, however, that ultimately this project must be administered as much as possible by Ethiopians themselves. When debating whether or not the responsibility for the employment and supervision of Gondar graduates be entirely taken over by the Americans and the WHO, or, as initially agreed, 'be recognised and assumed by the Ethiopian government' with a greater level of assistance from external partners, officials agreed upon the latter. As one official argued, the second option would be more 'fruitful over the long term,'

[420] United States NARA, RG469 UD394, Records of US Foreign Assistance Agencies: Ethiopia - Health 1958-1960 (College Park, MD, 1960).
[421] United States NARA, RG469 P246 (College Park, MD, 1958).

because it would continue 'the basic philosophy of our program,' that is 'to help recipient countries help themselves.'[422]

On the part of Ethiopian officials, there were repeated assurances that the problems facing the Ministry of Public Health were largely financial. In 1959, Ato Abbebe Retta, the Minister of Public Health, argued that 'the general pattern in Ethiopia is one in which solutions are slow but nonetheless ultimately reached.' While the Council of Ministers had not yet approved the budget, Ato Abbebe was certain that this would occur in due course, once larger financial concerns of the state were more clearly sorted. Haile Selassie had announced the introduction of a national 'health tax' that would come into effect in 1960, providing direct revenue to the health budgeting so that the Ministers did not have to argue over the limited state funds to fill their respective coffers. Ato Abbebe confidently announced that once the tax revenue was in place, the construction of health centres could begin in earnest.[423]

Princess Sophia, daughter of Haile Selassie's eldest child, Tenagnework, had her own meeting with American officials in 1959 to address the concerns of the Gondar project. The princess was given copies of all the financial disputes currently stalling the continuation of the project, and expressed surprise at the extent of troubles facing the nation's public health enterprise. Sophia argued that her mother and grandfather were clearly 'not aware of the true situation,' given the emperor's 'deep commitment to the future success of the Gondar programme.' She announced that she would address the situation with her grandfather, the emperor, and even promised to personally fund half of the construction costs for a health centre in

[422] Ibid.
[423] Ibid.

Gamu Goffa province.[424] As was often the case in Haile Selassie's Ethiopia, once the emperor's attention was drawn to a specific area of concern, action was taken immediately. Indeed, the emperor understood not only the prestige in funding medical projects for his empire, but also the potential scandal if his government was seen to be incapable of cooperating with foreign aid agreements.

While it is unclear exactly what measures Haile Selassie took in relation to the inaction of the Ministry of Public Health, after 1960, there was a visible shift in the Ethiopian government's expenditure and activities surrounding public health. Wary of repeating the budgetary debacle of 1958-60 in the future, foreign partners also worked on modified terms of reference regarding their level of assistance in implementing the Gondar project beyond the internship year. The WHO agreed to provide personnel to supervise graduates working in health centres until the government had set up the necessary provincial health administration structures. In addition, Julius Prince proposed a new construction plan for the health centres that lowered production costs to $15,000 per facility.[425] Finally, the US also agreed to provide an emergency budget for the first six months of all health centre operations and worker salaries to ensure health services could at least commence, future budgetary pitfalls on the side of the Ethiopian government notwithstanding.

Geopolitics and the place of medicine in Haile Selassie's larger modernisation mission

It is notable that the salvation of the health centre budget relied once more on direct intervention of the emperor. This is unsurprising, given the absolute power of Haile Selassie in terms of administrative decision-making and budget allocation.

[424] Ibid.
[425] Approximately $126,000 in today's dollars.

This narrative does help expose, however, the broader context of Haile Selassie's political concerns in relation to national modernisation efforts. While the emperor had stated publically his support for the Gondar project, asserting that public health occupied an 'important and prominent place' in his plans for Ethiopian modernisation, his support of health projects was largely secondary within the greater political context of the time.[426] Modernisation did not rest solely on medical expansion, and in examining imperial budgets throughout the 1950s, and 1960s, the priorities of the emperor are made more clear: while a small fraction of national budget was allocated to health, half of the budget was spent on military and executive administration costs.[427]

Military expansion was a key aspect of Haile Selassie's modernisation efforts, and foreign officials themselves were cognisant of the need to negotiate social aid projects with their own military interests. British officials were frank in stating that the Tsehai Hospital was a symbolic gesture in their fight to secure 'Lake Tana interests.'[428] Lake Tana is the source of the Blue Nile in Ethiopia, and was a critical waterway for troop and supply transportation for Britain to Sudan, Egypt, and the Mediterranean.

Ed Korry, the US ambassador to Ethiopia in the 1960s, was also remarkably forthright in a speech he made at the Gondar Public Health College, stating that while the college was a wonderful effort, it was only 'rent payment [to the emperor] for the Kagnew military station' in Eritrea.[429] The Kagnew base on the Red Sea Coast

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[426] Selassie, *Selected speeches*, p. 537.
[427] Imperial Ethiopian Government Ministry of Community Development and Social Affairs, *The Training of Manpower in Ethiopia During 1963 E.C. (1970-1971 G.C.)* (Addis Ababa, 1973).
[428] United Kingdom National Archive, FO 924/184, British Council representative to Ethiopia, British Council Activities in Ethiopia (London Kew Gardens, 1945).
[429] Carlson and Carlson, *Kossoye*, p. 201.

was established by the US military in 1943, and only dismantled with the removal of the emperor in the 1970s. In her study of US-Ethiopian relations under Haile Selassie, *Enlightened Aid*, Amanda McVety has written about the considerable negotiations between the emperor and his American allies between humanitarian and military efforts. Haile Selassie was persistent in requesting further military aid from the Americans, while they continued to push the emperor for permission to station military outposts in his territory as part of their larger Cold War strategy in Africa. American officials were concerned that given Ethiopia's location between Africa and the Middle East, the volatility of the region would have to be contained with greater military and humanitarian presence. One official explained that the extension of aid to Ethiopia was merely a feature of 'enlightened self-interest.'[430]

Haile Selassie played off this strategic view of his territory to solicit greater aid from Western allies. In a speech to US Congress in 1954, the emperor called Ethiopia 'the granary of the Middle East,' and a 'significant factor in world affairs.'[431] The emperor benefitted from American diplomatic anxieties, arguing that if they wanted stability in the contested Cold War regions, they would have to invest heavily in the technical development of Ethiopia, not just in terms of social services like medicine, but also in the expansion of a modern military.

When examined from this larger political context, the insecurity of the Ethiopian government's financial support for health projects is less surprising. Medicine was a critical feature in the emperor's conception of modernisation, as evidenced by his continued solicitation for external support for hospital and health projects. However, medicine was only one feature of a larger effort at national modernisation that preyed off geopolitical interests for military might and the securing of African peace.

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[430] McVety, *Enlightened Aid*, p. 111.
[431] Ibid., p. 143.

Haile Selassie was highly invested in medicine's expansion in Ethiopia, but not at the expense of personal interests for militarism and diplomatic prestige.

Prevention versus cure: Official intentions versus patient predilections

The limitations in health infrastructure in rural Ethiopia continued to damage the reputation of modern medical services among patients themselves. While medical services had been designed to re-invigorate communities into the principles of preventive health, patients continued to view the public health centres as curative 'hospitals.' Patients sought cures, but the policy was designed to offer mere prevention. The mid-twentieth century saw a shift in global discourses on health to preventive medicine and the power of social origins of disease, but this rhetoric was poorly translated into the patient experience in Ethiopia. This disconnect between policies and patients represented one of the most fundamental challenges for the expansion of Ethiopian medicine. This section of the chapter will first describe the actual limitations in health centre practice in wake of inadequate state support, while then explaining the significant problems among patients who demanded curative services that did not exist within the preventive health-focussed health network of the countryside. This was an especially acute problem in regards to maternal health, where preventive medicine cannot fully eliminate the presentation of obstetric emergencies.

The incapacity of rural health centres

By the end of 1960, there were five major health centres functional in Ethiopia, including the three model health centres built by the US in Begemidir province. In

addition, the foundations for twelve further health centres had been laid and initial health work at these centres had begun. In Ethiopia's Second Five Year Development Plan for the years 1962-67, the government also pronounced a new goal to construct one health centre for every 50,000 people. Given the population estimates at the time, this would mean 400 facilities total for the empire.[432] An ambitious goal, this represented a considerable shift in policy from the First Five Year Development Plan (1957-1961), which had made no mention of public health at all.

At the same time, while Ethiopian officials had become more pro-active in implementing public health programmes, structural and financial challenges continued to limit the efficacy of the Gondar project throughout the 1960s. By the end of the Second Five Year Development Plan period, just 62 health centres had been built - a far cry from the initial goal of 400.[433] Even those that had been constructed were consistently hampered by lack of equipment and poor supervision structures. Gondar graduates employed to man the centres were described as 'disillusioned' with their work. A US report explained that despite the increased efforts among partners to create an active public health network for Ethiopia, health workers were still not being 'given the tools with which to do the job they were trained for . . . It is not even possible for them to go about mapping the area and taking a census because they have no paper and pencils with which to make notes.'[434]

In 1970, with support from the Ministry of Public Health, Swedish aid conducted a rigorous review of health facilities in Arussi province, south of Addis Ababa, the

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[432] Imperial Ethiopian Government, *Second Five Year Development Plan, 1955-1959 E.C. (1962/1963-1968/1969 G.C.)* (Addis Ababa, 1962), p. 275.
[433] G.E. Teka, *The Public Health College and Training Centre, Gondar: Review of Its Origin and Development in Twenty Years of National Service* (Gondar, 1975), p. 19.
[434] United States NARA, RG469 UD394, Records of US Foreign Assistance Agencies: Ethiopia - Health 1958-1960 (College Park, MD, 1960).

results of which clearly demonstrated the significant structural challenges in the operation of the nation's new public health network. With a total population of 763,000, Arussi's largest town was the capital Asella, with just over 18,000 inhabitants. Largely rural in nature, the province had one hospital in Asella and three health centres in operation at Ticho, Arba Gugu, and Chilalo. The Haile Selassie I Hospital was built in 1967 with 52 beds, but the reputation of the facility rapidly deteriorated and few patients arrived for treatment. There were 130 members of staff at the hospital, but with no matron or administrative head, the majority of workers were left idle. Further, with just two doctors on staff, one general practitioner and one surgeon, the physicians remained overworked and the quality of services severely suffered. Shoddy construction meant the hospital's infrastructure rapidly deteriorated, while there was no reliable store of essential medicaments. The poor services at the hospital meant patients deliberately avoided the facility, seeking alternative treatments within their own communities. Nowhere is this more evident than in cases of maternal health: while built with a large maternity wing, by 1970 the hospital saw an average of just 170 deliveries per year, despite serving a province of three-quarters of a million inhabitants.[435]

Within Arussi's three health centres, similar capacity problems left the centres poorly utilised and largely inaccessible.[436] Each of the health centres was located along newly-constructed roadways to facilitate easy transport of health workers and supplies, but this left the facilities largely removed from communities themselves. Further, none of the centres had their own vehicle, so health teams remained

[435] S. Lundin, *Survey of Health Facilities of Arussi, 1969-1970* (Asella, 1970), pp. 1-11.

[436] The Swedish aid report estimated the 'accessibility' of the health centres as 15% for Ticho, 17% at Arba Gugu, and 24% at Chilalo. This figure was calculated by estimating the number of people who lived within a 20km radius of the health centre, in addition to those who lived outside this radius but were located along roads with regular traffic that could lead to the health centre. Lundin (1970), pp. 19-21.

isolated, incapable of completing necessary domiciliary visits because villages were clustered in farming areas remote from new road networks.

Maternal and child health services especially suffered, as nurses were poorly engaged with the communities in which they were to serve. Province-wide, Swedish aid estimated that just 1.2% of all births were met with any level of health assistance, but the three health centres' successes in treating mothers varied considerably. In Ticho, just 0.8% of the target group of women from the health centre's catchment area came for the weekly maternal and child health clinic, but in Arba Gugu this figure rose to 3.4%, and to 4.4% in Chilalo.[437] While each figure remains only a fraction of actual mothers to be served, the variation in the percentage of patients treated is notable in demonstrating the considerable differences in the capacity of individual health centres. Not only was Chilalo located in a more accessible location than Ticho, but the health workers employed in the centre were more motivated to complete their work, even with inconsistent medical supplies and virtually no supervision.

The success of a health centre was largely determined by the personalities of the graduates working there, a factor which was, admittedly, challenging for officials to either predict or control. However, the lack of consistent supervision of health centres meant that those teams who poorly managed the health services in their areas would not be replaced, and few faced consequences for their inaction. Further, those teams who were motivated and hard-working remained similarly stilted in their capacity to operate at full capacity because of the neglect among officials to monitor the level of supplies and essential medical stores available within the health centres.

[437] Lundin, *Survey of Health Facilities of Arussi,* pp. 23-24.

In a 1975 follow-up survey of Arussi's health facilities, Swedish aid saw very little improvement in the capacity of services, and the poor reputation of government health projects among Arussi residents remained.[438] The situation in Arussi was symptomatic of the larger challenges facing rural health services in Ethiopia. While US officials confidently described villagers constructing the Kolladuba health centre all 'by themselves,' the majority of communities remained largely cut off from the burgeoning health network, given the chronically low number of centres constructed. In addition, even those who lived in proximity to a health centre remained reluctant to utilise the preventive health services offered. Problems in the planning of health centres carried into their operation, including poor levels of funding and supply chains, and a chronic lack of supervision of health teams' activities. The work of public health in Ethiopia would be a long-term project, necessitating a consistent stream of funding and staff support. Both the American and Ethiopian governments were optimistic in their goals to create the Gondar model of public health for the nation, but the persistent challenges of providing adequate budget lines, health teams, administrative and supervisory structures to support the perpetuation of the empire's modern health networks only escalated with the increasing number of Gondar graduates and health centres constructed. This was a project to be practiced over the *longue durée*, but structural short-sightedness on the part of government officials would leave health facilities and workers largely abandoned, ill-equipped, and poorly monitored.

[438] S. Lundin and R. Tornquist, *Health Services in Arussi 1966 E.C. : A Follow-up Survey and Supplement to CADU Publication No. 57* (Asella, 1975).

While official pitfalls in the administration of Ethiopia's public health network led to poor quality of rural health services, the participation and interest of local communities was equally crucial in determining the overall success of the Gondar project. Officials were cognisant of the need to build off community enthusiasm for modern medicine, but routinely misinterpreted or ignored local health priorities in their quest to build an ideal model of public health for the nation.

This misreading of indigenous priorities was exemplified in a 1959 scouting mission in Molale, a small market town in Shoa Province. Three US officials arrived at Molale to determine if the town was suitable for a health centre. After a three-day journey by both vehicle and mule, the officials were warmly welcomed by the region's governor and town residents, all of whom were described as 'most anxious to have a "hospital."' The governor assured the US envoys that land and labour for the construction of a health facility would be provided without cost, and officials noted with pleasure that Donald Levine, an American anthropologist, had been residing in the community for the last six months. While wary that all Molale residents called the proposed facility a 'hospital' rather than health centre, officials were confident that with the 'proper approach, educational methods, and knowledge of local cultural patterns,' a health team could easily succeed in re-orienting the community towards the principles of preventive medicine. It was noted that Levine had 'accumulated much information' in this regard that would be of 'priceless value' to the health team's work.[439]

It is telling that US officials were assured that with the assistance of an American anthropologist, Ethiopian health workers would be better able to educate Molale

[439] United States NARA, RG469 P247, Records of US Foreign Assistance Agencies: Public Health 1956-1959 (College Park, MD, 1959).

residents towards a proper understanding of preventive health and healing. This demonstrates not only the considerable degree of separation between Gondar graduates and their compatriots, but also the excessive optimism of health officials who, while recognising that local residents may have preconceptions about health, ultimately believed that indigenous ideologies could easily be supplanted by modern ideals. The biggest misunderstanding between Molale residents and officials was in the very name of the facility proposed: in persistently referring to the health centre as a hospital, the community was clearly demonstrating a predilection for curative medicine and the promise of foreign treatments for common illnesses. Officials acknowledged this discrepancy between local expectations and the intended plan to institute a public health model in the town, but felt confident that Gondar graduates would succeed in directing residents' enthusiasm for curative medicine towards the principles of preventive health.

Despite the carefully laid plans of officials, however, community predilection and need for curative services continued to overwhelm health centre staff, preventing Gondar graduates from practicing preventive medicine as intended. Ato Seifu Wolde Abraham, a former health officer, described working at a health centre in Wollo Province that had a catchment area of over 100,000 people. Seifu explained that because of the sheer number of patients, he and his team would provide almost only curative services:

> In our training, we were expected to spend 70% of our time in preventive activities, public health, and 30% of our activities in clinical. But in practice, when you go to the rural areas, that changed - practically 100% curative. I remember what we do in Wollo, in the morning we run the clinical activities, the out-patient department, but the morning extends sometimes up until 2 in the afternoon because you have to see 70 or 80 patients.[440]

[440] Author interview with Ato Seifu Woldeabraham, Addis Ababa, 25 April 2013.

After working at a clinic in Dire Dawa for half a year, another health worker explained a similar endless stream of patients seeking curative treatment: 'They were the most frustrating months I have ever spent. The cycle of infection and reinfection, cure and return, would overwhelm even the patience of Job, and at the close of the daily outpatient clinic, one could not help asking if one really was accomplishing anything.'[441] The Gondar model was deliberately designed to prevent this endless infection cycle in rural Ethiopia, but the persistence of infectious diseases and small number of health workers available meant that the balance of labour continued to be tipped towards curative medicine over preventive health.

As demonstrated in the narratives of the previous chapter, it was largely patients themselves who were responsible for this imbalance of curative and preventive services, as they continued to view newly-constructed health centres as mere outposts of the hospital. In an evaluative survey of the Gondar programme from 1974, the vast majority of health centre patients interviewed cited appreciation for the curative services offered at their local facility, with virtually no respondents mentioning preventive health or education programmes. Further, few patients were able to distinguish between a health centre and a hospital - while there was an understanding that health centres were often more accessible and cheaper than hospitals, there was no differentiation among patients regarding the type of services on offer.[442] Officials had designed the health centres to be the antithesis of the elite hospital institution, preventing rather than curing disease, but this is not how the facilities were viewed by patients. Simon Messing explained that health officers

[441] E.F. Torrey, 'School Health and Community Contacts', *Ethiopian Medical Journal*, vol. 4, no. 4 (July 1966), p. 133.

[442] In attending the health centre's outpatient department, patients were asked to pay a registration fee of 50 cents. They also had to pay for any medications prescribed, usually no more than $2. Curriculum Committee of the Gondar Public Health College, *Evaluative Study on the Relevance of the Public Health College Curriculum: Final Report* (Gondar, 1974), p. 21.

themselves were largely considered an additional '*hakim*,' or doctor, and were routinely asked by patients 'to abandon their schedule of teaching prevention the moment a clinical need arose.'[443]

Prioritising preventive health among Ethiopian mothers

Nowhere was this predilection for cure more pronounced than in the field of maternal and child health, despite its reputation for being the most reliable tool for propagating preventive medicine in Ethiopia. In weekly maternal and child health clinics, health teams would provide ante-natal consultation and instruction on child-rearing and home management. Again, there was significant optimism that mothers' predilections for cures and interest in the consultation of 'experts' would naturally lead to a gentle indoctrination into the principles of preventive health.

In the previous chapter, it was shown how even within Gondar town, community nurses may have succeeded in providing quality care for women at the time of pregnancy and delivery, but the full breadth of preventive medicine, with its demand for improved living standards, was never achieved by consultation with health workers alone. In rural areas, where patient incomes and resources were more limited, there was even less potential for mothers to adopt all necessary preventive health measures taught at weekly clinics.

While Gondar graduates were trained with an optimism about their potential to re-orient the cultural practices of their female patients, numerous additional sources, including historic surveys and interviews I conducted in fieldwork, demonstrate the continued preference of mothers to receive curative services over preventive education. In one survey of mothers' attitudes to the 'Well-Baby Clinic' at the

[443] S.D. Messing, 'Traditional Healing and the New Health Center in Ethiopia', *Conch,* vol. 8, no. 1/2 (1976), p. 56.

Kolladuba health centre from 1966, no respondent claimed that she would bring a healthy child to the clinic for preventive services. While half the women surveyed said they would bring a sick child to the health centre, the author of the study noted that there was a general lack of 'consultation culture.' Women largely relied on their own knowledge on how to feed and rear their children, sometimes receiving instruction from a mother or neighbour. Even then, 'women do not "seek" advice, they "get" it.' The author asserted that in constantly 'instructing and advising the women about matters of maternal and child health,' health centre personnel neglected to consider the actual 'needs and interests of the women.'[444]

The study also demonstrated that even while they had been trained to not separate preventive and curative medicine, especially in child health clinics, health workers perpetuated the curative model of care by first asking a woman what her child's symptoms were, requiring mothers to 'justify their visit to the centre.' Again, this did not allow women to air their own concerns, and simply fed into the common perception that health centres were to cure, not care.[445] One consultant obstetrician working in Addis also lamented the situation, stating that 'in theory, there are already quite a number of rural maternal and child health centres, but in practice, few of them seem to be doing real preventive work because they so often tend to become nothing but sick children's clinics.'[446]

The geographic inaccessibility of health centres also precluded the facilities from acting as effective community education centres. As Yewinshet Hailu, a mother who lived in the peripheral zone of Jinka, had explained in an interview, when her children were ill, 'I took them to the health centre to get help. If there was a chance to

[444] K. Wolde Sillasse, 'Attitudes of Women in Kolla Duba to Well-Baby Clinics', *Journal of Health (Gondar)*, vol. 6 (1966), p. 106.
[445] Ibid., p. 108.
[446] Y. Larsson et al., 'The Significance of Mother and Child Health in Ethiopia Today: A Review', *Ethiopian Medical Journal*, vol. 8, no. 2 (1970), p. 96.

go to the centre, they would give us advice and treatment. But the chance to see them was very rare, because there was no transportation and we lived far from the health centre, so we mostly relied on our own care at home with family members.'[447]

While health centres were typically built in towns of 2,500-4,000 people, they were meant to serve a catchment area that could reach several hundred thousands of residents. In cases of severe distress, patients like Yewinshet would arrive at the health centre from far distances in the hope of receiving cures. Such patients would swiftly inundate the health centre with their demands for treatment, and the possibility of practicing consistent education programmes that promoted preventive health became unrealistic. After describing her long journeys to the health centre in the case of severe child illness, Yewinshet told me that in her last pregnancy, she gave birth to twins. She took them to the health centre for immunisations, and received instruction on proper nutritional care for the children as they grew older. However, Yewinshet had given birth to the twins in a season of severe drought, and explained how challenging it was to care for the infants in this time of limited resources. Yewinshet received the necessary preventive health education prescribed within the Gondar model of maternal and child health, but the limitations in her material circumstances rendered the instruction irrelevant. Similar to the study of the well-baby clinic at Kolladuba, the actual needs and concerns of Yewinshet were poorly heeded, and health centre services were largely inadequate in treating the variety of health and nutritional problems experienced by her family.

[447] Author interview with Broukinet Mesfin, Jinka, 14 May 2013.

Not only did preventive health instruction often fall short in addressing the actual needs of patients, but the persistent emphasis on preventive health over curative treatment in health centres often left the facilities ill-equipped to treat severe health crises and illness. In the field of maternal health, the majority of births were normal and conducted in the home with the assistance of community nurses. However, because communities continued to perceive health centres as hospital outposts, cases of complicated deliveries were consistently brought to health teams, despite graduates' lack of capacity to manage serious obstetric crises. In a 1974 evaluative survey of Gondar graduates, respondents were unanimous in stating that despite receiving minimal practice hours in the field of obstetrics, health teams were most consistently confronted with medical emergencies at the time of labour and delivery.[448] One practicing community nurse stated that 'she did not feel quite secure in her knowledge of midwifery,' and doubted her ability to adequately treat women at times of birth complication.[449]

In an interview with Ato Amsalu Feleke, a former health officer, he admitted that the most dreaded cases at his health centre were women in childbirth, because he had so few tools or medicaments to assist parturients at the time of complication. In his first assignment at a remote health centre in Wollega, Ato Amsalu narrated the memorable case of a woman who presented with a dead foetus and puerperal infection after four days of unassisted labour:

> I told the family that for such cases they had to be referred to the hospital. But to go to the hospital, it takes two days, so they couldn't do it. So they were at

[448] Curriculum Committee of the Public Health College, *Evaluative Study on the Relevance of the Public Health College*, p. 22.
[449] United States NARA, RG469 P247 (College Park, MD, 1959).

> the health centre and said to me, "just kill her." Because it was the highlands, they had to walk through the mountains, and so they just said "kill her." I remember at that time, I told my health assistant, what should we do? So we discussed it. We said, let's save the woman, the baby is already dead… But what could we do? We were in a clinic! We had no tools. No forceps and the like. So I started around 8 in the night and I finished around the morning. We give her a high dose of antibiotic with IV fluid, she was semi-conscious. We took out the foetus and placenta, and finally she stayed for three days. And after three days she became conscious.[450]

Amsalu explained how critical it was for him to save the woman, or else the reputation of the health centre would be compromised and no further patients would come for treatment. His story also narrates several features of rural obstetric care in Ethiopia at the time: not only were communities often fatalistic about birth complications because of the inaccessibility of reliable medical treatment, but health centres themselves were typically not equipped for anything more than normal delivery. With their primary purpose to provide basic, community health services, health centres were meant to help care for patients and prevent medical complications through environmental and social measures. Providing sound ante-natal services, high-risk pregnancies were to be identified and complicated deliveries were to be referred to provincial hospitals for treatment. As Amsalu's experience demonstrates, however, this was largely impractical for communities who lived far distances from hospital facilities. In the case of obstetrics, emergencies like obstructed labour or uterine rupture can happen at random, even in women who demonstrate no predispositions for such crises in pregnancy. In such instances, health centres would often fall severely short of patients' expectations to cure. Amsalu had managed to save the woman's life, but at other times, deaths would inevitably occur.

In their survey of health facilities in Arussi province, Swedish aid lamented that 'only one health centre and a few mission clinics have the capacity for instrumental

[450] Author interview with Ato Amsalu Feleke, Addis Ababa, 10 February 2013.

delivery like vacuum extraction.' The authors noted that this 'sad situation' had led to an 'unnecessary high rate of maternal deaths' in the province, despite the presence of a health network.[451] At the same time, even if a health centre had basic instruments like forceps or vacuum extractors on hand, this was still not enough to prevent a large number of maternal and infant deaths, as explained by another former health officer, Dr. Hailu Yeneneh:

> Women would come when they would have, for example, prolonged labour. We'd try to help - if you can see the head is low and the presentation is cephalic, then we did forceps delivery. Otherwise, if it was foeto-pelvic disproportion, then we'd refer them to the nearby hospital - a six or seven hour journey. Some of them would die. Some of them would say we are condemned to death and go back home, and try rubbing the abdomen [to get the baby out]. It was a disaster, that aspect of the health work was really bad. Sometimes we had to do destructive delivery, for example - once we know the foetus is dead, we do the craniotomy[452] to save the mother. It was the only way. We referred critical cases, but women ended up dying. Most of the presentations were normal, and in fact even among those - most of them are cephalic, a few are breech delivery - it's a little bit complicated, but you can do it vaginally. But there are some who need surgery - of course we would advise them to be close-by, but we didn't push, because people could not afford the travel costs.[453]

Again, Hailu's story exemplifies the struggles in providing sound obstetric care at the rural health centre. Though certain basic interventions could be performed at the facility - forceps delivery, craniotomy - transfer to hospital for complicated delivery remained routine. While Hailu was able to cope with many challenging deliveries, he admits that in some cases of birth complication, he had to refer to his small library of gynaecology textbooks at the health centre, demonstrating a clear gap in health workers' obstetrics training. This problem of inadequate training

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[451] Lundin, *Survey of Health Services*, p. 6.

[452] The term 'craniotomy' is used in this instance to indicate the surgical removal of the foetus through the birth canal. The head of the foetus is severed, crushed, and then manually removed. Without the large obstruction of the head, the rest of the body is then delivered.

[453] Author interview with Dr. Hailu Yeneneh, Addis Ababa, 2 March 2013.

meant that some cases were misdiagnosed altogether, and patients could succumb to unnecessary deaths.

Pat Turton's notebook from the Jinka health centre in the early 1970s described one case when the community nurse unnecessarily referred a woman in labour, leading to the infant's death. The woman was primiparous and arrived at the health centre in a state of arrested delivery - the baby's head would not descend into the birth canal. The community nurse diagnosed the woman as having a ruptured uterus, and immediately persuaded the family to transfer her by plane to the nearest hospital in Arba Minch. At $75,[454] the cost of the air transfer was much too dear for the family, so they set out to collect the funds by soliciting emergency donations from homes surrounding the health centre. On arrival at the hospital, it was clear that the woman's uterus had not been ruptured, and the baby was able to be delivered vaginally. Because of the delay, however, the baby died from asphyxia.

The fact that health centres were not able to adequately treat birth complications led many women to doubt the capability of newly-arrived health workers altogether, preferring home-based models of care. As Dagmawit Workneh explained in an interview, she 'never had the help of doctors or nurses. All my births were at home, with the help of my neighbour who is more experienced even than the doctors and nurses. She knows how to touch the belly and decide the position of the baby. She tells me when I will give birth.'[455] In some instances, the youth and lack of personal experience on the part of community nurses was also seen as an impediment to their practice. As Simon Messing explained: 'people usually treated the community nurse

[454] Approx. $630 in today's dollars.
[455] Author interview with Dagmawit Workneh, Addis Ababa, Woreda 7 (Addis Ketema), 8 May 2013.

as another type of midwife, and if she herself had not had a baby, her instructions were merely listened to politely but regarded as theoretical and not followed.'[456]

Still, the level of care and participation of patients would vary considerably depending on the individual capacity of the health worker. Sister Yewagenesh Mesfin explained that when she was sent to her first health centre, she was able to gain the trust of the women and attended nearly all the births within the immediate health centre area. Yewagenesh concentrated on the women who lived within close proximity of the health centre, and encouraged home birthing. Admitting that her services were inaccessible to women who lived farther away, Yewagenesh explained that expecting women to travel for two to three days to receive assistance in labour was 'unrealistic.' Even those women who lived nearby the health centre were rarely willing to come to the facility to give birth, and Yewagenesh admitted that women laboured best 'in their own homes, in their own environment.' She would arrive at the home with a birth kit that included soap, gauze, sutures, a razor blade, and ergometrine injections to stop haemorrhaging.

While Yewagenesh treated all the women whom she had seen in ante-natal consultations, she would arrive at the house of any woman in labour, whether or not the woman had sought the care of the health centre during pregnancy. Yewagenesh described treating one woman who had laboured alone, but had a retained placenta. The woman had never been to the health centre, and Yewagenesh arrived after the baby had been delivered and assisted the woman in completing the third stage of labour. Massaging the abdomen and injecting the woman with ergometrine, the placenta was loosed, and the woman was immediately grateful to Yewagenesh for her care. Yewagenesh explained that her own nature as a supportive and kind person was essential in treating women and having them accept her services at the

[456] Messing, *The Highland-Plateau Amhara of Ethiopia*, p. 56.

time of pregnancy and delivery. She said that largely patients were 'happy to come to me,' and that they had 'become like relatives. I was not a health worker to them, but a mother, a friend, a daughter. And they accepted me!' Yewagenesh loved her work, and loved her patients: 'I support them, I go to their homes, I ask them what happened to them. I give love for them.'[457]

Yewagenesh's care and devotion helped her provide sound maternal support for numerous patients, but her model of service was still limited to the role of competent supporter and assistant in times of normal delivery. The community nurse training emphasised this caring role, but ultimately, many patients still looked to nurses like Yewagenesh to provide curative treatment in times of obstetric distress. Yewagenesh explained one case of obstructed labour where the woman died under her care because of her incapacity to treat the woman with necessary surgical intervention. The woman's pelvis was too narrow for the child to emerge, and while Yewagenesh knew that to save the woman they would have to complete a rudimentary craniotomy on the foetus, this would kill the child whose heart beat could still be heard. She would not perform the live craniotomy, and both mother and child eventually died from the protracted labour experience.

While such deaths did remain the exception, there was a tangible need for curative treatment in obstetrics in rural Ethiopia at the time. The interviews in the previous chapter demonstrated the widespread frustration of women who had no access to the medical cures they hoped would arrive with the construction of the health centre. The most urgent health need for mothers in rural Ethiopia was curative treatment at the time of complicated delivery. While normal deliveries could progress with routine progress in the home setting, situations of obstructed and prolonged labour, uterine rupture, or retained placenta required medical

[457] Author interview with Sister Yewagenesh Mesfin, Addis Ababa, 25 April 2013.

consultation unavailable to the majority of rural residents. With the arrival of the health centre, communities were eager to receive the curative treatments promised by the 'hospital' and the '*hakim*' who worked there, but many were left disappointed by the poorly equipped centres that were designed to prevent, not cure disease. Community nurses and health officers were trained in matters of maternal and child health that related primarily to the prevention of morbidity through sound ante-natal care and better nutrition and child-rearing practices. For many patients, this was simply insufficient to treat their actual needs: birth crises were spontaneous and could not all be prevented or predicted by ante-natal consultation, while material poverty largely restricted mothers from heeding the advice of workers demanding they provide better nutrition for their children.

Further, the fact that the vast majority of Ethiopians lived in areas remote from the health centres meant traveling to the facility to receive mere instruction on preventive health measures was impractical - patients would instead wait to make the journey until a severe disease left them with no other option for treatment. In the meantime, indigenous cures were used, and the multiplicity of medical systems in Ethiopia continued. As one health worker in Arussi explained, 'I did not see a single case coming for treatment which had not been treated first [by a *wogesha*].' The inaccessibility of cures often left communities bereft and fatalistic in the face of disease, especially cases of obstetric emergency. The same Arussi health worker wrote that 'one sometimes gets the impression that the only reason for [patients'] coming at this stage is for the relatives who accompany the patient to feel themselves absolved of responsibility.'[458]

Because the Gondar model for maternal and child health was fixated on correcting practices related to domestic management in the hopes of modernising

[458] Lundin, *Survey of Health Facilities*, p. 6.

communities and promoting national development, the actual priorities and needs of women struggling under the burdens of poverty and maternal morbidities were largely ignored. With health centres designed to educate, not cure mothers, cases of severe medical distress were to be referred to distant hospitals in provincial capitals and urban zones. However, this network of care was completely impractical given the infrastructural limitations of Ethiopia at the time, and maternal deaths continued to occur at a high rate, despite the presence of Gondar health teams.

Problems of livelihood

There was an additional problem with the Gondar approach: the fundamental blindness to livelihood restrictions in Ethiopian communities meant that the preventive health model could not advance unless serious structural issues were first addressed. The Well-Baby Clinics in rural health centres were designed to co-opt women into the state's preventive health mission: women attending the clinics would learn how to alter domestic practices related to food preparation, sanitation, and child-rearing to ensure that they modernised their homes and prevented unnecessary cycles of disease. Not only was this focus on preventive health wholly inadequate given the curative needs of rural Ethiopian women, but such instruction was simply impractical within the parameters of existing livelihoods.

In 1973, Simon Messing published a critique of the Gondar project which asserted that blindly expecting communities to adhere to health centre instruction, without considering livelihood constraints, was unrealistic and had left the project largely ineffective:

> Living standards and cash incomes are so low for the large majority that urgings by health officers to expend money for soap or for fuel to boil unsafe water go unheeded. For example, a landless peasant who arrives at the

> outskirts of town and asks for the use of a small plot of land to feed his family, has to agree to work the landlord's land as much as five times the size of the little plot. This is a frequent occurrence… if the peasant hires out as a night watchman, his monthly income there may be as little as $4; this has to cover food and clothing for himself and his family if he has brought them to town or has to send them money. Hence, it is uneconomical for him spend 50 US cents for a wooden latrine cover as urged by the Health Officer. It is similarly an uneconomical expenditure for a divorced peasant women who moves to town to earn 4 cents per glass of barley beer which she brews in the thatched hut on the outskirts of town and for which her monthly rent is $3.[459]

Dennis Carlson similarly noted how the constraints of rural livelihoods precluded community participation in preventive health measures, asserting that 'people who have extremely little risk capital are unlikely to deviate from the tested ways of survival.'[460] Indeed, 'this fundamental insecurity and marginality [of peasant life] made rural farmers conservative. They did not feel that their precarious position allowed any risk-taking behaviour that modernisers might propose.'[461] Messing argued that considering the majority of rural residents in Ethiopia lived a subsistence existence, it was only natural to 'discount health.' Messing asserted that 'discretionary resources of time, energy and money are not available to the chronically poor majority who barely subsist. . . . the poorer they are, the higher the discount rate. In these cases, preventive health behaviour does not bring sufficient payoff to be worthwhile, particularly if the costs incurred are immediate.' He decried the naivety of the health centre project 'to improve health attitudes and practices,' noting that problems in health could not be addressed in a vertical fashion, but must be seen as part of the 'whole' problem of rural Ethiopian life.

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[459] S.D. Messing, 'Discounting Health: The Issue of Subsistence and Care in an Undeveloped Country', *Social Science & Medicine*, vol. 7, no. 11 (November 1973), p. 914.

[460] D.G. Carlson, 'Eucalyptus Trees, Tin Roofs, and Intra-Uterine Devices: Indices of Modernization in a Traditional Rural Ethiopian Community', in *Proceedings of the First U.S. Conference on Ethiopian Studies* (East Lansing, 1973).

[461] A.J. Carlson and D.M. Carlson, *Kossoye: A Village Life in Ethiopia* (Trenton, NJ, 2009), p. 14.

Messing believed that before any changes in health-seeking behaviour could occur, this 'subsistence anxiety needs to be allayed.'[462]

Messing's arguments were largely correct: it was the more economically stable sectors of Ethiopian communities that were best able to benefit from health centre activities. This was evident in my own interviews, as those members of Ethiopian society who were able to access some other benefit of modern life in education or profession were also more likely to utilise modern medical services. There was an implicit link then between medicine and modernity, even within impoverished rural areas, and young Ethiopians were eager to align themselves with modern life, both in projecting a higher economic status and ability to access modern medical practitioners. A 1975 survey of rural Ethiopians asked what the 'best attribute' of modernisation had been, with the most common responses being manufactured goods, good clothing, and cleanliness.[463] Sanitation, a founding principle of preventive health, was largely linked with other outward appearances of wealth and economic stability, including Western clothing.

In her 1970 study of spirit possession in Ethiopia, A.L. Morton found a striking desire among informants to assert themselves as modern because of both their wealth and access to medicine. In interviewing a community of soldiers' wives, Morton noted that all the women wore modern clothing and had a steady diet of meat. Morton wrote that these women 'saw themselves, on the whole, as modern, forward-looking, though they were almost universally illiterate, unschooled, had not held jobs, and did not necessarily originally come from town.'[464] Because Morton was foreign herself, the women immediately associated her with modern medicine,

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[462] Messing, *Discounting Health,* p. 914.
[463] U.S. Agency for International Development, *Medical Survey: Ethiopia* (Addis Ababa, 1976).
[464] A.L. Morton, 'Some Aspects of Spirit Possession in Ethiopia' (London School of Economics Ph.D thesis, 1973).

as 'the only other foreigner with whom my informants had had any contact at all had been a doctor.'[465] Morton explained how the women 'were eager to show me how modern they were, and at the same time, to complain to me about "my" doctors and "my" medicine, and found this a more interesting subject than their own doctors and their own medicine.'[466] Morton was conducting fieldwork on *Zar* and other forms of spirit possession, but swiftly realised that she had to choose her informants carefully, as any member of the burgeoning middle class was reluctant to discuss any type of healing apart from the Western-style clinic and hospital. Most of her informants' experiences at the medical institutions were negative, and the women felt a significant degree of prestige in complaining about '*yeferenji medihanet'* (foreigners' medicine) because it proved their intimate knowledge with Western lifestyles.

The trouble with peasants: Imperial neglect and the continuation of land tenure

In his study of the demise of Haile Selassie, Patrick Gilkes noted that the emperor entirely 'misread the needs of the country' by viewing modernisation in superficial 'terms of increasing bureaucracy, schools built and arms provided.'[467] Education curricula worked largely to teach students 'how to become bureaucrats,' despite the fact that 95% of the country's population remained engaged in agriculture.[468] Rural life was poorly understood by officials, and elite students became increasingly alienated from the lived realities of the majority of the population. This ensured that programmes designed for the poor, especially the Gondar model of health,

[465] Morton, *Some Aspects of Spirit Possession,* p. 159.
[466] Morton, *Some Aspects of Spirit Possession,* p. 160.
[467] P. Gilkes, *The Dying Lion: Feudalism and Modernization in Ethiopia* (London, 1975), p. 97.
[468] Gilkes, *The Dying Lion,* p. 95.

fundamentally ignored the structural forces which dictated rural economic life, prohibiting 'peasant innovation.'

With the ascendancy of the Derg, the systemic nature of rural poverty in Ethiopia was addressed, and commentators criticised the previous regime's deliberate misreading of 'traditional' ways of life. In his study on the social factors driving the rise of the Derg, John Cohen noted that under Haile Selassie, the 'peasant' was seen as 'a prisoner of his religion, culture and history. As a result of these forces, he is said to be uneducated, lazy, illiterate, suspicious of innovation and differently motivated from commercial farmers in Ethiopia or progressive peasants in other third world countries.' However, similar to the arguments of Carlson and Messing above, Cohen asserted that 'the peasant is wary of induced development primarily when its risks are too great and its rewards small or negative; or in other words, when his poverty leaves him absolutely no margin for risk-taking, and when the fruits of growth are not fully his to reap.'[469]

Imperial policies characterised subsistence farmers as independent actors who determined their own fate and economic well-being, and rural residents were consistently blamed for not innovating their modes of living because of their inflexible backwardness. Cohen asserted that this was a grossly false generalisation of the nation's farmers, considering the numerous restrictions placed on their economic progression, most notably the land tenure system. The complex significance of land tenure in Ethiopia's agricultural economy has been explored extensively by scholars elsewhere, especially Donald Crummey and Allen Hoben.[470]

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[469] J. Cohen, *Land and Peasants in Imperial Ethiopia: The Social Background to a Revolution* (Assen, 1975), p. 16.

[470] D. Crummey, 'Women, Property, and Litigation among the Bagemder Amhara, 1750s to 1850s', in M.J. Hay and M. Wright (eds.), *African Women and the Law: Historical Perspectives* (Boston, 1982), pp. 19–32.; A. Hoben, *Land Tenure among the Amhara of Ethiopia; the Dynamics of Cognatic Descent* (Chicago, 1973).

While there is little space to explore the considerable variability and meanings of land tenure in this thesis, it is necessary to address the fact that under the traditional land ownership structure in Ethiopia, virtually all farmers were prohibited from selling or owning the plots they farmed as they belonged either to hereditary, communal systems of ownership (*rist*), or outright tenancy agreements that could not be altered (*gult*). In both systems, any surplus agricultural products derived from the land were not the property of the farmer himself, discouraging expansion, mechanisation, or innovation in farming techniques among the majority of rural residents. In ignoring this structural impediment to modernisation in rural areas, Cohen argued that Haile Selassie had 'essentialised the nation and constructed a façade of modernisation, without changing the land tenure system in any major way.'[471]

With his 1944 Land Tax Proclamation, Haile Selassie had made a superficial attempt to alter the servitude of the nation's farmers, enacting a programme of regressive taxation on all landowners. However, the Parliament allowed landowners to determine their own tax rate, and whole-scale evasion was common. In the following decades, the emperor made no further efforts to actively dismantle the land tenure system, despite his continued speeches proclaiming an interest in the development and improving living standards for rural Ethiopians.

John Harbeson wrote that 'observers of the pre-revolutionary Ethiopian order differ on the question of whether the emperor himself wanted to support fundamental changes but was politically unable to do so, or whether he simply dispensed inexpensive rhetoric to cover his own essential conservatism.'[472] It was clear that Haile Selassie was invested in creating a modern infrastructure for his

[471] Cohen, *Land and Peasants in Imperial Ethiopia,* p. 15.
[472] J.W. Harbeson, 'Revolution and Rural Development in Ethiopia', in *Rural Africana: Current Research in the Social Sciences* (East Lansing, Fall 1975), p. 1.

empire in the building of schools and hospitals. He assumed that with such a network of buildings in place, Ethiopians would naturally conform to modern modes of living, and if they did not, it was their own fault for relying on backward tradition. Cohen has explained that this 'stereotype of the peasant as fatalistic, culture-bound and resistant to change' helped characterise rural Ethiopians as uninterested in increasing their production capacity or improving their economic status. Instead, the fact remained that all Ethiopians continued to work under 'economic and power realities inherited from Ethiopian feudalism and enforced through the present land tenure systems.'[473]

There were implicit structural limitations to agricultural innovation for the majority of Ethiopia's rural population. Any measures to modernise rural life in Ethiopia, whether in the mechanisation of farming or the provision of preventive health education, served to benefit a small sector of the society, mostly landowners and bureaucrats. It was also this elite sector of society that benefitted most fully from the development of public health systems in the Ethiopian countryside. With a higher degree of flexibility in their incomes, middle-class Ethiopians were keen to align themselves with the most prominent signifiers of modernity, including improved sanitation and diet. This was a deliberate choice of a small elite whose livelihoods enabled innovation, while the majority of rural residents remained fixed in cycles of crisis and cure, largely prohibited from adopting the principles of preventive medicine by the constraints of material poverty.

[473] Cohen, *Land and Peasants in Imperial Ethiopia*, p. 2.

Had Haile Selassie's regime addressed the structural issues perpetuating poverty in rural areas, improvements in health could have been more widespread. Health centres were largely ineffective in promoting alterations to living standards without an additional degree of economic development. Further, improvements in economic status often succeeded in securing a higher degree of health even without the presence of a Gondar health team.

In 1967, Julius Prince headed a team of experts to conduct a 'Demonstration and Evaluation' study of the health centre approach, attempting to assess the actual impact of the Gondar model of health on rural Ethiopian communities. In their initial report, Prince and colleagues noted that the only quantifiable change they could measure in health centre communities was a reduction in the number of intestinal parasites among residents. At the same time, Prince noted that in the study's control communities (i.e. communities that had never had a health centre or Gondar health team working with the population), there was an identical reduction in the number of parasitic infections if the control town had access to a clean water supply. In other words, the level of impact of a health centre could be achieved solely through structural improvements to town life, regardless of the presence of public health instruction. Prince argued that in towns with health centres, attitudes towards health may have 'improved,' but practices remained the same: 'more people believe boiling water is a good idea, but few do.' The reason was again linked to livelihood constraints: 'fuel was expensive, and the people didn't have suitable containers.'[474]

[474] J.S. Prince, 'Demonstration and Evaluation Project: Ethiopian Health Centre Program Its Impact on Community Health in Three Towns', *Ethiopian Medical Journal,* vol. 5, no. 3 Conference Supplement - 3rd Annual Meeting Ethiopian Medical Association (July 1967).

The Gondar model of health misunderstood the principles of rural development, focusing solely on education without giving the population the means to actively appropriate what had been taught. Health centres succeeded in providing limited curative services, but could not develop communities as intended, unless the town experienced simultaneous improvements in the local economy. If the Ministry of Public Health had invested in providing Ethiopian towns with better water and sanitation networks, community health could have been achieved to the same degree as building and manning a health centre. In consistently blaming rural residents for their lack of innovation and adherence to modern modes of living, public health policies misdirected the onus of development to individuals, not the repressive economy and social structures in which they were operating.

The case for family planning

As demonstrated throughout this thesis, Haile Selassie's model of national development through medicine had rested in part on the shoulders of Ethiopian women. Tasked with rearing a new generation of modern Ethiopian children and altering living customs in a way that would secure a greater degree of 'civilisation' for the empire, women were repeatedly co-opted into national modernisation schemes, either in practicing medicine or attending a Well-Baby Clinic. The prominent place of maternal and child health in national health policies ensured that women were consistently targeted by health practitioners to become the vanguards of development for Ethiopia, using their intrinsic roles as mothers and domestic labourers to navigate the empire away from traditionalism and into modernity.

By the end of the imperial regime, however, it had become increasingly obvious that the state's emphasis on maternal health had entirely misread the position of

women in society, relying on generalised notions of a woman's role to reproduce and nurture. In privileging the reproductive role of women, maternal health under the emperor had largely neglected the provision of contraceptive care. In her study of maternal mortality in Addis Ababa, Barbara Kwast demonstrated that the main cause of maternal death in the city was un-safe abortion.[475] Maternal health services had expanded pregnancy and labour care, but the over-emphasis on a woman's reproductive role in Ethiopia left little room for services which ensured a woman could prevent pregnancy.

Kwast's study showed how students and domestic labourers were disproportionately affected by post-abortal sepsis, demonstrating the particular danger in neglecting reproductive health services for marginalised women.[476] There was deep shame associated with pregnancy outside of marriage, while lower-class women had little power to reject sexual advances of their employers. Kwast demonstrates that half of all pregnancies in Addis were unwanted, but women had little recourse for assistance in preventing pregnancy at the city's health institutions, largely because maternal health policies to date had worked off the belief that all women were interested in achieving early and repeated pregnancies.

By the mid-1970s, childbirth remained the principal cause of death and illness for women of reproductive age in Ethiopia, signifying the considerable gaps between official rhetoric on the place of women in securing the health and modernity of Ethiopia, and the actual position of women in navigating poorly-equipped medical facilities for their reproductive needs.[477] Septic infection from unsafe abortion was the highest killer of women of child-bearing age, and a full quarter of all maternal deaths occurred among students and maids. Nearly three-quarters of abortions were

[475] Kwast, *Maternal Mortality in Addis Ababa*.
[476] Ibid., p. 41.
[477] Medical Faculty Obstetrics Department, *Clinical Report*, p. 7.

performed by women at home, either by themselves or a neighbour, but the considerable risk to these women continued to be ignored by state policy.[478]

Maternal health was still equated with safe childbirth and child-rearing for married women, despite the statistical evidence demonstrating that there was a great need for actual pregnancy prevention, especially among single women. Franz Rosa admitted in 1971 that 'today many hospitals are being flooded with septic and traumatic, unqualified abortions. Many women choose to interrupt their pregnancies, with jeopardy to their own lives, rather than undergo the subtler risks and consequences of further unwanted pregnancies.'[479] The legacy of maternal health programming remained, however, fixed upon a rhetoric of national development and the mothers' role in rearing a new generation for an improved society, and marginalised women found little use or welcome in attending maternal health clinics. Kwast's survey showed that non-attendance of ante-natal care was directly correlated to poor birth outcomes, including maternal death, and that it was largely poor and single women who did not attend preventive clinics at the time of pregnancy.[480]

Contending with official neglect: the founding of the Family Guidance Association

The history of family planning in Ethiopia began with the foundation of the 'Family Guidance Association' in 1963. The FGA, as it came to be known, was formed with the assistance of the international Pathfinder Fund and opened its first clinic in Addis Ababa in 1966. The formation of FGA was highly controversial, however, and the association was not officially registered with the government until

[478] Kwast, *Maternal Mortality in Addis Ababa*, p. 88.
[479] WHO Archive, F. Rosa, *MCH/71.5 Organization of Family Planning* (Geneva, 1971), p. 2.
[480] Kwast, *Maternal Mortality in Addis Ababa*, p. 100.

1974. The ten-year delay in registering the FGA demonstrates the fraught political environment surrounding the notion of contraceptive care in Haile Selassie's Ethiopia.

In an interview, Tsehai Yetbarek, one of the founding members of the FGA, explained how it was Haile Selassie's specific instruction to use the term 'family guidance' instead of 'family planning,' as it sounded less invasive, linking proposed services to more than just population control.[481] In an FGA pamphlet, they argued that 'guidance' is indeed a more 'comprehensive' term, encompassing both contraception and fertility treatments, as opposed to the restrictive definition of 'family planning.'[482]

The stated aims of the FGA were carefully worded so as to emphasise that the group was not against reproduction, and would not actively promote the need to limit family size, writing that 'the objectives of the Association emanate from its fundamental belief that the family should be a source of happiness, health and welfare, and hence deserves the best possible assistance to achieve these requirements.' Services would help 'protect the health of mothers and children' alike, providing 'guidance and counselling for families in order to help them make a rational choice about the size of their families, as well as help childless couples by providing corrective medical aid.'[483]

While this caution was necessary from a legal standpoint, as imperial law prohibited the advertisement or display of contraceptive services in Ethiopia, it also helped assuage the considerable anxiety about family planning within the predominant Ethiopian Orthodox church. Priests were renowned for speaking

[481] Author interview with Tsehai Yetbarek, Addis Ababa, 19 April 2013.
[482] Family Guidance Association of Ethiopia, *History of the Association, 1969-1975* (Addis Ababa, 1975), p. 25.
[483] Ibid., p. 10.

against the practice of contraception, and devoted women would often abhor the idea of seeking family planning for religious reasons. Introducing family planning into Ethiopia was therefore a delicate uphill battle, contesting both official neglect and religious adversaries.

The state against family planning

From the state's perspective, throughout the duration of Haile Selassie's rule, there was little concern for the issue of population control. Indeed, Ethiopia was viewed as a vast and underpopulated land that would only benefit from rapid reproduction. As stated in the Second Five Year Development Plan, 'such a rapid growth of population is encouraging both from the point of view of the availability of the labour force and the extension of the domestic market, particularly since Ethiopia is a scarcely settled country.'[484] Five years later, the government reiterated its commitment to rapid population growth, stating that 'the presence of large, rich and uncultivated tracts of land throughout the country is sufficient proof' of the need for greater reproduction, as 'there is no shortage of land and an Ethiopian population is very necessary to develop the country's minerals, soils, water, and energy resources.'[485]

In 1972, Akilu Mewaee, member of the Ethiopian Nutrition Institute, wrote the essay 'Is Family Planning a Priority?' in which he argued that the promotion of contraception was inappropriate for the needs of the Ethiopian population, arguing that family planning would only serve to 'distract the national attention from the initiation of appropriate ways and means to increase the well-being of the majority

[484] Imperial Ethiopian Government, *Third Five Year Development Plan*, p. 58.
[485] Ibid.

of Ethiopians.'[486] Akilu argued that in Ethiopia, 'where the majority of the people are preoccupied with mere physical survival, and where the economic and social infrastructure are not yet developed, the introduction of a national family planning would be of no avail.'[487]

The argument prevailed that the nation of Ethiopia first needed basic development, and could then concentrate on more cosmetic concerns like contraceptive care. At the first annual Ethiopian Medical Association Meeting in 1963, Cecily Williams herself weighed in on the issue of family planning for Ethiopia, once more challenging the need for population control when basic development has not yet been achieved. Williams argued that 'it was better to work for gradually improving health standards and reducing mortality rates. More food, better and cheaper contraceptives, are to my thinking of minor importance. The major effects should go into teaching parents respect for child life, confidence in children's survival, and pride in their future.'[488]

Having attended the meeting, Dennis Carlson explained the significant influence of Williams' opinion on Ethiopian medical personnel: 'with this statement from a famous public health expert, it was understandable that medical professionals felt justified in blocking and resisting efforts to offer family planning as part of government health services.'[489] As head of the WHO's maternal and child health division, Williams' rhetoric was crucial in the development of Ethiopia's public health campaigns which persisted in their focus on the social re-education of women to adopt modern ideals of childcare, ignoring the pragmatic constraints on families living in poverty.

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[486] Ethiopian Nutrition Institute, *On Family Planning in Ethiopia* (Addis Ababa, 1972).
[487] Ibid., p. 82.
[488] Carlson and Carlson, *Kossoye*, p. 93.
[489] Ibid., p. 93.

In Akilu's essay on family planning, he acknowledged the challenges of subsistence living for the majority of the Ethiopian population, but did not equate the burdens of bearing large numbers of children with the continued impoverishment of families. Akilu and William's rhetoric asserted that family planning was a mere luxury that could be considered by highly-developed societies, but both commentators neglected the economic and health benefits of limiting reproduction, especially for women themselves. There was a prevailing notion in Ethiopia that large families helped parents secure immediate sources of labour and future support in old age, and it was argued that 'delivering many children is more of a necessity and less of a random behaviour.'[490]

While there is an indisputable logic to having children to support the family economy, there is additional evidence to show how too many children only proved to over-burden families, aside from presenting considerable health risks to the mother. In a study of women in Golja village in Arussi province, while 62% of women said there was an advantage to having many children to ensure security in old-age, 76% argued that having many children was a disadvantage to families not only because of the physical weakness it caused in the mother, but also the difficulty in providing the large family with the 'basic needs of life.'[491]

Aside from rudimentary forms of abortion, contraception was generally unavailable to women in Ethiopian custom, and families were typically fatalistic about the number of children they would have. Carlson explained that when he attempted to introduce family planning services into the village of Kossoye, near Gondar, he would ask women how many children they wanted. The immediate response would usually be 'however many God wants to give me.' When Carlson

[490] P.D. Balsvick, *Social Survey and Kap Study of Mothers Living in Lideta, Gullele and Yeka Areas in Addis Ababa* (Addis Ababa, 1970), p. 3.
[491] G. Arhammar, *KAP Study of Mothers in Golja (Ketar Genet)* (Asella, 1969), p. 8.

rephrased the question to ask how many children a woman would *choose* to deliver, at one point a respondent 'nearly exploded' with the declaration, 'I don't want more, I have enough already. We are a poor family with many problems. We can't afford to support even the children we have.'[492]

Resistance to the expansion of contraceptive care

There was a clear need for family planning among Ethiopian women, and despite official reluctance to promote contraception or enact a national policy on reproductive health, the Family Guidance Association did move forward in its efforts to improve access to contraceptive services across the nation. By 1974, the Association had helped establish 146 'Well-Women Clinics' within health centres and hospitals throughout Ethiopia, with a specific aim to target youth and remove any prejudices within communities against the practice of contraception. The Association also had an active training programme to sensitise health workers on family planning methods. Trainees would undergo the training voluntarily, expressing a keen interest in learning about contraception 'because they felt that they were tackling the felt need of the people in their respective communities.'[493] In expanding the opportunity to limit family size, the Association felt confident that 'an unprecedented demand for services has been created' in Ethiopia, and public conversations were increasingly open to the value of contraception. The rapid expansion of contraception clinics in Ethiopia proved 'in no uncertain terms, that

[492] Carlson and Carlson, *Kossoye*, p. 95.
[493] United States NARA, RG286 P548, Records of the Agency for International Development: FP/POP Training (College Park, M.D., 1976).

family planning service becomes a felt need whenever and wherever the services are provided.'[494]

Still, even with the expansion of Well-Women Clinics in Ethiopia, opposition to contraception continued, both among officials and within communities themselves. A survey of women at the Kolladuba health centre from 1971 saw an equal split among those who had positive and negative attitudes towards family planning.[495] There was even debate among officials if improving access to family planning services had only worked to increase abortion rates, 'since when women have contraceptive failures after being convinced of the value of family planning, they seek abortion as a result of this.'[496]

Dennis Carlson argued that health professionals themselves had particular reservations about the creation of the Family Guidance Association.[497] Within the Gondar Public Health College, there was a 'strong resistance' to introduce family planning measures into the training curriculum, 'especially from male teachers on the college faculty.'[498] Some health officials cautioned against the aggressive introduction of family planning into national maternal health services, as this may prove to alienate women from seeking medical assistance in times of pregnancy and birth altogether. Franz Perabo of the WHO asserted that 'family guidance as an individual, non-obtrusive, person-to-person service will get a foothold within the maternal and child health services in this country. If, however, family guidance is

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[494] Ibid.
[495] Bonnlander, *Maternal and Child Health*, p. 128.
[496] WHO Archive, *MCH/72.4 Corr. Health Family Planning and the Status of Women Prepared for the Inter-Regional Seminar on the Status of Women and Family Planning under the Auspices of the Division of Human Rights, United Nations 11-24 July 1972 Istanbul* (Geneva, July 1972), p. 2.
[497] Carlson and Carlson, *Kossoye*, p. 93.
[498] Ibid.

forced upon an unprepared population, the future of this new chapter in preventive medicine may run the risk of being misunderstood and rejected.'[499]

The greatest opposition to the expansion of family planning in Ethiopia rested among husbands themselves: Tsehai Yetbarek explained how in the first years of operation, the Family Guidance Association required husbands sign a contract agreement allowing their wives to receive contraceptive care. This concession to a husband's right to consent was enacted in order to appease official concern that family planning would be too aggressive and work to only limit population growth, not promote the well-being of families. Tsehai described how women would try to flaunt this restriction, however, arriving at the clinic without forewarning their husbands. In such cases, men would frequently come to the Association offices and openly beat their wives in the facility, angry that they had sought contraception without their permission. Some would threaten the health workers as well, bringing guns to the clinic and fiercely shouting, 'I will kill you!'

Tsehai explained that men's reluctance to family planning was related both to concerns about 'controlling their wives,' and also ensuring healthy reproduction and future security. She asserted that 'men thought that one of their biggest tools to keep their wives under their rule was to have them produce children, one after the other.'[500] And that even then, because infant mortality rates were so high, a woman may produce ten children, but see only three or four would grow to adulthood. Men would argue that if their wives took medicine to restrict their reproduction, how would they have any children left? Considering children were a security against the future, the idea of restricting the number of births seemed too severe a risk to families accustomed to frequent mortality.

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[499] Perabo, *Assignment Report,* p. 12.

[500] Author interview with Tsehai Yetbarek, Addis Ababa, 19 April 2013.

In my fieldwork interviews, the issue of family planning arose several times. Opinions on contraception varied considerably among women, but there was no doubt that the problems of unwanted pregnancies were widespread. In my conversation with Sister Likimyelesh, she told me two stories of her own maids resorting to self-abortions due to unexpected pregnancies. As a Seventh-Day Adventist, Likimyelesh believes that pre-marital sex should be prohibited, but acknowledged that the consequences of pregnancy outside marriage were a common and difficult problem that she had to face. She explained how she had told her own three daughters that if they ever fell pregnant, they must tell her of the pregnancies and she would care for them in a loving way: 'I don't want to say to them that you are wrong, you did something bad, you should be condemned.' Instead, Likimyelesh said she tried to project a spirit of support to the women around her.

Likimyelesh's caring attitude could not prevent her maid from aborting an unwanted pregnancy, however. She said that after traveling for three months, she came home and noticed that the girl was pregnant. The girl had worked for Likimyelesh for ten years, but Likimyelesh did not want to shame her by sitting down and asking her directly if she was pregnant. She merely observed the pregnancy from a distance, not 'encouraging her or discouraging her.' One day, the girl was in the bathroom of the house for the whole morning. Likimyelesh called to her, but she would not come out. She then realised what the girl had done: Likimyelesh gently prodded the girl enough so that she would open the door. The baby had been aborted at five months, and was there, delivered on the floor of the bathroom. Likimyelesh said that the maid had taken a purgative medicine that she had never heard of, and the foetus was expelled. Likimyelesh immediately took the

girl to the Zewditu Hospital and paid for her to stay in the first class ward for two weeks as she recovered, ensuring she did not become infected from the home abortion.

This treatment of the maid is exceptional: typically young women were left entirely on their own throughout the ordeal, but as a midwife, Likimyelesh felt a sense of duty to care for any pregnant woman around her. When another maid got pregnant several years later and threatened self-abortion, Likimyelesh told her from the beginning that she should deliver the child and she would support the two of them in her home. She wanted to avoid another dangerous home abortion, and the maid consented, giving birth to the child and raising him in Likimyelesh's home until he was a young teenager.

Likimyelesh understood that the main reason for abortion among single women was shame, but in other cases, it was also a casualty of a woman's profession. In Addis, I spoke with Bititsefa Ayalew who explained that she had never married, working her whole life in a *tej* house. Bititsefa described having multiple abortions throughout her career as a prostitute, as she could not afford to raise a child or lose the income from her profession while pregnant. When asked if she knew of any contraceptive methods, Bititsefa said that family planning was completely unknown at the time. She would go to a well-known local healer who gave herbs to ingest very early on in the pregnancy. Bititsefa did this 'several times' in her life, each time with success. But she never heard of any alternative preventive measures, despite occasionally attending an urban health centre for other illnesses.

Rediet Bitew also lived in Addis Ababa, and her husband was a teacher. She gave birth both at home and in hospital to eight children total. Rediet said that it was only later on in the 1990s that she realised she could have prevented her pregnancies. Rediet explained the challenges of giving birth to so many children and raising them

on a meagre teaching salary, but she explained that family planning was 'not possible back then.' The services were simply so limited, that few women understood it was a possibility for them, even in Addis.

Conclusion

I began this thesis with a discussion of Haile Selassie's predilection for prestige projects to create a superficial brand of modernity in his empire. From the outset, medicine was to be an intrinsic feature in modern Ethiopian life, with elite hospitals constructed and foreign doctors hired. In describing the ways in which this imperial medical project moved forward over the last four chapters, the sincere limitations in Haile Selassie's efforts are evident. This chapter has rounded out the narrative, exposing the essential problem with the emperor's modernisation efforts: in consistently focusing on superficial projects that granted the regime a degree of prestige at the expense of actual reform, the nation's medical mission was fundamentally unable to reform Ethiopian life on a large-scale.

This chapter has used several case studies to illustrate the superficial nature of state actions. The budgetary crisis of 1958-60 displayed the actual reluctance of Ethiopian officials to support public health efforts over the long-term. Considering the Gondar project relied on remote, rural health centres rather than lavish, urban facilities, there was even less interest in supporting the preventive health network with a significant financial investment. The imperial regime's neglect to reform regressive agricultural practices like land tenure is further example of the weakness of Haile Selassie's modernisation model. The Gondar health programme rested on the development of communities via the principles of preventive health, but the

continued poverty of the countryside severely limited the impact of the burgeoning health centre network.

While there were great expectations for the place of women in shaping modern Ethiopia, the priorities and needs of women were consistently overlooked in favour of idealistic, modernising rhetoric. Women needed expanded curative services to assist in obstetric emergencies, but the priority remained on preventive medicine. Didactic public health programmes repeatedly confronted the restrictions in women's livelihood, as few women were able to incorporate the lessons of preventive health education into their subsistence lifestyles. By entirely neglecting the question of family planning, state policies showed further ignorance of the reproductive needs of women. High death rates from un-safe abortion only confirmed the troubling effects of the absence of contraceptive care in the expanded maternal health programming.

In the conclusion to follow, I discuss the implications for my criticisms of the imperial medical project in Ethiopia beyond the time of Haile Selassie. While both the Derg and current regimes have been critical of the narrowness of the imperial medical project, up to the present day, the primary role of women in the modernisation of Ethiopia has not been questioned. Further, the primacy of the clinic in educating women and their communities in the principles of modern life has also continued throughout the last four decades since Haile Selassie fell. Despite the obvious failures of the imperial medical mission in Ethiopia, the ideological foundation guiding imperial actions has remained largely intact.

Conclusion

This thesis' exploration of maternal health's history in Ethiopia has demonstrated the connection between biomedicine and cultural reform in the development of the nation's first medical network. As the first analytic history of medicine in the Ethiopian context, I have revealed the ways in which Ethiopian communities coped with state directives for medicine's expansion. Official narratives for change were constantly contested within the community, especially among women, as they sought pragmatic solutions to persistent problems of ill health and poverty.

The first two chapters demonstrated how both Haile Selassie and his foreign partners used medicine as a tool for national modernisation, targeting women in domestic re-orientation campaigns. While the emperor favoured prestigious hospitals and medical schools, diplomatic efforts encouraged the development of a rural health network that emphasised preventive medicine. In both scenarios, women were asked to reform cultures of maternity and child-rearing in an effort to 'modernise' Ethiopian daily life.

The third and fourth chapters narrated the ways in which Ethiopian women coped with state medical policies as practitioners and patients. The first generation of professional Ethiopian women used medicine as a means of personal advancement, asserting their individual modernity and mediating patients' clinical experiences. As nurses and midwives, these women appropriated the messages of national health policies within the clinic, instructing their patients on how to alter lifestyle traditions and benefit from the promises of modernity. The fourth chapter exposed the ways in which female patients rejected the didactic overtures of the clinical practitioners. Patients were pragmatic in their use of clinical cures in conjunction with home-caring models at the time of pregnancy and birth. Women

were careful in delineating which practitioners best suited them in times of labour and delivery, reserving the medical clinic for its capacity to cure should complications arise. The overly didactic nature of maternity clinics prescribed by official policy was poorly translated to the patient experience, and attempts at cultural reform through medicine were unsuccessful.

The last chapter exposed the multiple ways in which imperial medical policy failed to reform cultures of maternity and domesticity in Ethiopia. The emperor's predilection for prestige projects in medicine meant that the quality of national health services continued to deteriorate in the decades of imperial rule. State policies also fundamentally mis-read the needs and predilections of patients, providing inadequate curative services in favour of didactic health instruction. Finally, by neglecting the primacy of poverty and restrictions of livelihood in determining patients' life choices, health centre activities failed to penetrate the lived experiences of patients. The actual needs of women were particularly overlooked, especially in regards to contraceptive care. While the state had crafted a socio-cultural narrative for maternity disorders, officials completely ignored the importance of family planning and dangers of widespread home abortions among female patients. Imperial policy operated under a tidy prescription for maternal health, defining pathologies solely within the framework of 'backward tradition.' The state prioritised erroneous cultural explanations of maternal disorders, all the while neglecting to address more pressing concerns of poverty, class and gender biases, and reproductive control.

In my conclusion to this history of women and childbirth in Haile Selassie's Ethiopia, I describe both the academic contributions of this thesis and also implications for further research. I first outline the ways in which my thesis contributes to feminist development theory and global medical history, and then

move on to explain the implications of my thesis beyond Haile Selassie's Ethiopia. In this final section, I briefly narrate the continuation of imperial-era policies regarding women, health, and development under the succeeding regime in Ethiopia. It is important to emphasise the rootedness of the connection between maternal health disorders, cultural tradition, and national development in official state policies. While Megan Vaughan was instrumental in demonstrating how the 'social origins of disease' were ever-present in colonial medical discourses, the continued pursuit of cultural explanations for African pathologies demonstrates the rootedness of cultural consciousness in biomedicine beyond imperialist campaigns.[501] The historic origins of culturally prescribed biomedical policies are poorly acknowledged and rarely researched in current affairs. I intend this thesis to help expand the framework of understanding of the historic pathologisation of African reproductive cultures, and conclude with suggestions for further research that arise from my own arguments.

Contributions of the thesis: gender theory and global historiographies

In exploring the intersection between poverty, gender, and health in Ethiopia's medical history, this thesis makes a significant contribution to the theoretical debates on the meaning and origin of women's poor health in Africa. This section begins with an explanation of how my thesis relates to other studies on gender and reproduction in Africa, and then moves on to describe the ways in which this thesis helps narrate an 'alternative modernity' in African history. My focus in the previous five chapters on individual and community agency in shaping the expression and practice of medicine in Ethiopia helps expand the primacy of indigenous actors in the construct of history. This has implications beyond Ethiopian historiography, and

[501] M. Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford, 1991), p. 6.

speaks to larger concerns on the fraught definitions on what is 'modern,' 'local,' and 'foreign' in relation to medicine's expansion.

Gender and development discourses

The overthrow of Haile Selassie in the mid-1970s corresponded with the global women's movement, and an increased academic consciousness on the question of African women and their 'status.' Earlier assertions of African women's essentialised domestic and maternal natures came into question, while Hafkin and Bay's seminal study, *Women in Africa,* worked to reposition women as economic agents working both inside and outside the home.[502] Coming to power at the height of the women's movement, the Derg regime capitalised on the increasing feminist consciousness by commissioning their own critiques of Haile Selassie's modernist efforts in relation to women, most notably the work of Zenebework Tadesse. Zenebework wrote a study on the 'condition of women in Ethiopia,' asserting that the previous regime had operated under the 'false assumption of categorising women as just housewives and mothers,' and family-oriented training programmes only served to 'neglect women's important economic role in a subsistence economy.'[503]

My own thesis is an extension of these feminist critiques produced both within and outside Ethiopia, but in focusing on reproductive health and childbirth, it could be argued that I fall into many of the same patterns of prejudice criticised in feminist literature. Everjoice Win has written that 'for decades now, the development industry has thrived on the stereotypical image of an African woman who is its "target" or "beneficiary."' Win argues that this stereotype is 'always poor, powerless

[502] N. Hafkin and E. Bay, *Women in Africa: studies in social and economic change* (Stanford, 1976).
[503] Tadesse, *Condition of Women in Ethiopia,* p. 33.

and invariably pregnant, burdened with lots of children.'[504] In narrating women's reproductive experiences, I have in part perpetuated the image of the 'invariably pregnant' Ethiopian woman, but this focus was strategic in exposing the actual limitations of imperial health policies as related to women. Patient narratives help combat the image of the subservient parturient, and instead demonstrate the pragmatic determination of Ethiopian women to secure health and well-being for themselves and their families. At the same time, my description of female practitioners' careers in Ethiopia's medical history exposed the ways in which women subverted persistent gendered norms at the time. While officials viewed female practitioners as 'mere' nurses and midwives, capable of caring, not curing patients, the first generation of female medical workers were determined to lead more advanced careers in health that required skills in both leadership and curative medicine. In their pursuit of health as both patient and practitioner, women in Ethiopia did not conform with official expectations. Patients largely absented themselves from development policies by ignoring the preventive health education doled out at the clinic, while practitioners evolved their careers away from the supposedly 'feminine' arts of nurturing/nursing.

While many women described in this thesis may have been 'invariably pregnant,' this does not make them passive recipients of either familial or state patriarchies. Pregnancy and reproduction were lived realities for Ethiopian women, and real sources of ill-health. This thesis contributes to feminist studies of African women by re-positioning reproduction as not just an inevitable burden, but also a site for the active assertion of agency.

[504] E.J. Win, 'Not very poor, powerless or pregnant: the African woman forgotten by development', in A. Cornwall, E. Harrison, A. Whitehead (eds.), *Feminism in Development* (London, 2007), p. 79.

I also build on larger debates of what Margaret Turshen has defined as 'the nature of poor health in African women.' Turshen's numerous studies on gender and health in Africa have helped examine the various explanations for women's poor health on the continent, including the materialist tendency to view health problems as socially constructed and economically determined by the patriarchal and capitalist societies under which women live. Turshen introduces another vector in women's poor health: the unequal distribution of medical services themselves. She argues that 'because women command less power than men, women's healthcare is rarely of the same quality or of equal technical sophistication as the care offered to men.'[505]

In Ethiopia, Turshen's argument is especially relevant. Numerous studies of hospital patients throughout the Haile Selassie period confirm that men were more prone to visit the hospital than women, while the persistent emphasis on preventive care for women in the home demonstrates the lack of sophisticated treatments for women's health problems.[506] Modern mechanisms for birthing care were all low-tech solutions in Ethiopia, despite the pressing need for skilled surgical intervention at times of obstetric distress. Women were viewed primarily in their capacity as mothers, and policy solutions rested on improving caring models and cultural re-education. In this way, Ethiopia is a perfect case for feminist critiques on the limitations of modernisation policies. But while both Zenebework and other authors, like Win, have positioned women's reproduction as a contributing factor to her collective oppression, I argue that reproduction was oppressive only in the ways in

[505] M. Turshen, *Women and health in Africa* (Trenton, 1991), p. 14.

[506] See: L. Molineaux, 'Analysis of medical admissions to the Gondar Hospital 1963-1965', *Ethiopian Medical Journal*, vol. 5, no. 1 (1966), pp. 47-56; A. Teferra and J. Abdulkadir, 'Analysis of medical admissions to Princess Tsehai Memorial Hospital from April 1966 to March 1967', *Ethiopian Medical Journal*, vol. 6, no. 3 (1968), pp. 96-102; E. Habte-Gabr et al., 'Analysis of admissions to Gondar Hospital in North-Western Ethiopia, 1971-1972', *Ethiopian Medical Journal*, vol. 14, no. 2 (1976), pp. 49-59).

which it determined a woman's position in official discourse. Turshen has alluded to a thread of feminist psychology that has named reproduction and motherhood as key subordinators of women.[507] It is clear that in fixating on low-tech health solutions and mere domestic didacticism for Ethiopian mothers, the primacy of reproduction in women's lives was unduly emphasised above their additional contributions to domestic economies and community life. This does not mean that reproduction is *itself* oppressive, but as argued throughout this thesis, motherhood *can* become a factor in female subordination when it is used by patriarchal authorities to limit the spaces for women in modern life.

Alternative modernities: redefining what is 'local' and 'foreign' in modern medicine

While this thesis has demonstrated the limitations in official spaces for Ethiopian women, I have also countered these limitations by narrating women's own experiences in reacting to and coping with official policy prescriptions. In presenting the active narratives of women as practitioners and patients, I assert that the history of medicine in Ethiopia was shaped primarily by the negotiations between the state and community. By foregoing clinical birth practices, or pursuing medical professions formally reserved for men, women were essential actors in determining the trajectory of Ethiopian medicine. It was not only the structural limitations of state actions which determined the extent to which medicine infiltrated Ethiopian life: communities themselves played active roles in determining how modern medicine would alter - or not alter - practices related to reproduction.

This assertion of community agency is relevant not only to discourses on gender, but also to larger histories on the expansion of Western medicine in non-Western

[507] Turshen cites the work of Jessica Benjamin, Nancy Chodorow, Carol Gilligan, Juliette Mitchell, and Christiane Olivier.

contexts. Ethiopia's exceptionalism as a non-colonial state exposes the problems in early historiographies of African medicine, which focused solely on the actions of colonial administrators in determining the practice of medicine on the continent. The last decades have seen a surge in scholarship on African actors in biomedical projects, but such studies are often limited to descriptions of local agents' fraught negotiations with and reactions to colonial regimes. In charting the development of modern medicine in Ethiopia, colonial actors are not a feature of the historic landscape, so notions of indigenous agency are therefore complicated. This study's exploration of indigenous actions outside of a colonial medical project therefore contributes vital new source material to the question of local agency in shaping experiences of medicine in Africa.

In describing the primacy of indigenous actors in directing and shaping medicine's expression in Ethiopia, I join Projit Mukharji in his call for further exploration into the *productive* role of both medicine and state power in addition to its repressions.[508] Mukharji has argued against the constant view of 'western' medicine as 'foreign,' and 'having only an external, repressive role in South Asian lives.'[509] Instead, Mukharji has demonstrated how the Bengali *daktar*, or indigenous practitioners of Western medicine, used medical practice to advance personal careers and community health. This thesis has demonstrated the productive potential of medicine in the Ethiopian context, both for the first generation of professional practitioners, and also those women who actively sought medical cures in times of obstetric emergency.

Mukharji is careful to note that the '"global" and the "local" or the "foreign" and the "indigenous" are not descriptive commonplaces, but rather historically

[508] P. Mukharji, *Nationalizing the body: the medical market, print, and daktari medicine* (London, 2009), p. 10.
[509] Ibid.

contingent categories which emerge within particular historical and political contexts and are continually being mutually reorganised.'[510] In Ethiopia, the relationship between 'foreign' and 'indigenous' is contentious. Haile Selassie himself was very eager to advertise his unique position as an independent African emperor, but only followed this cry of indigenous power with an announcement of his own initiative to re-direct the nation towards 'foreign-inspired civilisation.'[511] The emperor's firm stance on personal sovereignty against foreign invaders, juxtaposed with a simultaneous devotion to 'European civilisation' in modernising his empire, is symptomatic of the trans-local tensions within the imperial medical project. Introducing 'foreign-inspired' medicine into an independent African nation meant importing non-Ethiopian physicians, funds, and technical advisers to construct a health system that was still operated, and ultimately led, by local personnel. Foreign practitioners operated at the invitation of the local ruling class, and it was the foreign medical staff who worked in deference to their indigenous hosts. Thus, while local medical practitioners in neighbouring African countries were forced to negotiate the hegemonies of colonial medical systems, Ethiopians were actively soliciting the aid and advice of foreign medical bodies in constructing their own public health network.

Haile Selassie was explicit in naming modern medicine a 'foreign-inspired' advancement for his empire, but the actual practice of medicine was increasingly performed and led by indigenous actors. Given the primacy of indigenous medical practitioners, can modern medicine in Ethiopia still be defined as 'foreign?' I argue that the local ownership of medicine's development in Ethiopia is symptomatic once more of the 'alternative modernities' described in the academic work of Warwick

[510] Ibid.
[511] Selassie, *My Life and Ethiopia's Progress*, p. 6.

Anderson, Dilip Gaonkar and others mentioned in the introduction to this thesis.[512] This study is an exploration of an 'alternative modernity:' in describing the ways in which both the Ethiopian state and citizens negotiated the terms of Western medicine within their national context, the tidy definitions of 'foreign,' 'local,' and 'modern' are all complicated. I follow the thread of Lauren Minsky's work in privileging indigenous histories without relation to Western narratives.[513] It is possible to re-construct national histories in non-Western countries through the vehicle of indigenous voices. By highlighting the oral testimonies of female patients and practitioners in Haile Selassie's medical project, I have worked to re-orient the history of medicine's expansion in the twentieth century into less familiar contexts. This enriches existing narratives both on Western-driven teleological modernisms, and postcolonial investigations of local populations' reactions to foreign hegemonies.

Implications for my research beyond Haile Selassie's Ethiopia

The themes presented in this thesis are by no means limited to the historic and geographic context of imperial Ethiopia from 1940-1975. I have argued that in pathologising domestic culture in Ethiopia alongside biomedical expansion, Haile Selassie both overlooked the actual needs of the nation's communities, and also failed to create an effective public health network. This criticism is relevant within multiple contexts, including subsequent regimes in Ethiopia. In this section, I will outlining the ways in which Haile Selassie's successor continue to misread the needs

[512] See: D.P. Goankar, *Alternative Modernities* (Durham, 2001); W. Anderson, *Colonial pathologies: American tropical medicine, race, and the hygiene in the Philippines* (Durham, 2006).
[513] See: L. Minsky, *Cultivating Health: Commercial Agriculture, Material Religion, and Collective Healing in the Punjab from Late Medieval to Modern Times* (forthcoming book).

of women and communities, despite a rhetorical shift to socialism. I then conclude this section with a discussion on the place of these criticisms outside Ethiopia.

Policy failures under the Derg

Donald Donham's history of the socialist revolution in Ethiopia, *Marxist Modern*, provides a sound overview of the interactions between missionary medicine and community health under the Derg regime. Apart from this study, however, there are no analyses of Ethiopian medical history beyond the Haile Selassie years. This gap in the literature is troubling, as while my own criticisms of Haile Selassie's regime continue to be relevant under the Derg, additional research is needed to expand the lessons of the imperial era into the socialist context. The Derg was founded on an anti-imperial agenda that worked to overturn the elitist rhetoric of their predecessor, but the practice of socialism in Ethiopia proved no more successful in developing a public health infrastructure or improving the standard of living for Ethiopian citizens. The socialist machine published numerous rhetorical tracts proclaiming the government's sensitivity to the plight of women and other marginalised groups in the nation, but living conditions of the rural poor were little altered in the years of socialist rule. Aggressive villagisation and resettlement programmes created widespread insecurity in rural areas, and while women were now included in community councils for health and development, their social status remained precarious at best.

In regards to maternal health, the Derg was equally insensitive to the actual reproductive needs of women as the imperial regime, confusing rhetorical proclamations on the value of women to socialist Ethiopia with actual improvements in their health and well-being. This is nowhere more evident than in the continued

gap in contraceptive care for Ethiopian women, a problem which, though prominent under Haile Selassie's maternal health programming, was likewise poorly addressed with the change in government.

Throughout the late 1970s and early 80s, the Family Guidance Association remained the only organisation that actively promoted contraceptive services in Ethiopia, and the Derg became suspicious of the Association's activities because of their ties to the US-based Pathfinder Fund and International Planned Parenthood Federation. Tsehai Yetbarek and other Association officials were arrested and interrogated about their connections to the West, and their 'true motivations' for starting an organisation that aimed to control the Ethiopian population. Tsehai explained that the Derg still felt no need to limit reproduction in Ethiopia, adopting similar arguments from the previous regime on the need to expand the labour force in order to best utilise the expansive and under-developed tracts of land in the nation.[514]

While Haile Selassie had operated under his own rhetoric of imperial autocracy and Westernisation, the Derg shifted Ethiopia's ideology to a Russian-style socialism. This rhetorical shift meant that the ways in which women were neglected within state policies no longer related to problems of land tenure and a class-based impoverishment of the peasantry, but were now joined with deterministic state narratives for collective action and anti-Western sentiment. In both scenarios, the actual needs of women were overlooked, but the origins of official 'failures' in the development of a functioning medical network or community development schemes differ greatly. The continued neglect of lived realities within communities under the Derg merits further exploration, as while my own research conclusions are adaptable to other historic contexts in Ethiopia, the ideological roots of state action was shifted

[514] Author interview with Tsehai Yetbarek, Addis Ababa, 19 April 2013.

with a change in regime. The concept of state-driven modernisation and its relation to women and maternal health is problematic not only in the context of imperialism and Westernisation, but also collective action and socialism.

Beyond Ethiopia: research implications for the post-colony

My critique of Ethiopian policies which operated under cultural explanations for maternal pathologies is not limited to Haile Selassie's regime, but follows a long line of health policy in Africa beginning with colonial conquest. The work of Lynn Thomas and Nancy Rose Hunt has been especially instructive in locating the cultural origins of maternal health policies in the British and Belgian colonies in Kenya and Congo, but my own study outside of colonial Africa works to expand this literature beyond colonial medicine. This thesis compliments the work of Thomas and Hunt, but also helps draw previous questions of the 'social origins of disease' to post-colonial and non-colonial contexts. My study of Ethiopian medical practitioners is positioned near John Iliffe's work on *East African Doctors*, investigating new ways in which the policies of colonial regimes influenced the development of post-colonial medical norms.

The relevance of colonial lessons in health outside the colony is especially relevant when examining the history of the WHO and other international aid bodies responsible for the codification of global health policies in the twentieth century. This thesis has demonstrated how the WHO in particular worked to pathologise African reproductive cultures in ways similar to colonial regimes before them. WHO-driven discourses on maternal health in Ethiopia were replicated across the African continent, and the problems of utilising preventive health education for

mothers as a means of assisting national modernisation schemes are found in nearly all other country contexts.

There is considerable room for new studies on the WHO's history of enacting colonial-influenced global health norms in other African countries after 1950. In exploring the ways in which WHO rhetoric on maternal health was co-opted within Ethiopia's discourses on modernisation, I also question the relationship between international bodies and their partner governments, exposing the ways in which teleological trajectories on the global scale are implicated within national politics.

While the conclusions of this thesis can be extrapolated to additional national histories outside Ethiopia where international aid organisations have been active, they are also relevant in current policy debates on global health, especially as regards women and reproduction. In the case of maternal health, programmes which target social origins of disease have continued to the present day. A pressing example is the current policy for the eradication of obstetric fistula, a birth injury caused by obstructed or prolonged labour and prevalent in low-income countries. Policy tracts continually locate the origin of obstetric fistula in community marriage practices, despite little statistical evidence of the link between marriage and fistula. When Cecily Williams codified the origins of maternal health disorders in backward cultural traditions, she set a global policy norm that locates the site of disease and illness within social practice. For the last seventy years, maternal health policies across the world have largely operated under the assumption that impoverished communities are to blame for the presentation of disease by virtue of their ignorant continuation of dangerous social practices. The conclusions of this thesis demonstrate the failures of this culturally-determined narrative to enact actual change. Preventive health measures are insufficient to treat maternal disorders not only because of the ways in which they overlook limitations in livelihood, but also

because they are fundamentally rooted in erroneous socio-cultural explanations of disease.

Final thoughts

This thesis has presented the case of a failed modernisation project, perpetuated by an elite, authoritarian regime in an independent African country. In this conclusion, I have also described in brief the ways in which these failed policies have been replicated in other historic and geographic contexts. In terms of expanded historiography, this thesis has demonstrated how histories of modern medicine's development cannot be limited to descriptions of the interactions between Western donors and non-Western recipients: medicine does not 'belong' to any one culture, but has instead been adopted and co-opted across global geographies. Non-Western medical practitioners are not always reacting against foreign bodies in the practice of biomedicine, but are instead legitimate actors in crafting local medical norms. At the same time, medicine has been used by numerous elite actors, both colonial and non-colonial, in crafting new forms of indigenous knowledge that often limit the space of communities to negotiate the terms of their own health. As a consistent partner in national development schemes, medicine has worked to create new social elites in all nations. These elites occupy unique spaces in the national landscape: while increasingly such elites are 'local' themselves, their position as medical practitioner and administrator has the tendency to set them apart from communities of patients so that they then become tainted with a new definition of 'foreignness.'

Given this common separation between medical elites and patients, the construction of official health policies is often wholly inappropriate within the lived experiences of 'target communities.' Official knowledge is muddled with teleological

narratives of social progression and national modernisation, and the structural limitations hampering the 'advancement' of impoverished communities are entirely overlooked. There is considerable damage done in fixating on the modernising potential of medicine when communities lack the basic capacity either to live healthfully or treat existing medical disorders.

For women, there are further implications in the fixation on cultural reform within the clinic. Women are continually placed in a mere reproductive capacity, and the onus for domestic modernisation is laid squarely on their shoulders. When investigating the medical choices of women, it is clear that most patients choose those caring models that best serve them within existing circumstances. While wealthy women can project their social status in paying for elite medical care, the majority of women use the clinic as a site for practical improvements to their daily life. There is little belief in the transformative power of the clinic unless pre-existing conditions of wealth and geography intersect with the patient's status. For women, the pragmatic need for obstetric cures has often been overlooked in policies which aim to alter maternal cultures. There is great space for further investigation into the damage of fixating on cultures of maternity at the expense of curative treatment.

The old adage 'an ounce of prevention is worth more than a pound of cure' has dictated the development of public health policies both in Ethiopia and across Africa, but it remains unclear how effective the didacticism of most public health programmes has been in routing out disease. The 'Demonstration and Evaluation' study cited in the fifth chapter of this thesis exposed the equal benefit of either constructing a costly health centre versus merely providing clean water to a community in rural Ethiopia. What is the potential of basic infrastructural improvements in safeguarding community health, especially when compared to the persistent call for didactic auxiliaries? History indicates that the emphasis on public

health education is mis-placed, and the benefits of preventive medicine are only relevant within stable economies.

Finally, this thesis has primarily been a story about childbirth, and the ways in which both states and individuals ascribe external values and meaning to the management of pregnancy and labour. As the definitions of 'modern' birth practices are continually re-negotiated by both patients and practitioners, it is important to locate the source of social anxieties about birth and its primacy in shaping the status of women within larger narratives of modernity and progress. Childbirth is saddled with external values that belie its physiological expression, natural necessity, and quotidian reality. While birth is an inevitable feature of humanity's progression, the ways in which it is socially marked and culturally determined is constantly shifting. Additional studies of childbirth's history, especially in relation to its medicalisation, will continue to have implications for our current understandings about birth and its social significance.

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