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Camel milk, amoxicillin, and a prayer: Medical pluralism and medical humanitarian aid in the Somali Region of Ethiopia

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ABSTRACT

This paper details how exposure to new clinics, diagnostic technologies, and pharmaceuticals during humanitarian relief operations in the Somali Region of Ethiopia shaped local pluralistic health systems and altered the ways in which residents subsequently conceived of and treated illness and disease. Despite rising demand for pharmaceuticals and diagnostic technologies among Somalis in Ethiopia, local ethnophysiologies continued to draw upon popular ideas about humoral flows, divine action, and spirit possession. Demands for therapeutic camel milk, Qur'anic spiritual healing, herbal remedies, and other historically popular therapies persisted, but were shaped by concurrent demands for and understandings of diagnostic biotechnologies and pharmaceutical medications. The reverse was also true: contemporary understandings and uses of non-biomedical healing modalities among Somalis shaped evaluations of clinical care, including healthcare during humanitarian responses. To illustrate these phenomena, based on ethnographic research in eastern Ethiopia between 2007 and 2009, this paper explores three topics vital to Somalis' pluralistic healthcare systems: camel milk and the management of digestive bile; women's experiences and clinical presentations with pain and disorder in their reproductive systems; and the rising popularity of high-tech diagnostic tests. I conclude that medical humanitarian aid never happens in a vacuum or among truly treatment-naïve populations. Instead, aid unfolds within ever-changing and pluralistic health cultures, and it permanently alters and is altered by the frames within which people evaluate and make future decisions about healthcare.

1. Introduction

Having once again run out of her three-month supply of diazepam, a prescription medication for seizure disorders, Sara, a young mother from the Somali Region of Ethiopia sighed and looked heavenward. Shrugging, she said:

> I know that I have epilepsy (*suuxdin*). When God brings us something, we human beings call it various names, but God does not call it such names. I have been going to the [biomedical] doctors, and the religious healers have checked the Book [the Holy Qur'an] for me. They all have said the signs and symptoms indicate that this epilepsy is a disease of my brain, and it comes from heaven.

Sara's explanation and her circumstance of having, once again, run out of pills far from an adequate hospital, foreshadow the major themes of this paper. Popular health cultures and understandings of disease in the northern Somali Region were pluralistic, ambiguous, and shaped by both the scarcity of various forms of healthcare as well as the recurrence of episodic medical humanitarian interventions. After numerous positive experiences with clinicians during relief operations, many Somalis, like Sara, desired more and better clinical care, diagnostics, and therapeutics. But too often, these demands went unmet. Provisional medical humanitarian programs in eastern Ethiopia have repeatedly raised local expectations about the potential benefits of biomedicine, yet a few months or years after emergency relief funding ends, organizations exit, effectively abandoning people, like Sara, they were tasked to serve. This paper examines what is left in the Somali Region, with regards to healthcare, when medical aid organizations repeatedly depart.

Despite rising demand for pharmaceuticals and diagnostic technologies, and even in the midst of different public health and humanitarian interventions, I find that demands for so-called

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"traditional" medical practices persist and transform. Local ethnophysiologies – in other words, conceptions of bodily functioning and wellbeing – continued to draw upon popular ideas about humoral flows, divine action, and spirit possession. Demands for therapeutic camel milk, Qur'anic spiritual healing, herbal remedies, and other historically popular therapies continued, but were fundamentally shaped by people's concurrent demands for and understandings of diagnostic biotechnologies and pharmaceutical medications. The reverse was also true: contemporary understandings and uses of non-biomedical healing modalities among Somalis shaped evaluations of clinical care, including healthcare provided during humanitarian responses.

By way of example, I outline three topics vital to Somalis' contemporary, pluralistic experiences of healthcare: camel milk and the management of digestive bile (*dacar*); women's experiences of pain and disorder (*xanuun*) in their reproductive systems; and the rising popularity of high-tech diagnostic tests (*imtix-aammo*). These topics exemplify the complexity of changing popular health cultures during and after humanitarian emergencies; they testify to the transformations of health cultures and health systems experiencing episodic foreign medical interventions; they illustrate the gendered nature of pain, illness, and treatment-seeking; and they complicate notions of discrete categories of medical care among Somalis as ever either "traditional" or "biomedical".

2. Methods

This paper is part of a larger ethnographic investigation into the lasting social effects of recurrent medical humanitarian interventions in the Somali Region of Ethiopia. Multi-sited ethnographic research was conducted during thirteen months between July 2007 and August 2009. Additionally, on various separate assignments, I investigated issues pertaining to food security, migration, and child survival for the UN World Food Program and UNICEF in Ethiopia between 2003 and 2009. For this project, I conducted a total of 193 semi-structured ethnographic interviews with 146 individuals. I also conducted 20 structured observations within nongovernmental aid organizations, governmental bureaus, local markets, and clinical facilities, and I shadowed Somali nurses on fourteen occasions as they responded to crises in the Somali Region.

In addition to interviews with a diverse sample of male ($n = 25$) and female ($n = 49$) laypersons, I conducted ethnographic interviews with a diverse sample of male ($n = 58$) and female ($n = 14$) healthcare professionals involved in the local distribution of medicines and herbal treatments, including licensed pharmacists, physicians, nurses, so-called "pastoralist health extension workers" (community health workers trained and employed by the Ethiopian government in pastoralist areas of the country), unlicensed sellers, herbalists, and religious leaders (*wadaddo*). Because most of the licensed Somali healthcare professionals in my sample were men, I recruited ten additional female lay health experts for participation in at least two ethnographic interviews each, including traditional midwives (*ummuliso*), female experts in massage (*duugto*), and female rural doctors (*dhakhtarad baaddiye*). Participant observation was conducted as I went about everyday life, spending time with women and their children, and accompanying families as they sought medical care.

I conducted at least two serial interviews with most of the lay and professional adults in my sample: first, I conducted interviews focusing on common illnesses, etiologies, treatments and conceptions of the human body, and later, interviews focusing on pharmaceuticals, various biotechnologies, and healthcare facilities. The latter interviews were designed to evoke narratives about past treatment-seeking ventures and popular discourses about specific medicines, and were facilitated with elicitation devices such as samples of popular medications and tonics (Bledsoe and Goubaud, 1988). This research was approved by the Institutional Review Board at The University of Arizona; verbal informed consent was obtained from all participants in this research, and all personal names have been changed to ensure anonymity.

Most interviews with lay Somalis and health extension workers took place in the Somali language; most interviews with other providers and policymakers took place in English. To aid in language interpretation, translation, and my own education in the Somali language, I enlisted the help of three Somali research assistants (one woman and two men). I took notes by hand, and in most cases, interviews were both audio-recorded and transcribed. Each interview was attended by me plus one Somali assistant; later, each transcript was independently translated from Somali to English by me plus one research assistant. Discrepancies and difficulties in translation became fodder for further discussions among the research team and with interlocutors about local uses of the Somali language and interesting contemporary changes in the ways in which Somalis talk and think about medicine.

Methodologically, I traced the "social lives" (Whyte et al., 2005) of medicines and healing encounters in their contemporary forms as well as historically; I accompanied persons as they sought or provided care, and I asked people to think retrospectively about past illnesses, treatment-seeking ventures, and clinical and healing experiences. I took into account how historical events (such as particular relief operations) and personal memories of healthcare during these events shaped subsequent healthcare seeking and evaluations of care. Therein, this research highlights the lingering effects and the social work of various medical encounters.

2.1. Ethnographic setting

A vast majority of the residents in the northern Somali Region of Ethiopia identify as ethnically Somali, and most also belong to the Issa clan (*Reerka Ciise*). A few important characteristics are shared by most northern Somalis in the Horn of Africa: a Sunni Shafi'ite Islamic tradition, a cultural ideal of nomadic pastoralism, a history of colonial domination and partition, and a history of recurrent humanitarian crises and interventions. At the time of this research, a majority of the residents of the rural northern Somali Region were displaced and dispossessed pastoralists or agro-pastoralists; while most families still depended on small herds of goats, sheep and donkeys, many had lost significant camel and cattle herds in the last thirty years due to multiple droughts, disease outbreaks, and interclan and interstate conflicts.

This paper focuses on three communities in the Aysha district (or *woreda*) in the northern Somali Region: Aysha town, Degago, and Elahelay. Aysha town had the largest public health facility in the area – called the Aysha Health Center – but this facility employed, almost exclusively, ethnic *Habasha* (Amharic- and Tigrynia-speaking) clinicians who did not speak the Somali language and who were assigned to work there by the Ethiopian government. Geographically isolated, ethnically segregated, and disenfranchised by repeated injections of inadequate foreign aid monies, the Health Center staff struggled to meet the needs and gain the esteem of the local Somali population. The health system in Degago served as a case study in the lasting effects of temporary medical humanitarian interventions, namely, a sprawling refugee camp and clinic that was opened during the regional famine in 1984 and closed in 2005. Finally, I profiled Elahelay because I could conduct ethnographic research there before, during, and after one medical humanitarian intervention.

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