

**PURVEYORS OF HYBRID MEDICAL
SERVICES IN WÄLLO: THE *MĀRFIE*
WĀGIE, 1940S-1970S**

ASSEFA BALCHA

ABSTRACT

The limitations of modern western medicine following the Italian expulsion in 1941 created space for a range of alternative therapies to flourish. No longer persecuted, and officially recognized by the state, cleric/non-secular and other forms of indigenous healing modalities thrived during the Imperial era. A new system of therapy that combined indigenous medical knowledge with allopathic medical practice, particularly of the ‘injectionists’, ‘injectors’ or ‘needlemen’ (Amh: mārḥie wāḡie) emerged during this period. Consequently, older forms of indigenous therapeutics underwent transformations in response to changing social conditions, including the growth and proliferation of modern medical ideas and technologies. These situations assisted therapeutic pluralism to be a feature of the post-Italian medical landscape. People seeking medical treatments during the imperial era picked up their therapeutic preference/s from this pluralistic healthcare delivery system.

There are very few and fragmentary researches on the subject in Ethiopia. This study relying heavily on archival and oral sources provides a critical historical account on the training, degree of acceptance and popularity of ‘injectionists’ who provided an alternative medical service in Wällo, Ethiopia. While full references are given in the bibliography, the following acronyms are used in the in-text citations: Dässie Hospital (DH); Dessie Zuria Workers’ Party (DZWPP); Imperial Ethiopian Government (IEG); Ministry of Health (MoH); Ministry of Public Health (MoPH); Ministry of Interior (MoI); Municipality of Dässie (MoD); Wällo Provincial Governorate Office (WPGO); Wällo Provincial Health Department (WPHD).

KEYWORDS: Biomedicine, Drug Shops, Drug Vendors; Ethiopia, Injection, ‘Injectionists’, ‘Injectors’, *Marfië Wägje*; ‘Needlemen’, Italians, Dässie, Wällo

“Confidence and hope do ... more good than physic.”

Galen (129 - 199?)

Ethiopia’s Medical Ecology

The dearth of the public health service to tackle both endemic and epidemic diseases in the post-Italian period, combined with the growing popularity of injections (Amh: *marfië*), created an opportunity in Ethiopia, as elsewhere in Africa and many different countries around the world,¹ for individuals who administered injections to portray themselves as biomedically-trained practitioners. Mass eradication programs against epidemic and infectious diseases (Amh: *worarshigine* and *talalafi bashita*) more than vaccination campaigns (Amh: *yaketebat zamacha*), seemed to have increased the acceptability of the injection needle. By emphasizing the alleged efficacy of their healing strategies, which were based on a mix of western and indigenous ideas about disease causations, the ‘injectionists’ had little difficulty attracting a growing number of clients. Though the ‘injectionists’ have permeated the African-Ethiopian medical landscape over the last several decades, little research has been done on their history.² While the biomedical community expressed their concern on the random use of injection, anthropologists were said to be interested in studying this phenomenon

1 S. Van der Geest, “The Illegal Distribution of Western Medicine in Developing Countries: Pharmacists, Drug Pedlars, Injection Doctors and others. A Bibliographic Exploration, *Medical Anthropology*, Fall 1982a.

2 See, for example, L.J. Slikkerveer, “Rural Health Development in Ethiopia: Problems of Utilization of Traditional Healers,” *Social Science and Medicine* Vol. 16: 1859-1872, 1982; W.F.L. Buschkens & L.J. Slikkerveer, *Health Care in East Africa: Illness Behaviour of the Eastern Oromo in Hararge (Ethiopia)*, Assen: Van Gorcum, 1982; H. Kloos et al, “Buying Drugs in Addis Ababa: A Quantitative Analysis,” in S. Van der Geest & S.R. Whyte (eds.), *The Context of Medicines in Developing Countries: Studies in Pharmaceutical Anthropology*. Dordrecht: Kluwer Academic Publishers, pp. 81-106, 1988.

believing that “it is a spectacular example of the willing acceptance of Western medical technology by non-western cultures.”³

Both rural and urban residents in Ethiopia sought the services of the ‘injectionists’ in part because they filled the unfulfilled and splayed gap in the biomedical system. For most rural households, the decision to visit healthcare facilities was a difficult one; distance, medical and transport costs, not to mention time and personal expenses, were serious challenges that discouraged the majority of the rural masses from tapping the existing biomedical facilities. In most instances, a family with few household resources could not afford to pay for such a costly trip. Even those who decided to pay for treatments often had to do so by sacrificing other essential household expenditure, which would naturally result in the depletion of the assets of already impoverished households. No less serious, many people resisted making significant financial sacrifices to attend a healthcare institution that they viewed as providing inadequate care. For instance, after reaching healthcare facilities many patients were not willing to give samples of blood, urine and stool for diagnosing their illness. These demands were strange, unacceptable and abhorred. For them, experienced health workers like indigenous healers were expected to diagnose their illnesses just by looking at the patients’ outward conditions. Such misconceptions got meaning by the ‘needlemen’ who knew their clients’ perception of sickness without any laboratory examination, the simplest means of diagnostic tool. Similarly, most health workers in government clinics provided their services without laboratories and laboratory technicians. Furthermore, the *mārḥie wāḡie* were often close at hand to help patients who viewed their treatment as inexpensive, gratifying and effective.

The dossiers also mentioned about the mischievous acts of the *mārḥie wāḡie* who misled [brainwashed] people in some lowland areas not to co-operate to have them or their homes fumigated with DDT or to be treated with anti-typhus and anti-malarial tablets, while they were ‘hundred percent’ willing to have injections only.⁴ For instance, people believed that a fumigated house would soon start breeding lice, fleas,

3 AnneLoes van Staa and Anita Hardon, *Injection Practice in the Developing World: Results and Recommendations from field studies in Uganda and Indonesia*, Prepared for WHO-DAP, (Amsterdam: The University of Amsterdam), ND. P. 19.

4 Ministry of Health, File No ጁ-17, Yimer Muhie to Dässie Health center, 23 May 1966; Ministry of Interior, File No 131-፬-5, Malaria Eradication Center to Wällo provincial Governorate *Endarassie*, 28 February 1967.

bedbugs and other insects. To counteract such erroneous belief and resistance, the Ministry of Public Health and the Wällo Provincial Governorate Office in 1955, requested the Ministry of Interior to grant local governors the authority to forcibly vaccinate the public against typhus and small pox.⁵ For the treatment a variety of diseases the ‘injectionists’ blended their use of injections, such as analgesics, vitamins and water-diluted antibiotics and serums without impinging on local etiological beliefs of their patients.⁶ “In addition to preceding traditional attitudes and practices relating to health there is usually also what might be called an ‘intermediate level’ of infiltration into the rural hinterland by self-styled, unqualified ‘dressers’ [health assistants] who have equipped themselves with hypodermic needles hopefully filled with some healing liquid,” observes Messing in the early 1970s.⁷ Mekonnen has also made a passing remark on the expansion of western medicine and the emergence of a new and growing number of pseudo-modern ‘injectionists’,⁸ who were also referred to as ‘specialists’ of the ‘transitional medical system,’ a concept initially introduced by Buschkens and Slikkerveer⁹

While the *mārjje wāgje*, also sarcastically branded as ‘injection doctors’, were popular among the wider public, indigenous healers scorned them for blending indigenous and biomedical products. Indigenous healthcare providers viewed these ‘hybrid’ healers as indecent practitioners whose principal motive was to exploit the credulity of the common people to their own advantage. They also held ‘hybrid’ healers accountable for dishonoring genuine practitioners, who offered their services ethically and without a taint of hypocrisy. For them these ill-motivated and insincere practitioners conspicuously assisted individuals who were purposefully working on defaming and discrediting indigenous therapeutics. Indeed, the posturing of ‘hybrid’ healers as skillful practitioners of indigenous and biomedicine greatly

5 Ministry of Interior, File No *sm*-5/27, Ministry of Public Health to Ministry of Interior, 14 July 1955; Ministry of Health, File No *ጁ*-17 Wällo Provincial Governorate Office to the Ministry of Interior, ND, 1955.

6 See Jan Leendert Slikkerveer, “Rural Health Development in Ethiopia: Problems of Utilization of Traditional Healers,” *Social Science and Medicine*, 16, 1982, P.1863.

7 Simon Messing, *The Target of Health in Ethiopia, a Holistic Reader in Applied Anthropology*. (Southern Connecticut State College, 1972), p. 245.

8 Mekonnen Bishaw, “Promoting Traditional Medicine in Ethiopia,” *Social Science and Medicine*, 33 (2), 1991, P.195.

9 W. F. L. Buschkens, & L. J. Slikkerveer, 1982 *Healthcare in East Africa*, p. 53.

assisted public health officials to depict all alternative healthcare providers as quacks or impostors,¹⁰ argued healers.

Healers also claimed that the ‘injectionists’ use of resources from both indigenous and biomedicine reflected their lack of knowledge of either therapeutic system. Needless to say, the *mārḥie wāḡie* were threatening healers’ financial interests by drawing away patients from them. As a result, the majority of indigenous healers like modern healthcare practitioners sought the prohibition and eviction of ‘hybrid’ healers from the medical marketplace. In most instances, however, patients wanted the medical assistance of the ‘injectionists’ when the medical treatments they received from indigenous healers proved ineffective or vice versa. Hence, such complaints and accusations in the medical market seemed to have arisen from conflict of interest among the three groups of healthcare providers, i.e. indigenous, hybrid and conventional medicine.¹¹

The problem of using and abusing antibiotics by the *mārḥie wāḡie* was the other subject of criticism of trained biomedical practitioners which was probably contemporaneous with the sporadic use of Penicillin injection since the late 1940s or early 1950s. Calling the *mārḥie wāḡie* as ‘itinerant village doctors,’ biomedical health personnel accused them of engaging in unlawful clinical practices and distracting the people from tapping the qualitatively superior and standardized conventional medical treatments.¹² Instead of emphasizing on the unsafe and unhygienic practices and the obvious risks that certain ‘strains of bacteria’ would become resistant if antibiotics were haphazardly used, clinic administrators were mostly concerned about the loss of revenue of public health institutions and the personal enrichment of the unlicensed *mārḥie wāḡie* and drug vendors. The head of a newly-established government clinic (a clinic operating only for a little more than a couple of months)¹³ wrote that the many ‘injectionists’ and illegal drug dispensers were drawing patients away from his clinic, making it impossible for the clinic to provide modern medical services to the local community. His report, which appears to have been exaggerating

10 Oral Informants

11 Oral Informants

12 Ministry of Health, File No ጵ-17. Mohammed Wolde to Dässie Provincial Health Department, 31 September 1966.

13 Wällo Provincial Health Department, File No ፱-6. Gobena Yimer to Dässie Provincial Health Department, 24 July 1971.

the actual state of affairs in order to gain the attention of higher authorities, stated that the number of patients coming to the clinic daily was between 100 and 160, but now it had suddenly dropped to zero. Be that as it may, he advised the provincial health office to banish these illegal practitioners from his catchment area and suggested that they may be allowed to work in places where there were no government clinics.¹⁴

Regardless of the uncompromising stance of both biomedical practitioners and indigenous healers toward ‘hybrid’ healers, and the apparent proliferation of modern western medicine and medical knowledge in the country, the number of *mārḥie wāḡie* or ‘injectionists’ appeared to have increased substantially from the 1940s through the 1970s. This growth, while difficult to quantify, reflected a growing demand for medical practitioners who would fill the huge gap created by the dearth of western medical facilities. The scarcity was so serious in the early 1950s that the medical director of St. Paul Hospital, Dr. Lares (?), wrote a recommendation letter to the ministry of health for a janitor (cleaner) to be employed as a first level health assistant or dresser for the reason that he observed the capability of the said person in administering injection efficiently and treating malaria, typhus and typhoid-fever patients with hypodermic needle.¹⁵

Training of the *Mārḥie Wāḡie*

Where did the ‘injectionists’ come from and how did they acquire their knowledge? Some indigenous healers believed that a few crafty individuals, having some knowledge of botanical remedies, were the ones who first indulged in learning some biomedical practices, notably prescribing antibiotics, with or without administering hypodermic injections, for their parents, relations or acquaintances.¹⁶

This view may be partially correct, but we can obtain a much better assessment of their backgrounds from other written and oral sources. Though archival documents are almost silent about the ways in which the ‘injectionists’ got their medical training in the 1950s and 1960s, there is some evidence that the ‘injectionists’ constituted individuals

14 Ibid

15 Ministry of Public Health, File No Φ -9, Director of St. Paul Hospital to the Ministry of Public Health, 30 September 1951.

16 Wällo Provincial Health Department, File No ω - 6. Gobena Yimer to Dässie Provincial Health Department, 24 July 1971.

who had at least not less than six months of medical training and certification (either as junior or advanced health assistants or dressers), most of them had been working or retired from after many years of medical service in the military or in government clinics.¹⁷ Trained ‘injectionists’ were the ones who had been properly instructed on how to administer subcutaneous, intramuscular and intravenous injections. Even then, they were not fully trained on how to contend with allergic or drug reactions, nor were they entitled to diagnose illnesses or prescribe appropriate medications.¹⁸ However, using their long-time observation and experience, they were the ones who would be consulted to diagnose and treat maladies with commonly perceived signs and symptoms. Interview with current and former ‘injectionists’ provides a richer picture of these pervasive purveyors of ‘hybrid’ medicine. These sources indicate that many ‘injectionists’ received considerable hands-on training with very little or no theoretical lessons.

Looking back with the benefit of hindsight, a good number of *mārfīe wāgīe* had been retired health assistants from the armed forces and public schools. However, these trained ‘needle-men’ (former and current employees) in the army and public schools were the ones who had been repeatedly accused of traveling to several sub-districts or Wārādas on part-time basis to administer injections and treat patients.¹⁹ The head of a government clinic at Awrājā or district capital appealed to the district governorate office to ban these itinerant health workers and to notify lower level officials to send patients suffering from non-communicable diseases directly to the clinic; and if these officials reported on communicable diseases, healthcare providers from the clinic would quickly move to the affected places and offer medical assistance to the people. The clinic administrator also added that this procedure would help differentiate the types of maladies that prevailed in those places and deliver the necessary report to Asfa Wossān hospital in Dässie.²⁰

17 Wällo Provincial Health Department, File No **ወ- 6**. Hayq District Clinic to Ambassel District Governorate Office, 26 June 1959.

18 Wällo Provincial Health Department, File No **ወ- 6**. Asfa Wossān Hospital to Dässie Provincial Police, 6 January 1958; for the persistence of this problem; see also Wällo Provincial Health Department, File No. **ወ- 6**. Wällo Provincial Governorate Office to the 12 District Governorate Offices, 2 July 1972.

19 Wällo Provincial Health Department, File No **ወ- 6**. Hayq District Clinic to Ambassel District Governorate Office, 26 June 1959.

20 Ibid

Claiming to have been serving as an emergency medical provider or First Aid worker in an artillery unit and later became a renowned *mārfie wāgīe* recounted that he had obtained training on how to take care of the wounded, including those with bone, joint and muscle injuries, and to arrest bleeding using his First Aid kit until a trained healthcare provider arrived. He claimed that some First Aid givers, serving as health assistants for trained medical practitioners, were recruited to receive additional training on how to observe the physical constitution of a patient and diagnose his/her sickness. These trainings included on how to perceive signs and symptoms like fever, diarrhea, head or stomachache, a boil or a lesion on the body or an inflammation of the tonsils, intestinal worms, fever, skin diseases and eye or ear infections as well. After some time, a trainee would be shown on how to use a stethoscope to listen to the breathing and heartbeat of patients, to count their pulses, and to administer injections along with some other commonly used medicinal prescriptions.²¹

In some ways the training of ‘injectionists’ resembled that of cleric and/or knowledgeable secular healers. An oral informant who had been working as an ‘injectionist’ since the late 1950s observed that to become a good ‘injectionist,’ ‘one has to be patient and obedient.’ This meant, establishing a long-lasting relationship with a trained medical practitioner, listening to his words carefully and watching him as he practiced, were important preconditions before gaining enough knowledge to begin practicing on his own. It had taken him nearly two years to master all the necessary knowledge. After quitting his military career, he went back to his rural village and began to serve as an ‘injectionist;’ he later moved to Dässie and continued his injection duty until he stopped working due to ill-health. ‘A physician slapped me on the face when I was about to give injection to a patient without removing the air from the syringe as it should be,’ he reminisced an incident during his training.²² During training sessions the *mārfie wāgīe* also learned how to prescribe medicines for different non-life threatening illnesses and to administer antidotes to avoid allergic or drug reactions. These were important pieces of knowledge, which the ‘injectionists’ applied when they started practicing medicine independently.

21 Oral Informant

22 Ibid

Not all ‘injectionists,’ however, were formally trained. Several ‘injectionists’ admitted to having joined the medical field without receiving proper training; they had simply developed the skill from trained ‘injectionists’ who showed them how to administer injections. Initially, this group of ‘injectionists’ had been employed in public health facilities as guards, gardeners, cleaners or other similar lower level jobs. Mission hospitals were particularly congenial to provide practical training to their lower level employees in different fields of healthcare services. By cultivating congenial relationship with trained ‘injectionists’ a number of preliterate workers were able to learn how to sterilize syringes and needles and the specific body sites they would administer injections. However, the ‘trainees’ were not allowed or had very little opportunity to practice openly of all the techniques they observed from their mentors, including giving injections. This practical training was no more than observing closely when their trainers administered injections into the arteries, muscles, veins, or into or under the skin. After going through a long period of observation, however, these ‘trained’ individuals at some point in time would be allowed to start giving injections to patients in the same institution. But the majority of them would become part-time *mārfie wāgie* while still working in the health institution or as full-time ‘injectionists’ after leaving it for various personal reasons and before their retirement. With a few reusable syringes and needles at their disposal, they started their own medical business. They served their community by constantly moving from house to house or from neighborhood to neighborhood. The act of sterilizing injection instruments with a boiling water in front of patients would suggest that the *mārfie wāgie* were well aware of the danger unsterilized syringes and needles may have caused, including the transmission of ‘blood borne’ or other transmissible diseases.

To use disposable needle and syringe, if not ‘auto-disable’ ones, for every injection has been a recent phenomenon. Though the first syringe and hollow needle came into use in the second half of the 19th century, that is, before microorganisms and infections became common knowledge, it was in the late 1950s that disposable syringes and needles began to be applied for drug injection purposes.²³ It was during the Italian occupation period that a large segment of the Ethiopian public

23 Craig, Robert. 2018. A History of Syringes and Needles. <https://medicine.uq.edu.au/blog/2018/12/history-syringes-and-needles>

in urban areas had been acquainted with injections. The Italian medical staff, which was estimated to be around twenty thousand, carried out a number of extensive preventive health programs and mass campaigns among the local people.²⁴ In particular, the highly praised strength-giving Calcium preparation, locally called *calço*, seemed to have increased the acceptability of western type medical treatments with hypodermic needles.²⁵ The spectacular curing effect of such injections during the Italian rule undoubtedly increased the public's admiration for Western medicine,

While almost all 'needle-men' learned their skills in urban areas, the best opportunity for developing experience and attracting clients for them was to roam around in rural areas as itinerant 'injectors.'²⁶ Whatever the degree of their medical training, the *mārfie wāgie* as conveyors of western biomedicine would begin to sell their utilitarian medical expertise to the rural public, including retail of medicines in their kiosks, drug shops and weekly markets. Some experienced 'injectionists' working in Dässie recounted that they had been officially and repeatedly invited to participate in vaccination/immunization campaigns when epidemic diseases broke out in rural areas.²⁷

The *Mārfie Wāgie* and the Medical Market

Facing very little competition from government clinics situated at Awrājā (district), Wārāda (sub-district) capitals and along the main roads, the 'injectionists' were able to dominate the medical market in the countryside. To counter this situation, clinic administrators, relying on the support of local administrative officials, persistently tried to repress the 'injectionists.' Ignoring the contribution of the 'injectionists' in supplementing, not supplanting, the western healthcare delivery system, clinic administrators frequently reminded local administrative officials to be vigilant of the 'injectionists' working in their respective

24 Richard Pankhurst, "The Medical History of Ethiopia during the Italian Invasion and Occupation (1935–1941)". *JES* 4(2), 1973: pp. 108–117

25 Asrat Waldayes, "The Postliberation Period (1941-1973)," in Richard Pankhurst, *An Introduction to the Medical History of Ethiopia* (Trenton, NJ: The Red Sea Press, 1990) P.245.

26 Oral Informants

27 Oral Informants

areas and to send patients directly to the government clinics.²⁸ Written reports often stressed that the *mārḥīe wāḡīe* and rural drug traders violated the public health proclamations and posed serious health threats to local populations.²⁹ But the crux of the matter was that the ‘injectionists’ and drug traders retailing pharmaceutical products in the rural areas did effectively compete for clients. Biomedical institutions, in order to gain control of the medical marketplace, felt ‘duty-bound’ to take action against the ‘injectionists.’³⁰ The *mārḥīe wāḡīe*, working as competitors of allopathic healthcare practitioners, were accused of treating patients with unknown or harmful medicines. Besides frequent appeals for legal measures against them, almost all government-owned clinics were in favor of strict implementations of the regulations on those who administered injections and the few drug shops that vended ‘inappropriate and even expired medicines.’³¹ Despite the ‘manipulation of traditional and cosmopolitan medical principles and practices’, the ‘injectionists’ purveyed timely and useful medical interventions in rural Ethiopia, especially in places where both traditional and cosmopolitan medicine were unreachable or in short supply.³²

Though well aware of the limited availability of therapeutic options in the countryside, biomedical practitioners refused to acknowledge the role of the ‘injectionists’ and drug peddlers in the rural medical market. They were more concerned with controlling the ‘injectionists,’ whom they portrayed as exploiters of the preliterate public, than rationalizing the actual situation/s that deprived the rural public of better healthcare delivery system. Instead, the majority of government clinic administrators persistently asked the collaboration of higher authorities

28 Wällo Provincial Health Department, File No **ወ- 6**. Hayq District Clinic to Ambassel District Governorate Office, 26 June 1959; Wällo Provincial Health Department to Borena District Governorate Office, 23 August 1963; Wällo Provincial Health Department, File No **ወ- 6**. Wällo Provincial Health Department to Sayo Tebela Sub-district Governorate Office, 27 September 1962.

29 Wällo Provincial Health Department, File No **ወ- 6**. Qallu District Clinic to Asfa Wossän Hospital, 8 June 1959.

30 Wällo Provincial Health Department, File No **ወ- 6**. Raya and Kobo District Clinic to the Ministry of Health, 19 May 1959; Wällo Provincial Governorate Office to the Twelve District Governorate Offices, 2 July 1970.

31 Wällo Provincial Health Department, File No **ወ-6**. Teferi Yimer of Ancharo Clinic to Wällo Provincial Health Department, 11 June 1974.

32 Leendert Jan Slikkerveer, *Plural Medical Systems in the Horn of Africa: The Legacy of ‘Sheikh’ Hippocrates* (Leiden; Kegan Paul International, 1990), pp. 256-57.

and the police to detain the ‘injectionists’ and drug vendors to be convicted and fined. Referring to more than half a dozen letters of the Ministry of Health (MOPH or MOH) and the Wällo Provincial Governorate Office (WPGO) in the period between 1951 and 1958, the head of a district health office complained about why legal measures were not taken against unlicensed drug shops in its district.³³ At times, the police were requested to provide justification how unlicensed needlemen and drug sellers being apprehended of illegal practices could not be taken to the courts and punished.³⁴

In the face of such assaults, however, some *mārfie wāgie* seeking for accreditation applied for a work license and serve as legitimate ‘health workers.’³⁵ The need to create jobs to help themselves and their families was often stressed by the applicants.³⁶ Applications came not only from places where there were no public health facilities, but also from a number of localities where government clinics had been functioning for years. These applications were not entertained, and health offices as in the past continued to point to the danger that could be created by unschooled practitioners, who did not have even a modicum of elementary health education and whose medical knowledge was limited to giving injections only.³⁷ Health workers also argued that these self-proclaimed medical practitioners were damaging the reputation of biomedicine by mismanaging medications. In other words, the ‘unbridled action’ of untrained practitioners and their pseudo-treatment was blamed for making the rural people less enthusiastic about western medicine, which would eventually lead them to preparing *wādājā* ritual

33 Wällo Provincial Health Department, File No *ω*- 6. Qallu District Clinic (Kombolcha) to Asfa Wossän Hospital, 8 June 1959.

34 Wällo Provincial Health Department, File No *ω*- 6. Asfa Wossän Hospital to Dässie Provincial Police, 6 January 1958.

35 Wällo Provincial Health Department, File No *ω*- 6. Wällo Provincial Health Department to Sayo Tebela Sub-district Governorate Office, 27 September 1962.

36 Ibid.

37 Wällo Provincial Health Department, File No *ω*- 6. Gebre Medhin Gebre Egzi of Lalibela Health Center to Wällo Provincial Department of Health, 8 March 1971; Wällo Provincial Department of Health to the Borena District Governorate Office, 23 August 1963; Wag District Clinic (Korem) to Wag District Police, 7 November 1959; Hayq District Clinic to Ambassel District Governorate Office, 26 June 1959; Qallu District Clinic to Asfa Wossän Hospital, 8 June 1959; Raya and Kobo District Clinic to the Ministry of Health, 19 May 1959; Asfa Wossän Hospital to the Wällo Provincial Police, 7 March 1959; Wällo Provincial Health Department to the Wällo Provincial Governorate Office, 12 May 1971.

sessions or resorting to village seers and other forms of indigenous medical treatments.³⁸ The *wādajā* seemed compulsory when a community was affected with communicable diseases (human or animal) and natural calamities such as drought, heavy rain, and locust invasion. The ritual was also used for healing purposes when, for example, the family of the sick would summon *wādajā* experts to conduct a healing session to free the sick from physical or socio-psychological illness and help the patient regain his/her health.³⁹

To control the ‘injectionists,’ who traveled from place to place with their syringes and tablets, clinic administrators repeatedly requested the cooperation of the police. To do this they held the ‘injectionists’ responsible for patient fatalities.⁴⁰ Some *mārḥie wāḡie* were repeatedly accused of causing permanent disability and physical injury on their patients.⁴¹ Despite the steady growth in number of unlicensed practitioners and recurrent accusations against them, there was no effective mechanism to restrain them from their activities. The 1948 legislation was intentionally issued to control practitioners of indigenous medicine and the rapid proliferation of new forms of healers such as ‘injectionists’ and ‘hybrid’ healers, whose diagnostic and therapeutic modalities combined indigenous and Western methods.⁴² However, its implementation was so complex that the targeted groups continued their duty as usual. The punishments specified in the 1957 Penal Code did very little to discourage unlicensed medical practitioners from committing repeated infringements. One of the sub-articles 518 (1) under the title ‘unlawful exercises of the medical or public health professions’ reads: “Whosoever, having neither the professional qualifications prescribed and controlled by the competent authority nor

38 Wällo Provincial Health Department, File No **ወ-** 6. Gebre Medhin Gebre Egzi of Lalibela Health Center to Wällo Provincial Governorate Office, 8 April 1971.

39 Assefa Balcha, “Wadaja Ritual: Portrait of a Wällo Cultural Coping Mechanism.” *Eastern African Literary and Cultural Studies*, 3.1 (2017): 40–52. DOI: 10.1080/23277408.2017.1323170.

40 Wällo Provincial Health Department, File No **ወ-** 6. Wällo Provincial Governorate Office to the Twelve District Governorate Offices, 2 July 1972. See *Penal Code* 1957 Article 518.

41 Wällo Provincial Health Department, File No **ወ-** 6. Asfa Wossän Hospital to the Wällo Provincial Police, 7 March 1959; Wällo Provincial Health Department to the Wällo Provincial Governorate Office, 12 May 1971.

42 Imperial Ethiopian Government, *Nägarit Gazāta*, Sub-article 3(B), (Addis Ababa: 1948).

the authorization to set up in official practice ... is punishable with simple imprisonment and fine.”⁴³

This situation did not show any sign of improvement in the early 1970s when, for example, an ‘injectionist’ was accused of deceiving his patients by telling them that ‘his injections and medicines were effective and much better than similar products from the government clinics.’ He was blamed for misinforming patients (while entertaining them with coffee) to accept his ‘blessed’ medicine.⁴⁴ The success of the ‘injectionists’ in attracting clients through persuasion or deceit may not be surprising. In 1967, an estimated three million people of Wällo had a hard time accessing healthcare institutions. There were only three mission hospitals, a leprosarium, five health centers, twenty clinics,⁴⁵ and about forty-six health workers (which amounted to one health worker per 65,000 people) in the whole province.⁴⁶ The first three health centers in Wällo, the one in Dässie included, were established in 1961.⁴⁷ The only change that we see in the same province in 1971 was that the number of health centers and clinics grew to eight and twenty-four respectively.⁴⁸ Yet, even with this increase, four out of twelve Awrājās or districts had no health centers until 1973,⁴⁹ a year before the popular Ethiopian revolution of 1974. The number of medical doctors in Ethiopia in 1973 was about 370, of which about 70% of were expatriates working in major towns like Addis Ababa, Asmara and Harar.⁵⁰

43 Imperial Ethiopian Government, *Penal Code* (Addis Ababa, 1957).

44 Wällo Provincial Health Department, File No **ወ**- 6. Asfa Wossän Hospital to the Wällo Provincial Police, 7 March 1959.

45 Wen-Pin Chang, “Development of Basic Health Services in Ethiopia” Reprinted from the *Journal of the Formosan Medical Association*, V.68, N.6, 1969, P.309.

46 Wen-Pin Chang, “Development of Basic Health Services in Ethiopia”, *Ethiopia Observer*, V. 12 N. 4, 1969, p. 231; Dässie Hospital, File No.32/**ሙ**-10/2, June 17, 1967.

47 Ministry of Public Health, “Directory of Medical and Health Institutions in Ethiopia,” January, 1972. P14; during the First Five-Year Plan, 1960-1965, the number of health centers at a national level was no more than 58.

48 Ministry of Public Health, “Directory of Medical and Health Institutions in Ethiopia,” January, 1972, P.8.

49 See Richard Pankhurst, *An Introduction to the Medical History of Ethiopia*, P.263.

50 Ibid.

The Search for Alternative Treatment

The aggressive stance of health authorities toward the ‘injectionists’ and other non-biomedical health practitioners did little to diminish their acceptance and popularity. This hostile approach deprived biomedical practitioners the opportunity to gather information as to how the ‘injectionists’ popularized the injection needle in Ethiopian society. As a result, the information that could have been used to adapt western medical practices to local socio-cultural settings and to devise accommodative or interventionist strategies was never collected. Efforts to eliminate competition from unlicensed providers of biomedical treatments failed and people continued to take advantage of the multiple sources of healing available in the Ethiopian medical marketplace. Since access to government or mission-run healthcare facilities remained very restricted, the only option for people in remote areas was to use the services of the *mārḥie wāḡie* and rural drug vendors. These people were left with two alternatives: to suffer and die without getting any medical help, or to look for and use other streams of indigenous healing methods. The *Enderassie* of Wällo, stating about the unavailability of even Aspro for treating headache, consistently reported why the health tax paying people living in faraway areas of the province was deprived of a clinic.⁵¹ This situation greatly abetted the ‘injectionists’ to maintain their dominance and acceptability in the relatively competitive medical market. As *flow-through cases* had been common, patients had the opportunity to alternatively exploit different medical systems for a number of illness episodes. This situation implied that there was an apparent increase in demand for both practitioners of the transitional, such as the *mārḥie wāḡie*, and modern healthcare delivery system.⁵²

Those who chose to visit the ‘injectionists’ did so for a number of reasons. In some cases local understanding of the etiology or pathology of a disease may be the best choice for a patient to be treated by an ‘injectionist.’ For example the ideas surrounding an undifferentiated sickness called *meç* (a disease attributed to the influence of the sun,

51 Ministry of Interior, File No 131-*፬*-5, Wällo Provincial Governorate Office to Ministry of Public Health, 24 March, 1964; Ministry of Interior, File No 131-*፬*-5, Wällo Provincial Governorate Office to Ministry of Public Health, 24 March 1969.

52 W.F.L. Buschkens, & L.J. Slikkerveer, *Healthcare in East Africa*, pp. 101, 103.

causing fever and aching of the whole body) often encouraged patients to seek treatments with hypodermic injections. The alleged swiftness of injections in providing relief for acute illnesses like *meç*, a self-curing illness, prompted patients to attach particular importance with the injection needle and the ‘injectionists.’ The need for immediate or quick relief from their illnesses was the prime reason why many patients became highly enthusiastic about having injectable treatments than swallowing tablets. But, as Taylor remarked, “The greatest hazard is the tendency of [these] practitioners to use the most powerful drugs possible in order to achieve quick results.”⁵³ Most unschooled patients did not understand why biomedical practitioners preferred to prescribe tablets than injectable medicines. For them the idea of taking oral therapy for several days was not an attractive option. Such patients had a problem observing times to take tablets, including skipping doses (especially during fasting days) and overdosing. In other cases, *mārfie wāgie* were chosen for social reasons. For example, ‘injectionists’ were often called on to treat patients with venereal disease, who, fearful of being censured or stigmatized, wished to avoid being treated at a public health clinic. Offering such a discreet service was valuable for the ‘injectionists’ to create strong social networks and obtain gifts from their clients and ex-patients.⁵⁴

Patients who wanted to conceal or unwilling to admit their infection with sexually-transmitted diseases did not immediately come to the ‘injectionists’ because it was widely believed that to have an injection would only bring short-term relief, not a lasting cure. The saying, መርፌ አትውጉ በሽታውን ይደብቀዋል “Do not take injection because it stashes away the disease,” indicates the hesitancy of VD patients on the efficacy of modern medicine. In fact, many VD patients often used variety of medicaments indigenous herbalist-healers prescribed to them. They came to consult the ‘injectionists’ as a last resort when the indigenous treatments could not bring the desired results. In a similar vein, immunization against cattle diseases was also a serious challenge as cattle owners did not believe in the efficacy of modern inoculation methods. Among the rumors circulated included ‘a vaccinated ox would not be able to pull the plow for about seven months’, while ‘the milk,

53 Quoted in Leendert Jan Slikkerveer, *Plural Medical Systems in the Horn of Africa: The Legacy of ‘Sheikh’ Hippocrates* (Leiden: Kegan Paul International, 1990), p.254.

54 Oral Informants

butter and meat of a vaccinated cow would get spoiled and would not be used for consumption.’⁵⁵ Relying on the available indigenous therapeutic resources and for cultural reasons, cattle owners were not enthusiastic about ascertaining the efficacy of the alleged ‘wonder-working’ preventive or curing power of modern veterinary services. It was in the early 1950s that a permanently-based veterinary service had been established in Dässie, Wällo.⁵⁶ It is no wonder that public reception towards modern veterinary services was lethargic at best, if not totally negative.

There were also other cultural reasons why patients might avoid therapeutic injections. It was widely believed that diseases caused by the action of certain spirits might be made worse by an injection. This was because the needle could hurt the disease-bearing spirit, causing it to endanger the life of the patient by making him/her unresponsive to other local therapeutic or exorcizing procedures. While treatments with the injection needle were highly acclaimed in curing physical illnesses, patients believed to have been attacked by disease-causing spirits were mostly advised to avoid injections and seek indigenous treatments as quickly as possible. This suggests that the acclaimed “hypodermic needle fails to challenge traditional attitudes and beliefs that govern healing in the popular mind”, argued Messing.⁵⁷

It is worthy of note that the widespread use of Tetracycline seemed to have played a pivotal role in reversing the public’s unbounded appreciation of treatment by injection. Tetracycline had a special place in changing this entrenched perception towards injections, and people named it ሸጉጥ ኪኒን *Segut Qinin*, (pistol pill, a misnomer for bullet), an adjective still reminisced today. It appeared that Tetracycline, being widely perceived as a ‘magic pill’, was indiscriminately taken for treating various kinds of ailments. Breaking the capsule and applying its contents on minor body sores and using its potion for treating domestic animals such as sheep, goats and chickens was not unusual. Giving a few Tetracycline pills to a sick neighbor or family member was a gesture

55 Municipality of Dässie, File No. ሰ 3-4, Ministry of Agriculture to Wällo Provincial Governorate Office, 27 July 1949.

56 Municipality of Dässie, File No. ሰ 3-4, Wällo Provincial Governorate Office to All Awraja Governorate Offices, 26 June 1952.

57 Simon D. Messing, “Interdigitation of Mystical and Physical Healing in Ethiopia: Toward a Theory of Medical Anthropology” *Behavior Science Notes* V. 2, 1968, p. 103.

of generosity and concern. Taking a couple of Tetracycline capsules before engaging in a sexual act was an exceedingly common phenomenon among those who had some modern education. Later on, some people even used to take other antibiotics called Bactrim and Sulfa drugs as a prophylactic. And those who had been infected with VD would also drink an infusion of the boiled leaves of *çät* (*Catha edulis*) and a good amount of *čalla* (home-made beer) thinking that the disease-causing pathogen would be washed out by increasing the excretion of urine.

Patients often preferred to consult an ‘injectionist’ of high reputation and experience to that of an ordinary or inexperienced needleman. The adage አጁ መድኃኒት ነው ‘he has a curing hand’ or ‘his hand is medicinal’ expressed the need for an ‘injectionist’ with a reputation for bringing immediate relief and for administering injections without hurting his patients. An additional characteristic looked for in *mārfje wāgie* was his comforting gesture and the ability to instill a spirit of encouragement into his troubled clients. ‘Injectionists’ did more than inject medicines into their clients. As part of their treatment regimen, they offered pieces of advices on how to manage diseases, the value of emotional strength and the damaging power of too much worrying, including evading spicy or peppery foods besides milk and alcoholic drinks. This idea of avoidance is believed to be one of the legacies of the Italian period.⁵⁸ These counsels may be of some help to avoid the irritation of the patients’ mouth, throat and the digestive system. The *mārfje wāgie* believed that the ability to manage sickness was as important as the ability to inject medicines.⁵⁹

In some cases, the *mārfje wāgie* refused to administer injection to seriously ill patients, fearing that they might be held accountable for the patients’ death, a situation that could readily be exploited by the health authorities. It was not uncommon to attribute a patient’s death to an incorrect diagnosis and a medication administered by an ‘injectionist.’ In contrast to this, the ‘*mārfje wāgie* discouraged some patients from having treatments with the injection needle because they felt that other local mode of treatments, such as inhaling the boiling steam of medicinal herbs, drawing some blood from the body, or spiritual

58 Asrat Waldayes, “The Postliberation Period (1941-1973),” in Richard Pankhurst, *An Introduction to the Medical History of Ethiopia*, P. 245.

59 *Ibid*

treatments, would be more effective. They at times recommended bloodletting for undifferentiated febrile illnesses and spiritual treatments for some psycho-social or mental illnesses.⁶⁰ Bloodletting was widely practiced around the end of the 1970s. In an attempt to fight against the disease known popularly as *moñe bageñe* (lit: ‘If I get fool’), some indigenous healers and few ‘injectionists’ incised the veins of patients with a razor blade for drawing out the allegedly tainted or diseased blood. No one knew the disease-causing pathogen including the public health personnel; and the disease was so sporadic that the provincial public health office wrote a letter to the Ethiopian News Agency in Dessie to transmit to the public a message about the danger of drawing blood and the potential health hazard that this would entail.⁶¹ This shows that the ‘injectors’, sharing similar socio-psychological outlooks with their clients, oftentimes adhered ‘to traditional disease concepts and methods of healing’⁶²

More often than not, patients visiting the *mārfie wāgie* expected to receive injectable treatments. As one ‘injectionist’ succulently put it, ‘with the exception of a few ailments which can be easily distinguished by looking at the condition of patients, the best therapeutic choice for almost all human maladies was the injection needle.’⁶³ The majority of ‘injectionists’ believed that they administered injections in response to the demands of their health seeking clients. Many patients came with a preconceived notion of getting immediate relief from their sickness with injectable medicines; and it was not an easy undertaking, underlined an ‘injectionist,’ “to persuade patients not to have injection or to try other treatment modalities.”⁶⁴ To satisfy the wishes of their inflexible clients or malingerers the *mārfie wāgie* at times injected them distilled water. This action, which was based on unreserved admiration for injections and their trust in the *mārfie wāgie*, may be of assistance in weakening the hold of a disease/s on their patients and speeding up their recovery. This treatment method, having some placebo effect,

60 Oral Informants

61 Dässië Zuriä Workers’ Party Office, File No. 49-08-9, ከሠ 12; 5 Megabit, 1971 EC

62 Helmut Kloos, ‘The Geography of Pharmacies, Druggist Shops and Rural Medicine Vendors and the Origin of Customers of such facilities in Addis Ababa’, *Journal of Ethiopian Studies*, Vol XII, 2, 1974: p. 84.

63 Oral Informant

64 Oral Informant

“had more to do with psychological than with real biological or therapeutic worth,”⁶⁵ reasoned an informant.

Even when the treatment of choice was the injection, the *‘märjie wājie* would mindfully advise patients in accordance with the socio-culturally-rooted perceptions and understandings of the causes of their sickness. In this regard they differed in a fundamental way from biomedical practitioners who refused to acknowledge the importance of these understandings. For example, for gonorrhoea afflicted individuals, to whom they administered penicillin injections, the ‘injectionists’ advised them to avoid exposure to the sun while peeing or not to pee on the spot where a dog had previously urinated. Such inexplicable actions were believed to initiate sexually-transmitted diseases. To avoid contracting hemorrhoid they advised their clients not to sit on a hot spot or not to relieve themselves at or near the spot where a person with hemorrhoid had previously relieved himself. They also advised to take care of themselves from getting sick arising from contaminated water, malnourishment, and abuse of alcohol and bites of certain insects.⁶⁶ While administering injections to VD patients, they asked about the willingness of their spouses to undergo similar treatments. To break the cycle of reinfection, the ‘injectionists’ persuaded and advised patients to abstain from sexual contacts for some time to come, that is, until they had been fully cured and regained their health. Such persuasive engagements were essential in a society where VD patients were customarily advised to have repeated sexual intercourse.

In order to boost up the efficacy of their treatments and to maintain their reputation, the ‘injectionists’ offered pieces of advice to their patients. For instance, they advised patients to regularly bathe their bodies and maintain their personal hygiene, to have adequate rest, to prevent constipation and to go to the restroom on a regular basis, to clean their teeth with brushing sticks and to take hot drinks and cooked foods. Many ‘injectionists’ prohibited patients from taking salty, fatty or highly fermented foods, as well as drinking coffee and local beverages with strong alcoholic contents and engaging in licentious sexual behaviors. The *märjie wājie* ardently believed that to lead a healthy life a person had to consume different kinds of diets, and not to do so could

65 Oral Informant

66 Oral Informants

expose him\her to variety of maladies. They also considered some foods as potential sources of ill-health.⁶⁷

It was with the demand of the sick or his/her family members that the ‘injector’ would make a visit to the patient’s residence. Treating patients in their homes was one of the reputed services of the ‘injectionists.’ The *mārfie wāgi* as paramedics went to the homes of the sick to provide urgent medical assistance such as pain-killers (Caffenol, Aspro, Aspirin, and Algon) tablets or other therapeutic injections, and as midwives they helped pregnant women deliver their babies.⁶⁸ They may have administered a one-time injectable medication if they thought sufficient or for a number of days if the illness was serious. There were also few ‘injectionists’ who had the requisite skill of removing troubling tooth. Habitually, they administered injection topically before removing the diseased tooth.⁶⁹ Practitioners of the transitional medical system such as tooth-pullers, drug-vendors and needlemen comprise a major manpower resource for the urgently needed rural auxiliary health workers. These commercially oriented healthcare workers being familiar and experienced with the application of certain cosmopolitan therapies, instruments and medicines including worm killers and ointments⁷⁰ were widely accepted in both rural and urban areas in the province.

Though they carried out unethical medical tasks in secrecy, some health assistants who pretended to serve as ‘injectors’ were known to have been involved in unlawful and risky medical practice such as criminal abortion. To get access to this illegal service was not always easy to women, often school girls, sex workers, unmarried and divorced ones, who had sexual contacts without taking contraceptives and gotten pregnant and desperately decided to terminate their pregnancy. Such misdemeanors had greatly assisted those who would want to discredit and smirch the reputation of the ethically-governed and genuine *mārfie wāgie* as a whole.

Others provided their services day and night. An ‘injectionist’ remarked: “To help patients living in nearby areas and to provide emergency medical assistance, I used to travel to their homes in the middle of the night, often accompanied by my sons”.⁷¹ At other times,

67 Oral Informants

68 Personal Communication

69 Personal Communication

70 Jan Leendert Slikkerveer, “Rural Health Development in Ethiopia.” pp. 1868-69.

71 Oral Informant

particularly for patients having injection prescriptions for several days from public healthcare institutions, the *mārḥie wāḡie* went to their homes either early in the morning or after sunset, the two most preferred times to give injections. The idea of giving injections during these times of the day was to keep patients away from the evil influence of the midday sun, which was believed to aggravate many illness conditions. Occasionally, the ‘injectionists’ helped their patients procure injectable medicines prescribed by health workers from drug shops or pharmacies;⁷² they also encouraged the sick to have some food before getting treatments, to lie down when given injections, to relax and drink some water after treatments were administered. Apart from selling injection equipment and injectable medicines to ‘informal injection providers,’ pharmacies in Ethiopia were also the ones who administered injections frequently.

Though the first modern clinic in Dässie was setup in the precinct of the Italian commercial agency in 1907, it should be reiterated that the number of health institutions in the whole of Wällo in 1967 were 4 hospitals (3 of them Missionary); 5 health centers; 20 health stations and clinics and 9 physicians (all of them foreigners).⁷³ In Dässie in the early 1970s, there were about 3 pharmacies, 4-5 drug shops; 1 health center, 1 government (Asfa Wossän Hospital) and 1 mission hospital (of the Seventh Day Adventist hospital named after Teferi Mekonnen), not to mention the Sudan Interior Mission’s Leprosarium at Boru Meda, around 10 kilo meters north of the provincial capital.⁷⁴ The growth in healthcare provision in Dässie was far behind the geometric increase of the city’s residents. The SDA hospital that had been established in the late 1920s and *Ospedale Civile Campo Allogio*, the Italian hospital founded during the occupation, which became the first government hospital, was rechristened as Asfa Wossän Hospital after

72 See E. Nordberg, “Self-portrait of the Average Rural Drug Shop in Wollega Province, Ethiopia,” *Ethiopian Medical Journal* Vol. 12 (1): 25-32, 1974. And for a later period, see H. Kloos et al, “Buying Drugs in Addis Ababa,” pp. 81-106, 1988.

73 Wen-Pin Chang, “Development of Basic Health Services in Ethiopia,” *Ethiopia Observer*, V.12, N. 4 1969, p. 231.

74 Assefa Balcha, “Political and Socio-Economic Spectacle of Dässie, 1917-1991”, *Journal of Afroasiatic Languages, History and Culture (JAAL)* Volume 10, Number 2, 2021, pp. 202-216; 221.

the liberation of the country in 1941. This meant there was no government hospital in Dässie prior to the Italian occupation.⁷⁵

In the post-Italian period, official correspondences have shown that medical doctors, ambulance service and pharmacies were desperately needed in Dässie.⁷⁶ Public outcry for clinics remained a recurrent issue in the 1960s.⁷⁷ After the construction of a new 50-bed hospital at *Hotie* with the financial support of USAID in July 1962 (1954 E.C.), bearing the same name, Asfa Wossän, the old Italian hospital, *Ospedale Civile Campo Allogio*, at the outskirts of Dässie at a place called Qurqur, was left to provide a limited medical service for the people of the surrounding areas. It later became a treatment ward for tuberculosis patients up to c. 1977.⁷⁸ It must be in the spirit of Marxist ideology and in line with the class struggle against the exploitation of the masses that the so-called committee of physicians in October 1977 requested the government to close the few privately-owned clinics operating in the medical market so that the owners of these clinics who had been trained or educated with public funds should be returned to government clinics and hospitals and strengthen their services.⁷⁹

Finally, it has to be emphasized that the ‘injectionists’ and drug shops in both rural and urban areas were the primary healthcare providers from which many Ethiopians got acquainted with elements of western biomedicine; yet, they were not the only ones to incorporate western biomedical ideas and practices into their treatments. Though far from being realized, the military government’s move toward a mixed economy on the eve of its demise in 1990 created a space for the “injectionists and private drug retailers to regain the strong entrepreneurial position they enjoyed prior to the revolution, thereby perpetuating the illegal trade of antibiotics and their administration by

75 Mahatma Selassie Wolde Meskel, *Zekra Negar, (Recollection of Things Past)* (Amharic) 2nd ed., (A.A: Artistic Printing Press, 1962 E.C) pp. 690-693.

76 Ministry of Interior, File No 131, Dässie and Dässie Zuria District Public Health Office to The Health Department Main Office, 23 May 1944; Ministry of Interior, File No 131, Prince Asfa Wossän to Emperor Haile Selassie (Telegram), 23 May 1944; Wällo Provincial Health Department, File No 0- 6. Wällo Public Health Office to Health Works Main Department A. A., 25 May 1945.

77 Ministry of Interior, File No 131- 00-5, Wällo Governorate Office to Ministry of Health, 24 March 65.

78 Assefa Balcha, “Political and Socio-Economic Spectacle of Dässie, 1917-1991”, p. 216.

79 *Addis Zemen*, 19 October 1976.

injection.”⁸⁰ In an environment of ‘civil strife and lack of public confidence in government policy’, the envisaged reform could not be implemented.⁸¹

Conclusion

Supplanting ‘non-conventional’ therapeutic practices with western medical care proved impossible during the Imperial period. Scarcity in the rural areas of biomedical resources, in conjunction with bureaucratic bottleneck and inefficiency, made western style medical care difficult to access, and this meant public health interventions had very limited impact on improving the wellbeing of the Ethiopian population. Practitioners of biomedicine made little or no effort to understand indigenous medical beliefs and practices; and based on these understandings, they could have developed workable approaches to deliver improved healthcare service. It is therefore hardly surprising that alternative forms of therapy were widely employed and maintained. The popularity of the *mārfīe wāgie* and various ‘hybrid’ healers lay in their ability to bridge the conceptual divide between western scientific and indigenous medicine.

In the final analysis, the health situation of the majority of the rural masses living ‘on the borderline’ between the two medical worlds was not substantially changed even after the overthrow of the Imperial regime in the early 1970s. This situation confirmed that getting access to the costly, technologically-based scientific medicine was destined to be postponed indefinitely. In other words, during the Imperial era and a good part of the *Dārg* period the dawning of an era of modern scientific medicine or a substantial increase in the healthcare coverage of the rural areas was not around the horizon. Last but not least, after the downfall of the *Dārg* in 1991, there appeared a new generation of well-trained nurses who administered injectable medicines to a cross section of the population (especially for TB and other out-patients with physicians’ prescriptions of therapeutic injections and who could afford to pay) as previous *mārfīe wāgie* did in the past. These certified and experienced

80 Workneh Feleke and Helmut Kloos, “Sexually Transmitted Diseases” in *The Ecology of Health and Disease in Ethiopia*, Edited by Helmut Kloos and Zein Ahmed Zein (Colorado: Westview Press 1993), p. 304.

81 Helmut Kloos, “Primary Health Care in Ethiopia: From Haile Selassie to Meles Zenawi,” *Northeast African Studies*, V. 5, N. 1, 1988, p. 87: 83-11.

health workers, using clinical techniques, diagnosed, advised, prescribed, and administered variety of medications, including IV injections, by going to patients' homes. This part-time job would help them accrue a good amount of financial benefits. Besides, self-administration of insulin injection by diabetic patients may be taken as another example of the expansion of the injection needle.

References

Addis Zemen, 19 October 1976

- Asrat Waldayes. 1990. The Postliberation Period (1941-1973). In Richard Pankhurst. *An Introduction to the Medical History of Ethiopia*. Trenton, NJ: The Red Sea Press.
- Assefa Balcha. 2017. Wadaja Ritual: Portrait of a Wällo Cultural Coping Mechanism. *Eastern African Literary and Cultural Studies*, 3.1: 40–52. DOI: 10.1080/23277408.2017.1323170.
- Assefa Balcha. 2021. Political and Socio-Economic Spectacle of Dässie, 1917-1991. *Journal of Afroasiatic Languages, History and Culture (JAAL)*. 10(2): 202-216.
- Buschkens, W. F. L. & L. J. Slikkerveer. 1982. *Healthcare in East Africa: Illness Behaviour of the Eastern Oromo in Hararghe (Ethiopia)*. Assen: Van Gorcum.
- Chang, Wen-Pin. 1969. Development of Basic Health Services in Ethiopia. *Ethiopia Observer*, 12(4): 231-241.
- Chang, Wen-Pin. 1969. Development of Basic Health Services in Ethiopia. Reprinted from the *Journal of the Formosan Medical Association*, 68(6): 306–321.
- Craig, Robert. 2018. A History of Syringes and Needles. <https://medicine.uq.edu.au/blog/2018/12/history-syringes-and-needles>
- Dässie Hospital, File No.32/መ-10/2, June 17, 1967.
- Dässie Zuria Workers' Party Office, File No. 49-08-9, ከሠ 12, 5 Megabit 1971 EC.
- Imperial Ethiopian Government, *Nägarit Gazäta*, Addis Ababa: IEG, 1948.
- Imperial Ethiopian Government, *Penal Code*, Addis Ababa: IEG, 1957
- Kloos, Helmut. 1988. Primary Health Care in Ethiopia: From Haile Selassie to Meles Zenawi. *Northeast African Studies*, 5(1): 83-11.
- Kloos, Helmut. 1974. The Geography of Pharmacies, Druggist Shops and Rural Medicine Vendors and the Origin of Customers of

- such facilities in Addis Ababa. *Journal of Ethiopian Studies*, 12(2): 77–94.
- Kloos, Helmut. et al. 1988. Buying Drugs in Addis Ababa: A Quantitative Analysis. In S. Van der Geest & S. R. Whyte, eds. *The Context of Medicines in Developing Countries: Studies in Pharmaceutical Anthropology*. 81-106. Dordrecht: Kluwer Academic Publishers.
- Mahatma Selassie Wolde Meskel. 1962 EC, *Zekra Negar, (Recollection of Things Past)* (Amharic) 2nd ed. Addis Ababa: Artistic Printing Press.
- Mekonnen Bishaw. 1991. Promoting Traditional Medicine in Ethiopia. *Social Science and Medicine*. 33 (2): 193–200.
- Messing, Simon D. 1972. *The Target of Health in Ethiopia, a Holistic Reader in Applied Anthropology*. Southern Connecticut State College.
- Messing, Simon D. 1968. Interdigitation of Mystical and Physical Healing in Ethiopia: Toward a Theory of Medical Anthropology. *Behavior Science Notes*, 2: 87-104.
- Ministry of Health, File No ፩-17 Wällo Provincial Governorate Office to the Ministry of Interior, ND, 1955.
- Ministry of Health, File No ፩-17, Yimer Muhie to Dässie Health Center, 23 May 1966
- Ministry of Health, File No ፩-17. Mohammed Wolde to Dässie Provincial Health Department, 31 September 1966.
- Ministry of Interior, File No 131- ፱-5, Malaria Eradication Center to Wällo Provincial *Endarassie*, 28 February 1967
- Ministry of Interior, File No 131- ፱-5, Wällo Governorate Office to Ministry of Health, 24 March 1965
- Ministry of Interior, File No 131, Dässie and Dässie Zuria District Public Health Office to Health Works Main Department A. A., 23 May 1944
- Ministry of Interior, File No 131, Prince Asfa Wossän to Emperor Haile Selassie (Telegram), 23 May 1944
- Ministry of Interior, File No 131-፱-5, Wällo Provincial Governorate Office to Ministry of Public Health, 24 March, 1964
- Ministry of Interior, File No 131-፱-5, Wällo Provincial Governorate Office to Ministry of Public Health, 24 March 1969
- Ministry of Interior, File No ፱-5/27, Ministry of Public Health to Ministry of Interior, 14 July 1955
- Ministry of Public Health, 1972. Directory of Medical and Health Institutions in Ethiopia.

- Ministry of Public Health, File No Φ -9, Director of St. Paul Hospital to the Ministry of Public Health, 30 September 1951
- Municipality of Dässie, File No. ω 3-4, Ministry of Agriculture to Wällo Governorate Office, 27 July 1949.
- Nordberg, E. 1974. Self-portrait of the Average Rural Drug Shop in Wollega Province, Ethiopia. *Ethiopian Medical Journal*, 12 (1): 25-32.
- Oral Informants (repeated personal communications and informal interviews)
- Pankhurst, Richard 1973 “The Medical History of Ethiopia during the Italian Invasion and Occupation (1935–1941)”. *Journal of Ethiopian Studies* 4(2), 108–117
- Pankhurst, Richard. 1990. *An Introduction to the Medical History of Ethiopia*. Trenton, NJ: The Red Sea Press
- Slikkerveer, Leendert Jan. 1982. Rural Health Development in Ethiopia: Problems of Utilization of Traditional Healers. *Social Science and Medicine*, 16: 1859-1872.
- Slikkerveer, L. Jan. 1990 *Plural Medical Systems in the Horn of Africa: The Legacy of ‘Sheikh’ Hippocrates* Leiden; Kegan Paul International
- Van der Geest, S. 1982. The Illegal Distribution of Western Medicine in Developing Countries: Pharmacists, Drug Pedlars, Injection Doctors and Others. A Bibliographic Exploration. *Medical Anthropology*. 197-219.
- Van Staa, AnneLoes and Anita Hardon, ND. *Injection Practice in the Developing World: Results and Recommendations from field studies in Uganda and Indonesia*, Prepared for WHO-DAP, Amsterdam: University of Amsterdam.
- Wällo Provincial Health Department, File No ω - 6. Asfa Wossän Hospital to Dässie Provincial Police, 6 January 1958.
- Wällo Provincial Health Department, File No ω - 6. Asfa Wossän Hospital to the Wällo Provincial Police, 7 March 1959.
- Wällo Provincial Health Department, File No ω - 6. Gebre Medhin Gebre Egzi of Lalibela Health Center to Wällo Provincial Department of Health, 8 March 1971.
- Wällo Provincial Health Department, File No ω - 6. Gebre Medhin Gebre Egzi of Lalibela Health Center to Wällo Provincial Governorate Office, 8 April 1971.
- Wällo Provincial Health Department, File No ω - 6. Gobena Yimer of Gobeye Clinic to Dässie Provincial Health Department, 24 July 1971.

- Wällo Provincial Health Department, File No **ወ- 6**. Hayq District Clinic to Ambassel District Governorate Office, 26 June 1959.
- Wällo Provincial Health Department, File No **ወ- 6**. Qallu District Clinic (Kombolcha) to Asfa Wossän Hospital, 8 June 1959.
- Wällo Provincial Health Department, File No **ወ- 6**. Raya and Kobo District Clinic (Alamata) to the Ministry of Health, 19 May 1959
- Wällo Provincial Health Department, File No **ወ- 6**. Wag District Clinic (Korem) to Wag District Police, 7 November 1959.
- Wällo Provincial Health Department, File No **ወ- 6**. Wällo Provincial Health Department to Sayo Tebela Sub-district Governorate Office, 27 September 1962.
- Wällo Provincial Health Department, File No **ወ- 6**. Wällo Provincial Department of Health to the Borena District Governorate Office, 23 August 1963
- Wällo Provincial Health Department, File No **ወ- 6**. Wällo Provincial Governorate Office to the Twelve District Governorate Offices, 2 July 1970.
- Wällo Provincial Health Department, File No **ወ- 6**. Wällo Provincial Health Department to the Wällo Provincial Governorate Office, 12 May 1971.
- Wällo Provincial Health Department, File No **ወ- 6**. Wällo Provincial Governorate Office to the 12 District Governorate Offices, 2 July 1972.
- Wällo Provincial Health Department, File No **ወ- 6**. Wällo Public Health Office to Health Works Main Department Office Addis Ababa, 25 May 1945.
- Wällo Provincial Health Department, File No **ወ-6**. Teferi Yimer of Ancharo Clinic to Wällo Provincial Health Department, 11 June 1974.
- Workneh Feleke and Helmut Kloos. 1993. Sexually Transmitted Diseases. In Helmut Kloos and Zein Ahmed Zein, eds. *The Ecology of Health and Disease in Ethiopia*. 295-306. Colorado: Westview Press.

Assefa Balcha
Wollo University,
Department of History and Heritage Management
P.O Box 713, Dessie, Wollo