

voices of the **ETHIOPIAN** community

Introduction

Demographic changes in the Seattle area are having a profound impact on the local health care delivery system. Health care providers need to hear from ethnic communities about their experience in trying to access health care. Offering culturally appropriate care requires being open to the perceptions, realities and expectations of a community that may be different from one's own.

The Cross Cultural Health Care Program (CCHCP) at Pacific Medical Center works with health care providers, interpreters and community-based organizations to address these needs. Established in 1992, the CCHCP is funded by a grant from the W.K. Kellogg Foundation. This "Voices of the Communities" profile is one of a series developed by the CCHCP. The profiles and an earlier survey of 22 underserved ethnic communities are part of the CCHCP's effort to provide a forum for underserved communities to interact with the health care community. These profiles were developed by and in consultation with members of the profiled community.



Ethiopian Demographic and Cultural Background

History

Located in the horn of Africa, Ethiopia is the tenth largest country in Africa. Ethiopia traces its history as a country back 3,000 years and is the only African country that has never been colonized. In the mid-1970s, the government of Haile Selassie was overthrown and a repressive regime was established. Recent years have seen internal wars for liberation and ethnic conflicts. Many families left the country as refugees.

Ethnic groups and languages

The population includes many ethnic groups with nearly 80 languages and approximately 200 dialects. Major groups include the Amhara, Oromo and Tigre. Smaller groups include Afa, Isa, Somali, Wolaita, Sidama, Kimbata and Hadiya.

Economic and social system

The country is agrarian and the economy depends on subsistence agriculture. In recent years, crops have been poor because of drought. Approximately 85 percent of the population lives in rural areas. The settled rural population is scattered, making delivery of health and social services difficult.

Family life

Family structure typically includes the extended family. Family ties are strong. In times of crisis, the family will take full responsibility for the family member's problem, whether it is financial, health or social. Disputes are settled by elders of the community. The society respects elders and accepts their admonitions or advice. Interaction is personal, informal and intimate; a great deal of interdependence is needed to accomplish a task or solve a problem.

Women are considered to be subordinate to their husbands and girls receive less education than boys. Families tend to be large (seven or eight children). Knowledge and use of family planning is extremely limited.

Religion

There are two dominant religions: the Ethiopian Orthodox Church (Christian) and Islam. Some estimates put the Orthodox at just over half the population, while other estimates suggest that the Muslims are in the majority.



Population size and residence

Ethiopian refugees began arriving in the Seattle area in the 1980s and increased from 1989 to 1993. Most of Seattle's Ethiopian population lives in central and south Seattle (Rainier Valley, Yesler Terrace, Holly Park) and in High Point in West Seattle. But a number of families also live in north Seattle, Ballard, Redmond, Bellevue and Kent. The total Ethiopian population in the greater Seattle area is estimated at between 6,000 and 7,000, with women and children highest in number.

Employment and family life

Most of the Ethiopians settling in Seattle came from rural areas and have had little formal education. Those from urban areas are educated and had worked as health professionals, engineers, teachers and social workers. Unemployment or underemployment are leading problems for many Ethiopians in Seattle.

Households in the Ethiopian community include from one to six persons, half of whom are children under age 10. The divorce rate is high and mothers have a hard time raising children as single parents.

Community organizations

The Ethiopian Community Mutual Association (ECMA) is the primary organization representing all Ethiopians in the Seattle area. The ECMA's Board includes individuals from various ethnic groups, including Tigray, Oromo, Amhara and others. The ECMA uses the languages of these three groups and of smaller ethnic groups for its programs. Programs include English as a Second Language (ESL) and literacy classes, referrals for employment and social services, legal advice, and counseling for families with dependent children.

Traditional healing

Illness is often considered as a punishment from God for a person’s sins or as the anger of spirits. Rural Ethiopians depend primarily on traditional healers, who treat illnesses with local herbal and animal remedies. Spiritual healing, such as prayer, is the preferred treatment for many diseases. Mental illnesses are seen as the result of evil spirits and are treated with prayer. Rural Ethiopians who come to the city often keep their traditional beliefs and attitudes towards health.

Maternal and child health

Women in rural areas are assisted in childbirth by female relatives or a midwife. The new mother and baby stay at home for 40 days after birth, with female relatives and friends helping to care for them. The majority of women breast-feed; breast-feeding in public is acceptable. Mothers introduce other foods to the infant at four months of age but continue breast-feeding up to three years or until the woman is ready to have another child.

Circumcision

Male and female circumcision is practiced by most people who are Muslim, Christian and Ethiopian Jews.

Medical care

Where Western-style medical care is available, antibiotics are used frequently. Ethiopians who consult doctors usually receive a medication for every illness.



Medical care and providers

Most Ethiopians in Seattle get health care at Harborview, Providence, Group Health and Swedish medical centers. Refugees from urban centers in Ethiopia have experience with Western-style medicine, but rural people have trouble understanding the concept of disease and the causes, means of transmission and methods of prevention. They also don’t understand the practice of withholding treatment until diagnostic work is done.

Because Ethiopians are accustomed to receiving antibiotics or other medications for every illness, they feel it is a waste of time to go to a doctor if no medication is given, even for a minor illness. This is a common point of dissatisfaction with health care in Seattle.

The businesslike and direct approach of Western doctors is in contrast with the more interpersonal approach of Ethiopian doctors. For example, an Ethiopian doctor will never inform a patient of a terminal diagnosis. Instead the doctor will tell a close relative. This protects the patient from being discouraged; encouragement from relatives gives the patient hope and protects him or her from despair.

Language and interpreters

Language is also a problem. Ethiopians who came from rural areas have very limited English language skills. Although interpreters may be provided, the interpreters are not always appropriate. Patients are not comfortable with interpreters because of gender differences (women prefer female interpreters; men prefer male interpreters) or political/ethnic differences (for example, some Amharic-speaking Ethiopians are not comfortable with Oromo interpreters, some Oromos with Tigreans, and so forth). Because of these differences, patients often feel they cannot express all their needs and may not trust the medications prescribed.

Maternal and child health

Ethiopian women prefer female doctors and interpreters, especially for childbirth. Many think that American doctors are too quick to perform Cesarean sections for what Ethiopians consider to be normal variations. For this reason, they may wait at home until well into labor in order to avoid unwanted procedures. Because of school, work and other obligations, Ethiopian women in the United States are not able to take the traditional 40 days of rest after childbirth. They also worry that nursing in public is inappropriate or find that work or school interrupts the feeding schedule. They have trouble maintaining breast-feeding as long as they would like. Most are unfamiliar with pumping and storing breast milk.

A shortened period of breast-feeding is contributing to high fertility rates in Seattle's Ethiopian community, since breast-feeding an infant up to three years was the most common form of birth control. Although not much information is available to Ethiopian women in Seattle about family planning methods, they are starting to take oral or other contraceptives.

Cost

The cost of health care is a problem for many Ethiopians. Those who cannot afford to pay are afraid to use the health care system. Little information is available about the Basic Health Plan or other options.

Suggestions

- ⌘ Community organizations and health care providers should work together to avoid bias and break down cultural barriers through discussion. Health care staff should have training on cultural sensitivity.
- ⌘ The health care system should provide education about prevailing health problems and methods of prevention and treatment, and information about family planning.
- ⌘ Health care facilities should assign interpreters who are appropriate in gender and are from the patient's own language/ethnic group.
- ⌘ Community organizations and agencies should work toward making ESL classes available to all Ethiopians so they will not always be dependent on interpreters.

- ≈ Information about health facilities and health plan options should be available through community organizations.
- ≈ Use of child care centers for patients at health care facilities should be encouraged.

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This profile is based primarily on interviews and informal discussions with a total of 28 people from several parts of the Ethiopian community, including Oromo-speaking, Tigrinya-speaking and Amharic-speaking families and board members of the Ethiopian Mutual Association.

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