ETHIOPIAN AND ERITREAN CULTURES

Photo: Author's own

BACKGROUND INFORMATION

Ethiopia and Eritrea are located in the Horn of Africa. They are bordered by Sudan, Kenya, Djibouti and Somalia, and Eritrea by the Red Sea.

Ethiopia, unlike most other countries in Africa was never colonized. It was a monarchy for most of the 20th century with a brief rule by the Italians before World War II. The Emperor Haile Selassie held power until 1973 when he was overthrown by Marxist revolutionaries who established a dictatorship known as the Derg. The Derg's policy of forced collectivization and grouping of traditional settlements into villages, resulted in the devastating famine of the mid 1980's which killed over a million people. In 1991 a coalition, led by Eritrean and Tigrean People's Liberation Fronts overthrew the regime and attempted to establish semi-autonomous ethnic regions. However, much inter-ethnic conflict ensued and in 1993 Eritrea voted to secede from Ethiopia. The two countries, once allies in the fight again the Derg became locked in conflict and a bloody border war raged between them from 1998 and 2000. Over a million people died on either side of the border. The tension and disputes continue today. Although Ethiopians and Eritreans previously shared the same geographical boundaries (for a period of time), since the separation citizens of each country wish to be referred to as Ethiopians or Eritreans respectively. An incorrect reference is likely to be offensive.

Ethiopia itself is also plagued by internal ethnic conflict. In addition, land tenure policies, as well as droughts and soil erosion, leave the country constantly vulnerable to food deficits. It is one of the poorest countries in the world. It is reported that it is likely that more people have died of hunger in Ethiopia in the last 30 years than in any other country in the world. The conflicts have resulted in over 150,000 people being displaced, and in fleeing for refuge to neighbouring countries. Ethiopia also hosts refugees from Somalia and Sudan although these people are in the process of being repatriated.

Eritrea is also now an extremely poor country with about 1.7 million people displaced internally. They have also hosted refugees from Somalia and Sudan. Like Ethiopia, Eritrea faces serious food and water shortages and is in need of constant International Aid.

Ethiopians and Eritreans began fleeing after the coup in 1973. They fled in small groups under extremely dangerous conditions in order to reach the first place of asylum. New Zealand has received over 1300 Ethiopians and 300 Eritreans since the late 1990s and about 70% of them live in Auckland. They continue to arrive in small numbers under the quota refugee system and as asylum seekers. Some people immigrate under the family re-unification programme although very few are able to join families due to the prohibitive costs involved in re-location. Many refugees from these countries carry the burden of war, loss and extreme hardship.

COMMUNICATIONS

Greetings

Hello/goodbye greeting *Tena yistilign* *(a form of 'good wishes')*

Main languages

Amharic is the official language of Ethiopia, spoken by the Amhara, and **Oromia** (or Oromigna/Oromiffa) is spoken by the Oromo, the largest ethnic group (about 40%). Other tribes include the Tigray[1] who speak **Tigrigna**.

Tigrinya is the official language of Eritrea, spoken by the Tigre.

Although some people speak more than one language, and some Arabic, when working with interpreters it is **essential** that the interpreter is from the same ethnic and linguistic group as the client.

Gestures and interaction

- Ethiopians and Eritreans tend to be formal in their dealings with others, but also courteous
- Use **first names** with younger people, and **title and first name** with people over 35 or 40
- **Hand shaking** is common across genders (using the right hand), although not with more traditional Muslim women. If in doubt ask first, or use the customary verbal greeting
- Kissing on the cheeks, between and across genders occurs with people who know each other and is considered a polite and friendly greeting
- The **right hand** is used for shaking or passing items, or both hands, but never the left
- A slight **bow** shows respect
- **Eye contact** is usually direct but tends not to be prolonged
- **Pointing** is considered rude
- Showing **respect,** especially for elders, is appreciated (e.g. greeting the elders first, the **practitioner being on time for appointment** is very important in Ethiopian culture, greeting them in their traditional way)
- Showing an **interest** in the culture and practices will likely enhance relationship with the practitioner and compliance

[1] *There seems to be confusion, dissent and sometimes contradiction in the literature amongst terms and spellings regarding the ethnicities Tigre and Tigray. The Consular of the Ethiopian Consulate in Australia provided the following clarity: The peoples from the Ethiopian region of Tigray are called the Tigray/Tigrai and speak Tigrigna. In Eritrea there is a very small ethnic tribe referred to as the Tigre who speak Tigrynia (sometimes spelled Tigrigna). In essence the languages are very similar, although the ethnicities are distinct. He reported however, that there are very few Tigres who have resettled in New Zealand (and Australia) so that most of the people who speak Tigrigna will likely be people from Tigray in Ethiopia. 'Tigrean'/Tigrayan is essentially an adjective, but is often used to refer to people from Tigray in Ethiopia.*

- Health practitioners are usually highly regarded and clients may not ask **questions** as it is considered disrespectful. It would be helpful to invite the client and their family to ask questions

TRADITIONAL FAMILY VALUES

- Extended families are traditionally the norm although they tend to be smaller in resettled countries
- There is less segregation between genders in Ethiopian Muslim families than in some other Islamic cultures
- In traditional families males are heads of households and make decisions in relation to the outside world. However this is changing rapidly in countries of resettlement
- Elders are given enormous respect
- Disputes are generally settled by community leaders, or elders
- Boys and girls receive the same education, and literacy amongst women is higher than in some other Islamic cultures
- Marriages can be arranged or be of the individual's choice although family will need to approve of the match
- In some more rural areas marriage can take place at 14 or 15 and men can have more than one wife (Muslims). Laws in countries of resettlement alter these norms
- Although part of a collective culture, Ethiopians value independence and are expected to stand up for their rights and needs. These however, do not override family or community needs

HEALTH CARE BELIEFS AND PRACTICES

For more detailed information refer to Jackson (2006) Ch. 6, and Kemp and Rasbridge (2004) pp 160-163.

Factors seen to influence health

- **Western biomedical concept** of disease causation and disease communicability is accepted as explanation for some illnesses and is more likely to be understood by those living in the west. Other attributions of ill health may be preferred or may co-exist along with western concepts.
- **Equilibrium/balance**
- Generally Ethiopians/Eritreans believe that a balance between internal and external worlds (including the supernatural) is essential for wellness. Imbalance results in illness. Emotional wellbeing is thought to play an important role in physical health, and harmonious relationships are also seen to influence health significantly.
- Humeral concepts of 'hot' and 'cold' also apply in understanding certain physical ailments.
- **Spiritual/supernatural**
  Beliefs in spiritual and supernatural causation are well established. Mental illness is attributed, by those who subscribe to supernatural beliefs, to evil spirits by both Christians and Muslims. (For others, mental illness is understood in more 'Western' terms). The following are the most common beliefs:

- **'Zar'** spirit possession is common. It is believed that long-term possession can cause mental illness, especially amongst newer refugees or immigrants. *Zar* possession is believed to be higher amongst women in the home country and more common amongst men in the country of resettlement.
- Belief in the **'evil eye'** (called *Buda)* is common. It is believed that an individual can put a curse on others by looking at them. This mostly affects children
- Illness may be punishment from God for sins committed or as a result of anger from spirits (e.g. HIV/AIDS is believed by many to be punishment, hence the stigma)
- **Sorcery** and witchcraft is believed to occur as a result of the actions of people and evil spirits working together

Traditional and current treatment practices

- **Western medicine**
  This is more commonly practiced in urban areas. Most Ethiopians accept western interventions although they may also continue with traditional treatments concurrently.
- **Traditional/complimentary practices**
  - The use of **herbal medicine** is a highly and widely developed practice in Ethiopia and Eritrea. Kemp and Rasbridge (2004) report that there are 21 types of specialized traditional healers in these countries practising a number of traditions including herbalism.
  - **Cupping** is used to treat *wind* conditions. This may leave scars which should not be assumed to result from abuse (probably not practised in New Zealand)
  - **Moxibustion** is practised by the Eritreans, and possibly other ethnicities (probably not practised in New Zealand)
- **Magico-religious articles** and **spiritual healing** may be used by some:
  - Intercessory **prayer** is used to heal both physical and mental illness, and especially spirit possession
  - **Amulets** (*kitab)* are worn by some

Important factors for Health Practitioners to know when treating Ethiopian and Eritrean clients:

1. As many Ethiopians and Eritreans who enter New Zealand have arrived as refugees, extra sensitivity and care in treatment is necessary given the possibility of extremely difficult pre-settlement experiences (see 5**.** below).

2. Given the ethnic conflicts in both countries, as well as the disputes that continue between the groups in New Zealand, it is imperative that interpreters from the same ethnicity as the client are involved. Interpreters from the same country speaking the same language but belonging to a different ethnic group will NOT be trusted and information is highly likely to be withheld during the clinical session.

3. Women do not take the husband's name after marriage and records need to accommodate this preference.

4. Both men and women prefer same sex practitioners and interpreters, and particularly for gynaecological issues and childbirth.

5. Female Genital Cutting (FGC), Types I and II, is common throughout both

countries and is practised by people from all 3 religious groups. In Eritrea Type III is also practised. It is believed by local residents that it is not practised by resettled people in New Zealand. Respectful handling of the issue is crucial with assistance and/or education as needed. This is part of the culture and is expected and accepted as such by many women. Practitioners need to familiarize themselves with the needs and sequelae. (Please see Introduction to MELAA cultures for more information on FGC).

6. Clients respect health practitioners highly and will tend to take a passive and dependent role in illness. Back home families are involved in treatment decisions, however in New Zealand there are often few or sometimes no family members to take this role and the practitioner is expected to advise and support.

7. In Ethiopia medications and injections are usually received for every illness. When these are not prescribed in New Zealand, clear explanations about the reasons would be helpful, particularly with newly arrived clients who might otherwise believe that they are not being helped. In addition compliance is likely to be enhanced if some traditional practices can be encorporated within the current treatment plan when possible.

8. Compliance with prescriptions can be affected by language difficulties. Interpreters can assist with providing written instructions in the client's own language.

9. Ethiopians and Eritreans tend to be stoic in the face of adversity and in pain endurance and will often refuse pain control.

10. A **culture specific syndrome**, '*moygnbagegn'* is a traditional disease with symptoms of fainting, fever, headache, stiff neck and abdominal cramps. It is treated by blood letting and believed by some Ethiopians to be exacerbated by western medicine. The similarity of some of the symptoms to meningitis makes is important that this order is correctly identified. In the absence of a practitioner some people may make incisions over the brachial vein in the forearm and many hold scars from this practice (see Jackson 2006, p. 91).

11. Because of the emphasis on the role of mental health in physical health, news of poor prognosis or terminal illness is usually not delivered to the client, but to a (male) family member. Informed consent issues may need to be dealt with in such cases, and this is likely to be a new procedure for most Ethiopians/Eritreans and will need explanation.

12. It is believed by some that blood lost cannot be replaced from the body and so venous blood drawing and blood transfusion create anxiety and fear. Explanations would be necessary.

13. When doing HOME VISITS:
    - Give a clear introduction of nature of service, of roles and purpose of visit. Visits should always be scheduled
    - It is appropriate to remove shoes before entering the home
    - It is customary to address the male adult or elders of the household first
    - Food or drink will usually be offered and it is expected that the hospitality will be accepted

- Modest dress is appropriate
- Be aware that no food or drink is consumed from sunrise to sunset during Ramadan (in Muslim homes)

Stigmas

Mental Illness in Ethiopia is stigmatized and families prefer to manage the person themselves. If a family seeks help from a mental health practitioner it is considered a sign of a member having a major mental illness. Jackson (2006) reports that in 2000 there were 11 psychiatrists in a country of then 55 million.

Although suicide is considered a sin by Muslims and orthodox Christians, it is not stigmatized in the community.

Diet and Nutrition

Engera (pronounced en-jer-a) is the staple. It is a sour-like fermented pancake that is used with "wot", a stew made with spices, meats and pulses, such as lentils, beans and split peas. The bread eaten by Oromo people is called '*bedeena'* and made similarly. Coptic Christians do not consume meat or dairy products for more than half of the year and Muslims require *halaal* foods and do not eat pork. Oromos do not eat pork. Families would provide traditional breads and stew or soups for hospitalized clients who are unable to eat western foods.

Death and dying

- Many Ethiopians contribute financially to a 'burial society' on a monthly basis. After a death in the family, the society takes care of all procedures and expenses and for 3 days the family has only to mourn
- Burial takes place on the same day as the death unless the death occurs after 4.00pm in which case the body will be buried the following day (Muslims)
- Immediate family should be informed by **an elder** in the family (or close friend or community member if there is no family in the country of resettlement). It is important that the medical examiner consults an elder or community member in order to identify the best person to deliver the news to the family or person concerned. This is an act of respect and would be appreciated in this culture
- In the case of suicide, the body will not receive a service in the church or mosque. However it is acceptable if the family wishes to treat the death as a non-suicide and there is no stigma in the community if the family does not inform the religious practitioner that the death was a suicide
- Neither autopsy nor organ donation is prohibited by the religion or culture, but individual families will have their own preferences
- The deceased should be cleansed and clothed by someone of the same gender
- Burial in a cemetery is required, not cremation

HEALTH RISKS

According to the Perumal (2010) report on MELAA people living in the Auckland Region, key health concerns for African people include:

- Diabetes (significantly higher prevalence than Europeans, including associated hospitalizations)

- Respiratory diseases (asthma for females, and pneumonia)
- High HIV (23% of all the people diagnosed as HIV positive in the Northern region from 1996-2009 were African)
- Asthma, especially women
- TB (highest rate of hospitalization within MELAA group)
- Cellulitis (highest rate of PAH amongst females from all ethnicities)
- Kidney and urinary infections (highest amongst all Other females)
- Low vitamin D deficiency (particularly women and girls which may be due to avoidance of sun and because of dress code to cover up)
- Malnutrition (due to prolonged periods of war)
- Obesity after suffering malnutrition
- Lack of sufficient physical exercise (may be prohibitive for some women with conservative dress and behavioural expectations)

Social issues affecting health

- Isolation (including older people who spend a lot of time alone at home)
- Unemployment and poverty (many have significant financial issues and difficulties finding work)
- Loss of standing in society
- Being marginalized (race, cultural difference, clothes, education and refugee experiences)
- Cultural adjustments impacted further by the lack of support from usual networks of family and community
- Experiencing racial discrimination based on ethnicity (within own cultures)
- Stigma of mental health, HIV and disability often means no societal support, and no disclosure of issues

Mental Health issues (particularly PTSD and depression):

- African communities experience a disproportionately higher rate of mental health illness compared with the rest of New Zealand, largely due to their earlier life experiences and potential exposure to torture, violence, rape and harassment
- There may be strong emotions of grief and loss for family, culture, and country especially following refugee experiences
- Experiencing discrimination is strongly linked to high levels of anxiety and depression which negatively affects Post Traumatic Stress Disorders (PTSD)
- Mental illness is stigmatised which results in limited use of appropriate assessment and treatment services, especially in smaller communities

Unexmundi (August 2014) lists the following major diseases for people living in Ethiopia:

- Hepatitis A and E
- Typhoid fever
- Malaria
- Dengue Fever
- Yellow Fever
- Japanese Encephalitis
- African Trypanosomiasis
- Cutaneous Leishmaniasis
- Plague
- Crimean-Congo hemorrhagic fever

- Rift Valley fever
- Chikungunya
- Leptospirosis
- Schistosomiasis
- Lassa fever
- Meningococcal meningitis
- Rabies

WOMEN'S HEALTH

According to the Perumal (2010) report on MELAA people living in the Auckland Region, issues for African women include:

- Within the MELAA group, African women had the second highest number of live births followed by Latin American women.
- Low levels of health screening, particularly in cervical and breast cancer screening
- Female Genital Mutilation (FGM/FGC) and its associated complications (See Introduction, Chapter 3 for more details)
- The need for more education around pregnancy and child birth in New
- Zealand
- Health issues related to refugee backgrounds, and sexual violence in particular
- A preference for women to use interpreters and health care practitioners of the same gender. For issues of trust, appropriateness and awareness, it is important to engage professional interpreters whenever possible

For Ethiopian and Eritrean women who have resettled as refugees a careful history taking will be needed to ascertain whether sexual abuse or rape has occurred. This is a frequent experience amongst refugee women in general. The history taking will need to be done when women only are present and disclosure will depend on rapport and trust built. In general, refugee women (and men) need to be treated with extra sensitivity and care since they are very likely to have suffered the conditions related to the atrocities and trauma of war, of trauma during flight, and re-location stress. In addition they are often responsible for the emotional wellbeing of the family who too may be weighted by similar psychological and physical loads. Some women re-locate alone as a result of family losses, separations and displacements.

Female Genital Cutting (FGC) occurs extensively in both countries (see 'Important factors for health practitioners' above and Youth Health below). Over 70% of girls undergo FGC before 12, and statistics on prevalence over the last 8 years range between 75 – 90% across the two countries. Whilst it is a widespread practice, there is also often a reluctance to report the practice and this may contribute to the varying statistics about prevalence. Although in Ethiopia Types I and II are most common, Type III is practised around the regions bordering Somalia and Sudan. FGC tends to be a more common practice in some Muslim cultures, however, since statistics reflect extremely high percentages, it is assumed that it is also practiced by Christians in these two countries. It is reported by local community residents that educational programmes in Ethiopia are widespread and that the practice is diminishing.

Traditional fertility practices

- Family planning is not widely practised in the home countries but is well accepted by those people living in the west
- Breast-feeding is the most common form of contraception. However, after resettlement, fertility rates are reported to be higher (in the U.S.) because of women needing to return to work and stop breast feeding early
- Amongst traditional people, pregnancy is believed to be a time of vulnerability for the mother and that the fetus is at risk for harm from evil spirits and sorcery

Labour and Delivery

- Men are traditionally not involved in the process. A female friend or family member will be informed when a mother commences labour
- Traditionally deliveries are assisted by midwives/traditional birth assistants, or a female family member
- Resettled women prefer female health practitioners
- In order to avoid what is seen as hasty decisions by western doctors to perform caesarian sections, some mothers may delay going to the hospital for delivery until the last minute

Postnatal care

- Oromo people feed the infant on water only for 24 hours followed by butter which is used as a laxative to expel meconium before starting breast feeding. Eritreans use water with a little sugar during the first 24 hours
- Some women practice a brief symbolic rejection of the newborn for the discomfort and pain caused during pregnancy and delivery
- After delivery the mother stays home for 2-6 weeks (when possible)
- Family or friends will assist with cooking and housework to enable her to recover her strength. This is sometimes not possible after resettlement
- Breast-feeding is the norm and can last up to 3 years (sometimes for a shorter period after resettlement). However other foods can be introduced at about 4 months

Religious Ceremonies Related to Birth

- Orthodox Christians will baptize a baby boy on the 40th day after birth, and girls on the 80th day. Evangelical or Pentecostal Christians will baptize babies when the family is ready.

YOUTH AND CHILD HEALTH

According to the Perumal (2010) report on MELAA people living in the Auckland Region, key health concerns for African children include:

- A possible higher standardized mortality ratio (SMR) as compared to Others
- The PAH rates in children from all causes was higher in African children compared with Others

- Asthma was the main cause of PAH, followed by dental conditions
- African children had the highest rate of hospitalisation for asthma, pneumonia and bronchiolitis
- They had higher hospitalisation rates than Others for dental conditions and gastroenteritis
- At the 6 month mark only 23% of African babies were exclusively or fully breastfed, (below the recommended 2007/08 national health target of 27%)
- In children <5 years of age and in Year 8, there were more African children with caries than in Others
- FGM (FGC) for Muslim African girls has associated difficulties (See Introduction, Chapter 3 for more details)
- Chlamydia infections are prevalent in all teenagers in the MELAA group
- There is a common misconception amongst Muslim boys that circumcision is a protection against sexual 'disease'

Newborn & Child Health

- Circumcision for boys is mandatory
- Circumcision is practiced on 75-95% of girls
- Within the Oromo tradition female circumcision is preferred but not mandatory

Adolescent Health

- Most resettled adolescents will be faced with:
  - role changes at home
  - pressures from peers to integrate more quickly than they or their families may be comfortable with
  - the stigma of 'difference'. Assistance and sensitivity from authority figures will be helpful in the schools
- Many young refugee children and adolescents have been subjected to violence or have been witness to the atrocities leveled at their families and communities during war, and in refugee camps. They may bear their experiences unnoticed. Parents managing the challenges of resettlement as well as their own pre- and post-relocation traumas are often unable to attend to, or to manage the distress of their children adequately. Sometimes children do not tell their parents in order to avoid added stress on the family, out of respect, or because they believe they are in some way to blame. Symptoms of trauma may present as behaviour problems, withdrawal, learning difficulties, poor concentration and motivation as well as with various somatic complaints. These presentations may mask post-traumatic stress, depression, anxiety and other mental health conditions. Practitioners and teachers need to be alert to the possibilities of pre-relocation trauma.
- Some Islamic traditions and the difficulty in explaining these because of language barriers, may deter children from attending social or school functions (e.g. no cross-gender touching for adolescents, ablutions required during fasting and before prayers, time schedule for prayers, *halaal* food etc.)
- Menses, genital malformation, urinary infections and chronic pelvic complications can occur as a result of the FGC
- Young girls are equally as exposed to rape and sexual abuse in their home country as the adult women
- No sex education is given to adolescents and the subject is not discussed at home. Of concern are illegal abortions, pregnancy–related dropouts from school, and potential risk of HIV infection

SPECIAL EVENTS

Ramadan
Ethiopian New Year, September 11
Ethiopian Christmas, January 7

SPIRITUAL PRACTICES

The reported percentages of religious practitioners belonging to different religious groups differ amongst sources, however in general it seems that **Muslims** (Sunni) and **Ethiopian Coptic Church** share similar numbers of practitioners in both countries.

Some Oromo follow an **indigenous religion** whose God is *Waka (Waaqa).* For many Oromo this religion has been encorporated into other religions. Christians within the Oromo ethnicity tend to be Catholic or Adventist rather than Orthodox as the latter is associated with the dominant Amhara.

In Addition to Islam and Orthodox Christianity, some Eritreans are animists whose God is Anna. Roman Catholics and Protestants are also represented in small numbers in Eritrea.

(See Chapter 3 Introduction to MELAA Cultures, pgs 7-11 for more information related to Muslim religion).

Photos: www.care.org.newsroom and www.refugeesinternational.org



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Useful Resources

1. RAS NZ (Refugees As Survivors New Zealand) can provide assistance to mental health practitioners on clinical issues related to refugee and cultural needs, and contacts for community leaders/facilitators. They can be contacted at +64 9 270 0870.

2. ARCC can provide information on resettlement issues and contacts for community leaders. Contact +64 9 629 3505.

3. Refugee Services can be contacted on +64 9 621 0013 for assistance with refugee issues.

4. A number of health fact sheets can be found in **Amharic, Oromo** and **Tigrigna** in pdf. at: http://www.healthtranslations.vic.gov.au/

5. The http://www.ecald.com website has patient information by language and information about migrant and refugee health and social services.