

Horn of Africa Diaspora Communities in Toronto

A Preliminary Review of Health Promotion Issues

Table of Contents

	Page
I. Introduction & Purpose	3
II. Background and Common Challenges	4
III. General Perceptions & Experiences of Health Care	11
IV. Major Health Issues	29
V. Recommendations	31
VI. References	33
VII. Appendices - Program Info Sheet	34

I. Introduction & Purpose

In 2001, Lawrence Heights Community Health Center launched a pilot project on community peace building and health promotion for the Horn of Africa Diaspora Communities (HADCs) in the Lawrence Heights catchments area and beyond. For a detailed description of objectives and relevant project information, please consult the appendix attached to this review document. One of the objectives of the pilot project was to conduct a review of existing knowledge in health promotion pertinent to the HADCs.

The project considered the Ethiopian, Somali Eritrean and Oromo communities.

The goals of this review document include:

- to give a brief description of the challenges and commonalities of Toronto's newcomer HADCs
- to document and share existing body of knowledge on major health issues confronting HADCs and relevant health promotion strategies with community agencies, health centres and organizations serving HADCs in Toronto
- to identify individual, family and community issues that require programmatic intervention, further research, training and public education
- to promote harmony among HADCs by highlighting and celebrating the similarities in values and cultures among HAD Cs

This review will touch on many aspects of the lives of community members, such as: who they are, how they view their new Canadian environment, what their health and social challenges are how they fit in the Canadian society.

This document is not comprehensive but can be used by service providers to develop a better understanding of HADCs and thus enhance services and address HADC issues more effectively.

II. Background and Common Challenges

Health is a state of complete physical, mental and social well being not a mere absence of disease or infirmity. Health promotion is the process of enabling people to increase control over, and to improve their health. Fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic prerequisites.

Background

a) Somali Community

The Somali Community in Canada arrived here late eighties - mid nineties as result of political upheaval and a brutal civil war that devastated the whole country. Most of these refugees live in the province of Ontario, about 40 thousand in the greater Toronto area. These refugees have endured the indignities and horrors of war and prolonged stays in refugee camps in hostile societies. For a vast majority of the Somali refugees, Canada is the first exposure to Western culture. Single mothers who are either widowed by war or left their husbands back home due to various reasons lead most of the families here. Once in Canada, Somalis encounter a complex set of problems: language, new environment, harsh weather and cultural barriers. They are disadvantaged with the burden of raising children alone, heading the family and trying to cope with the enormous difficulties of adapting to totally new environment, different culture and above all communicating in a language that they absolutely do not understand. Nevertheless, they are expected to deal with immigration offices, lawyers, doctors, teachers, social services, and financial institutions. Most of these refugees feel lonely and helpless after being detached from their families and extended family member who most likely are scattered around the world.

The Somali community was faced with insurmountable difficulties because of lack of readily available information with regard to available services. As the community grew, it became apparent that there was a need for a kind of community organization to help with the settlement of the Somali newcomer. For this reason many community organizations started as a working group to advocate for the community and facilitate awareness of refugee plight, promote understanding of the impact of domestic law, practice of relief and encourage direct services to newcomers. Although some Somali Community based agencies have been created in the early nineties, the need of the community expanded as a result of the challenges of multi-layered barriers faced by the community.

One of the most immediate challenges they face is the immigration process, which is the key to settling in this country. They fled their home country without proper documentation. The changes to the Immigration Act of Canada 1995, which singled out the Somalis which required 5 years waiting period for the Landing Status after recognition as Convention Refugee has severely impacted the livelihood of the community. Most families have left some children, spouse or parents back home or in different camps in neighboring countries. Mothers could not sponsor their children or loved ones. As a result of this long process and the uncertainty of the decisions and anguish felt by most, lead to stressful lives.

The Somalis came here as refugees fleeing from repressive regime followed by prolonged civil war, because of that ordeal they still have fear about government institutions and therefore, tend to retreat from any sort of conflict, which leads to isolation. Somali seniors are the most vulnerable and isolated group among the community. They do not speak the language therefore do not know where to access services. They are on low fixed income and cannot afford transportation and other basic needs. They are left on their own to adjust and cope with a new way of living.

Somali children in schools encounter difficulties as well. Most of them have been through the political upheaval and have been uprooted from their own culture. It is always difficult for them to go to school when they do not understand the language. They are usually teased some times discriminated by their peers, which often leads to anger and confrontation. As a result of that most Somali kids are labeled as violent by the school system. Furthermore, they are confined to small apartments and lack the freedom of, playing in safe and wide playgrounds they use enjoy back home.

Child rearing and disciplining of kids has turned out to be a major issue for Somali parents. Fear for their safety of their children and fear of children losing their values and tradition often leads to being over protective. Many children feel deprived of their freedom and tend to rebel at an early age. In Somalia, both parents and elder siblings, as well extended family members and schools share responsibilities for disciplining the children. As we can see there is enormous difference between Somali and Canadian cultures, In extreme cases the anxiety of the parents and children's defiance lead to conflicts which may result in children opting for total independence from their parents and community.

Without the Landed Status Somali refugees are not eligible to higher education loans, grants or scholarships. In a competitive society such as Canada, it is difficult particularly for Somali women, even those with grade 12 education to enhance their living standard. Mothers of young children are the worst off They cannot go to school because of lack day care spots. In some cases, the wait period for daycare facilities take as long as 2 years during which time the mother is confined at home therefore, unable to improve her skills for potential employment. Most high school graduate students end-up wasting years at home or doing working in menial jobs and sometime end up in dangerous situations. Most adults with little or no formal education spend years in ESL programs and do not get the necessary skill training programs. Parents who have low level of education or have no education background are not able to understand the and therefore, cannot help their children with school. Another disadvantage faced by Somalis is the teachers' and educational system's lack of knowledge about the different ethno-cultures. The Somalis are considered one of the most disadvantaged immigrants in Canada. The community was severely affected by the Conservative government's reduction in Social Assistance, elimination of rent control, drug prescription fees and reduction in various services and benefits create' significant hardship for the community.

Their socio-economic profile indicates that ^{their} unemployment rate is two and a half that of all Canadians and their median income is a third less that other Canadians.

Difficulties in employment are naturally an issue for large number of refugees. Most them came to Canada with relatively minimum language skills, and need a period of language training and orientations. Lack of the opportunities, for example, has been a source of considerable frustration for Somali refugees. This is in part, a result of the situation in which Somalis find themselves, a difficult situation in which with out permanent residence documents, they are unlikely to be hired for many employment opportunities. Without Canadian experience, they continue to be overlooked in favor of those who do have the Canadian experience. This situation is a familiar issue for immigrants virtually from non-English speaking countries. What is unique is the length of time Somali newcomers must spend without landing status, with a range of discriminatory results. Somali professionals end up working as cab drivers, cleaning jobs, parking lot attendants etc, because most of them are not eligible for better jobs. With significant educational and public service cutbacks over the past decade, access for new comers is essentially denied unless they recommence their studies in Canada.

Somali community faces difficulties in finding affordable housing and has problems managing rental costs and other basic needs Somali families. Because of their economic status they live mainly in rundown public housing or subsidized units. Those who arc on social assistance face difficulties in renting apartments or houses because landlords prefer not to rent them and usually demand of them proof of high income. Most Somali families tend to have large and sometimes extended family members and are under housed.

As new comers to this country Somalis incur a great deal of systemic barriers in the following areas, immigration, education, employment, and culture. These barriers prove to be sources of great frustration for the community, who came to Canada with many hopes and dreams of being able to live freely and make a contribution to society.

Somali refugees have suffered hardship in their home country and arrived in Canada practically with out financial resources. As a result, their general health tends to be poor. Poor physical fitness is evident throughout the adult population. Nutrition is a major area of concern, especially for women and children of all ages. Since Somalis are used to eating fresh uncontaminated food, the nutritional integrity of Canadian food is inferior to the quality of food in Somalia. As Muslims, Somalis tend to avoid non-halal food, which is sometimes unclear to determine. Dental problems are evident in all segments of the population. Most Somali children need immunization and have in many case difficulties adapting to the climate, different foods and eating habits in Canada. Most of the notable health problems of Somali women are gynecological and obstetrical problems due to female circumcision, and post traumatic stress. Canadian health providers were not educated about special needs of these women and therefore, could not provide proper and sensitive prenatal and postnatal care, and avoid unnecessary operations on these women.

Most of the Somali refugees in Canada have experienced persecution in their homeland. Most of them have witnessed, their loved ones jailed, tortured or killed during the military regime or during the civil war. As a result, many adults exhibit post-traumatic

stress syndrome with depression and anxiety. Adapting to a new way of life added sources of stress. Women and seniors feel particularly isolated and lonely.

In spite of challenges and struggles facing any refugee community and particularly the Somalis here in Canada, they nevertheless, remain optimistic about present and future life in Canada. The struggle to become self-sufficient and integral part of this mosaic society is something that will, overtime become easier when certain facilitation and accommodations are met.

b) Oromo Community

According to the Oromo Canadian Community Association of Ontario, the population of Oromo people in Ontario is estimated to be round five to seven thousands. They are scattered all over Toronto and Ontario. They are a little concentrated around Lawrence Heights Area and they are one of the users of service provided by Lawrence Community Health Center.

In an attempt to try to develop a document on the Oromo Canadian Community, a search for information was done, by looking for any possible source. Local Oromo community agency was contacted, an Internet search was done, books were reviewed, individual were interviewed etc. But literally no documented information was found on specific to the Oromos in Canada.

As a new immigrant they have problems, which are common to other ethno-racial minority groups in Toronto area. There is some information on the Ethiopian immigrant, which also includes the Oromo community. One of which is the Orstein report of ethno racial inequality in city of Toronto, an analysis of the 1996 census. From this report it can be inferred that the Oromo community in Toronto as part of the Ethiopian and African immigrant have the lowest educational attendance and highest unemployment. As well the health status of the Oromo community can be said poor. This is noted in the report on the HIV/AIDS Epidemic among Persons from HIV-Endemic Countries in Ontario, 1981-1998, where this region accounted an increasing proportion of HIV/AIDS cases in Ontario. These regions are the sub-Saharan African and Caribbean countries. The other example is the study on mental health of the Ethiopian community. The mental illness in the Ethiopian community (Oromos included) is one of the highest in the Toronto area.

Taking into consideration the scarcity of information on the Oromos in Canada, the aim of this document is to assess the major health concerns of the Oromo community and produce a base line information on health and health related issues. It will also provide a framework for addressing the health needs of the Oromo community. So that health and community service providers, community members and others will make use of it.

c) Ethiopian Community

Between 1974-1996, 21591 Ethiopian immigrants were recorded in Canada and the majority, approximately 12000 were settled in Ontario. These figures do not include the inland refugee claimants and movements from other provinces and cities.¹ Between 1994-1996, a total of 1606 Ethiopians immigrants came to Toronto as a permanent resident.²

Studies suggest that, added to the sufferings in the home country and/or the country of asylum, arrival and resettlement in a new country often involves a period of significant re-adjustment and stress. Separation from family and community, inability to speak the dominant language, lack of familiarity with health and social services, failure to find suitable employment and negative public attitudes all contribute to vulnerability.³

Concerns about the growing needs in services particularly on causal factors such as trauma, isolation, unemployment and underemployment, housing problem and effects like mental illness and suicidal incidences by new Ethiopian immigrants has been articulated at a number of community meetings hosted by the Ethiopian association in Toronto. Hence, there are some initiatives in identifying the needs of Ethiopians in Canada.⁴

d) Eritrean Community

Before Coming To Canada

Eritreans started to immigrate to Canada in the early 1980s. Most of them left their country due to political instability and war. Others also left due to religious persecution and other personal reasons. There is no Eritrean family that in one way or the other has not been deeply affected by the thirty year long war and the new war with Ethiopia. Most Eritreans have experienced life in the hands of repressive political regimes that made their lives very unpleasant. Most Eritreans understand the feelings that stem from the trauma of war and displacement. Eritreans who came to Canada as landed immigrants or as refugee claimants have escaped from a frightening and disturbing situation in their country. This experience has left many with a profound negative effect.

Coming To Canada

Settlement

The 30-year war of independence made many Eritrean refugees and the number of Eritrean refugees increased dramatically with the recent border conflict between Eritrea and Ethiopia. The first flow of Eritrean immigrants to Canada dates back to the early 1980s. In the early 1980s, the Canadian government relaxed its immigration policy toward refugees from Africa. Therefore, many Eritreans were able to immigrate to

¹ Citizenship and Immigration Canada report from 1974-1996 ²

George, U. & Mwarigah, M.S., 1999.

³ Canadian council on Multicultural Health, 1989; Canadian Task Force, 1988 ⁴
Settlement Services Need for Ethiopian Newcomers in Toronto

Canada. The current number of Eritreans in the city of Toronto is not known, but is estimated to be around 10,000.

Like most refugees and landed immigrants, in settling into a new country Eritreans face a number of challenges. The experience of war and persecution in their country coupled with the challenges of coming to a new country whose language, culture, religious belief and world view is different affects the process of integration and rebuilding of their lives. To integrate into the new country and society, Eritreans must find a middle ground between preserving their own culture, religion, language and world view and the new culture (Scott, 19). Their settlement process is not only affected by the relationship between Eritreans and the host society, but also the relationship Eritreans have with each other. Eritreans seeking assistance with settlement issues were referred to agencies serving the Ethiopian community. There are few records or studies that focus directly on the Eritrean community.

In addition, many Eritrean refugees were not able to access settlement services provided by community-based agencies due to political perception and in the process they remained with less viable solutions to their problems. The above reasons are among the stumbling blocks that continue to render the Eritrean community invisible, hence marginalized and under-served. Consequently, this makes it difficult to assess the community's true needs and to hear the true voice of the people in the community. Moreover, the scattered nature of the Eritrean community in the city of Toronto and the lack of information sharing within the community in general, makes it more difficult for the community to be visible or to be served by the agencies providing settlement services to many communities across the city.

Parenting And Education System

The study of the Settlement Experiences of Eritrean and Somali Parents in Toronto has examined the challenges Eritrean parents face in dealing with parenting issues and the lack of understanding of the Canadian educational system here in Canada. Eritrean parents mentioned cultural differences as the main barrier to settling their children in school. Eritrean parents also indicated that they do not understand the Canadian school system. In coming in to a new country, loss of culture is among their biggest concerns because they feel that their children are not respecting their religion, tradition and particularly their elders.

Moreover, the lack of understanding of the Canadian education system makes parenting more challenging and frustrating for Eritrean parents. Eritrean parents indicated that when they need help or support with parenting, they turned to their family, friends and members of the community. For those who did not have friends and family members, it is extremely difficult to go on with out support. Many Eritrean parents wanted to know about the broader Canadian society and the services that are available. However, few parents had ventured out to use the services provided by mainstream organizations or agencies, only to be hindered by language, culture and religious barriers.

Very few Eritreans are familiar with family drop-in centres or services. According to the study by Praxis Research and Training, many Eritrean parents said they would use family drop-in centres if their services are available in their language and are staffed by people who are sensitive to their culture and religion.

A serious out-reach plan for Eritrean parents and identifying creating culturally appropriate resource centre for Eritrean parents will help ease the difficulties they face.

III. General Perceptions & Experiences of Health Care a)

Eritrean Community

General Perceptions of Health Care

Traditional Healing

Many traditional healers do not advertise their expertise, have no formal clinics and are usually reached only through word of mouth. Healers do not take any monetary form of payment. Usually, patients compensate for services by giving food or clothing or other material goods. Maichelot or hot spring waters are also thought to have curative powers. Rather than going to a doctor or hospital, many Eritreans prefer taking a dip in one of the country's numerous hot springs to cure sickness. The sacred pools of Maibad near the port Massawa and Mai-Wuie in the coastal region are very popular. Traditionally, Eritreans have believed that disease and the power to cure is the work of God. Diseases, along with natural disasters, are seen as punishment from God.

Many Eritreans believe that the "evil eye" can cause illnesses, such as, stomach pain, and even death. A person with an evil eye is usually forbidden from marrying. Some Eritreans also believe that a demon can enter the body and cause ailments until its demands are met. Some traditional healing practices have religious implications, other do not. For example, the treatment for a Christian suffering with mental illness is immersion in holy water for seven or fourteen consecutive days. Other healing practices include the treatment of warts by tying a horse hair to the wart tightly until it is removed from the skin, and of jaundice by putting a hot, thin iron bar on the patient's arm or skin until the skin burns. Eritreans also strongly believe in the healing power of certain plants and roots.

Other practices in Eritrea included the "burning" where a thin piece of metal was heated until it was red and then placed on the aiiii in different places to burn the flesh. Another practice was that of removing goiters. Often this is evident by visual tattoos around the neck area.

Eritreans strongly believe in the healing powers of different plants, and specifically roots. In their country they were often given a piece of a special root to chew and afterwards felt they were healed of their illness. They also believe in the power of some plants, in warding off snakes and curing them from snakebites. However since they are unable to bring these plants to this country, many of these practices are not available. However, Eritreans still strongly believe in the power of plants and often when a cure cannot be obtained in this country will return to Eritrea for traditional healing.

Experience With Western Health Care

Most Eritreans do not go to their doctors, clinics and hospitals unless they are seriously ill. They are troubled by some of the medical practices in Canada. First, most Eritreans feel that often too much blood is drawn for testing and would prefer this not performed

unless absolutely necessary. Most do not understand why blood is drawn on pregnant women, since they believe pregnant women need all the blood they have. They would prefer not to receive blood from others, but also understand that if that is what is needed they will comply.

Second, they would also like to be thoroughly informed, especially by an Eritrean interpreter before any procedures are done. Most Eritreans strongly believe that Eritreans understand one another and prefer not to be associated with Ethiopians even though they may speak the same language. Eritrean men would prefer to be cared for by men health providers. Eritrean women strongly wish to be cared for by women and would like to have an Eritrean female interpreter present when discussing their health problems.

Regarding surgery, they wish to be thoroughly informed, if possible, by an Eritrean interpreter. If an Eritrean becomes ill with cancer or another life-threatening illness, they may first follow the western medical plan, but if they do not improve they may resort to traditional medicine, such as, roots, herbs and other traditional medicines. Most Eritreans strongly wish that the family be informed first of a diagnosis or poor prognosis rather than the patient. Most believe that if they return to Eritrea and are treated with plant roots or other modalities they will be healed. They feel that many treatments in Western medicine allow the disease to spread further in the body. The following are among illnesses Eritreans complain about:

<i>Abdominal Pain</i>	<i>Asthma</i>	<i>Back Pain</i>
<i>Chest Pain</i>	<i>Constipation</i>	<i>Diarrhea</i>
<i>Dizziness</i>	<i>Fever</i>	<i>Headache</i>
<i>Hematuria</i>	<i>Jaundice</i>	<i>Joint Pain</i>
<i>Wheezing</i>		

Service providers need to be culturally competent in order to offer culturally appropriate care for Eritreans in Toronto and in Canada as a whole. Offering culturally appropriate care requires being open to the perceptions, realities and expectations of a community that may be different from the service provider's community (ethnomed). It is very important to identify the various assets, culturally appropriate resources, such as, Doctors, Nurses, Social workers, Community workers, Elders and Religious leaders who can contribute to community wellness.

Cultural Barriers To Health Care

Medical Care And Providers

Usually, most Eritreans do not see a doctor until a health problem becomes serious or even unbearable. They believe the pain will go away by itself. Most accept the doctor's authority, however. They expect the doctor to figure out what health problem they have and are willing to listen and learn.

Most Eritreans believe that getting a shot is more effective against disease than taking a pill. They also feel that too much blood is drawn for medical tests and prefer not to have this done unless absolutely necessary. Understanding of the prevention and causes of disease is limited. Many Eritreans do not understand that many agents and infections may cause similar symptoms. For instance, many of those who come through the Sudan were infected with malaria. Since they are familiar with the symptoms of this disease, they think they have malaria whenever they have muscle aches and high fever.

Women's Health

Pregnancy

Eritrean women seek prenatal care from community clinics and plan delivery in a hospital. In Eritrea, many had home deliveries performed by traditional birth assistants. They feel strongly that Western doctors do far too many unnecessary Cesarean sections and they would prefer the doctor wait for the baby to come naturally. Often they delay their coming to the hospital because of this reason. Many older Eritrean women do not practice birth control, as they feel this is interfering with God's will. Many others do not use birth control for religious reasons and lack of understanding of the birth control method. Even though, most women see the economical disadvantage of having large families in Canada, they are pressured by the above reasons. However, younger women tend to practice birth control.

Maternal And Prenatal Health

During childbirth, most Eritrean women are not comfortable in a delivery room since in traditional birthing with a midwife, women do not open their legs to give birth. Many Eritrean women feel strongly that western doctors perform too many Cesarean sections. Often they will wait at home before coming to the hospital for childbirth in order to avoid Cesarean sections. There is a huge gap in information about whether or not prenatal health services are utilized by the Eritrean community in general.

However, anecdotal information indicates that many mothers do not use prenatal health services due to lack of information or other barriers, such as, culture, religious and linguistic. There are definitely other inhibiting factors that are preventing women in the Eritrean community from accessing prenatal health services. Further investigation is necessary to better understand what the factors are and understand the reasons behind them.

Providing workshops about maternal and prenatal care or forming a focus group or women's group to discuss maternal and prenatal health along with other issues that are confronting women in the Eritrean community could be a starting point.

Child Rearing Practices

Breast-feeding is a common-practice in Eritrea. Most mothers breast feed for at least two years unless the mother becomes sick. Toilet training is often starts as early as 5-6 months of age. Bowel training can be accomplished as early as 6-7 months and bladder training after one year. This is done by the mother and requires close attention to the child's elimination patterns. In Eritrea, the children often sleep with their parents until the

first year or later. Coming to Canada, Eritrean children sleep in separate beds much earlier in life.

In some families the father is the strong disciplinarian and in others the mother is stronger. Children are raised to respect and honor their elders. If a child is disciplined everyone around the child is aware of it. Most Eritrean parents have many concerns about raising their children in the Canadian culture. In Eritrea, dating is not allowed and teenage pregnancy is shameful. Most Eritreans feel that if a girl were to get pregnant outside of marriage, she would suffer for the next eighteen years. Eritreans strongly emphasize education over social pleasures and believe in telling their children of their concerns and how they wish them to be raised. They are not happy about the peer pressure placed on teenagers in Canada.

Circumcision

Female circumcision is practiced in Eritrea and traditionally performed by lay healers. The type of female circumcision varies from region to region. Eritreans wish to have all males circumcised. There had been some initiative to educate people about the danger of female circumcision and the government went as far as prohibiting female circumcision. However, it is difficult to measure the success of this initiative.

For the majority of the people in Eritrea, female circumcision has strong cultural and religious significance and it will definitely take time to prevent it. Nevertheless, some progress has been made in the last 10 years. Regarding the Eritrean community in Toronto, there is no information available, but there are people who strongly believe in female circumcision and manage to take their daughters to Eritrea to have them circumcised.

Pain Expression

It is impossible to speak about the Eritrean culture or language or tradition or perception as Eritrea has nine ethnic groups with each ethnic group having its own distinct language or culture or perception for that matter. Pain is expressed differently in various ethnic groups, however, most Eritreans do not express pain openly, particularly by men. Most Eritreans customarily say that they are feeling ok' even when they are in the emergency room for a serious medical condition. Compared to Canadian women, Eritrean women are less vocal about expressing their pain and are less likely to receive medical attention.

Mental Health

Mental health in Eritrea is not understood in the way it is understood in Canada. The terms of mental disorders such as, depression, anxiety, Post Traumatic Stress Disorder (PTSD), schizophrenia, bipolar, phobia etc. are not common in the Eritrean languages. Only few may have a good understanding of the above disorders, but the majority of Eritreans do not comprehend the disorders and lack basic understanding of mental health in general.

Mental health institutions in Eritrea are severely under-funded and the infrastructure was non-existent specially, prior to independence. Currently, it is functioning in a slightly better atmosphere and is undergoing through a series of changes to establish itself. However, it is nowhere near to addressing the issues of stigma and isolation. In addition, a huge work remains to be done in terms of developing a language for people to express mental illnesses. Most Eritreans see mental hospitals as asylums where people are locked for life once they are identified as mentally ill with no hope to get better. For most Eritreans the term *Tetselilu/tetselila*, (gone crazy) could mean any thing from acting strangely to exhibiting symptoms of mental illness.

For most Eritreans, mental health invokes fear of stigmatization, isolation, and humiliation. This is the perception that most Eritreans bring with them when they come to Canada. Once they are in Canada, the resettlement process and the challenges of readjustment and coping with the stress that the new life brings drives them to resolve it by committing suicide. Suicide is becoming common in the Eritrean community. In the last four years, there had been 7-9 suicides of which most were newcomers to Canada. For a small community, this number is quite alarming. Even though immediate attention is required, nothing is forthcoming to deal with this serious issue either from community-based agencies or other agencies in the city.

To date, Eritreans are not aware of a study in the city of Toronto or else where that specifically examines the Eritrean community in the area of mental health and suicide prevention. The barriers that Eritreans face in accessing mental health services are either not identified or grossly underestimated due to lack of understanding of the Eritrean community. One has to infer from the few studies conducted in Somali and Ethiopian communities. Thus, there is a huge gap of information about mental health in the Eritrean community. A concerted effort from individuals who are working in the health sector and from community-based agencies in partnership with other service providers in the city is needed to tackle the issue of mental health in the Eritrean community.

b) Somali Community

Religion and Social Customs

Almost all Somalis are Sunni Muslim. Attitudes, social customs and gender roles are derived from Islamic traditions. During the month of Ramadan, people pray and fast together. Muslim tradition forbids drinking alcohol and eating pork meat

Family life

Family and social structure in Somalia is clan-based system. Since most are largely nomadic it is common for several sub-clans intermixed in one area. Membership in clan is determined by paternal lineage. Men who can afford to do so may have up to four wives. In rural areas it is common for all to live in a single household and care for the fiii or livestock together.

Traditional Healing

Somali traditional doctors are usually older men in the community who learned their skills from older generations. Techniques include fire burning on the skin, herbs and prayers. Some Somalis believe spirits reside with in each individual. Traditional doctors also help cure illnesses caused by spirits. Some cures involve a healing ceremony including reading from the Holy Koran, eating special foods and burning incense.

Maternal and Childbirth

Childbirth most often takes place at home, attended by a midwife. The new mother stays home for 40m days after birth with female family relative around to care for them. Newborn care includes waiin water baths, sesame oil massages and passive stretching of baby limbs. Breastfeeding is common up to two years of age, usually supplemented by goat, cow or camel milk.

Circumcision

Both males and females in Somalia are circumcised before age 7. This is viewed as a rite of passage for marriage. Male circumcision is done usually by traditional doctor or by medical doctor or nurse in hospital. Female circumcision is usually perfoiiued by female experts or in hospitals. The most common, known as "infibulation" involves removal and suturing of most genital tissue, leaving a posterior opening.

c) Oromo Community

Concept of Health Care and Medicine in the Oromo Community

Traditional Medical Practices

"Traditional Oromo healers are skilled at bone-setting, cautery, minor surgical procedures such as tonsillectomy or uvulectomy for throat infections and drainage of abscesses, and treating many illnesses with medicines made from local plants. They widely practice cautery to disinfect skin and prevent bleeding, as well as in treatment of snake and scorpion bites. Individuals were also accustomed to using plants for home remedies for minor illness. Hygiene is known to be important, and many diseases are recognized to be contagious, but many diverse forces are thought capable of affecting health. Illness and misfortune in general is often considered a punishment from Waaqa for sins a person has committed, and the "evil eye" is a malevolent influence from other people that can cause disease, especially in vulnerable young infants.

Endemic diseases in Oromia are similar to the rest of sub-Saharan Africa and include Hepatitis A and B, tuberculosis, falciparum malaria, syphilis, schistosomiasis and other tropical infectious diseases. AIDS is emerging as a significant problem, complicated by a social reluctance to discuss extramarital sexual activity, especially among teenagers""(8)

Circumcision

In Oromia, circumcision is performed on both boys and girls either in early infancy or at the time of marriage. Female circumcision is desirable but optional, while male

circumcision is considered mandatory for reasons of health/hygiene and social acceptance, as well as religious law for Muslims.

Experience with Western Medicine

Oromo immigrants from urban centers have some experience with Western-style medicine, but rural people may have trouble understanding the concepts of disease causation and the practice of withholding symptomatic treatment until a diagnostic workup is done. Back home, effective herbal medicines were available to treat respiratory and gastrointestinal viral syndromes, and antibiotics were used rather indiscriminately in cities and refugee camps, so Oromos expect to receive medications for every illness. Therefore, our failure to prescribe medicines for self-limited illnesses makes some people feel it is a waste of time to go to the doctor and is a common point of dissatisfaction.

People tend to be nervous about venous blood draws because they worry that the lost blood will not be replaced (and the traditional method of replacing lost blood - drinking fresh blood from a sheep or cow - is not possible here), so finger pokes for lab tests are much more acceptable. Blood transfusions also generate fear and concern, although there is no specific cultural proscription against them. As in any area of potential misunderstanding, taking the time to explain our reasoning and answer questions can go a long way toward improving a doctor-patient interaction.

Women are generally reluctant to discuss gynecologic issues with a male provider or male interpreter, especially on a first visit before a relationship has been established with the provider. The words used for parts of the body vary in different dialects, so an Oromo interpreter may not know the right term to use with a particular woman. Also the idea of a pelvic exam may be completely foreign and unacceptable if a woman is not familiar with western medicine, as there is no tradition of such a thing in Oromo culture. After about age ten, Oromos would much prefer a same-sex health-care provider.

Pregnancy Practice and delivery

Women continue to work during pregnancy. They try to have good nutrition and particularly increase meat in their diet.

Home deliveries with a midwife or traditional birth attendant are the norm in their native country. Some women from urban areas may have had a hospital delivery but technology intervention does not happen. Men do not participate in the delivery. Male interpreters are considered inappropriate in labor and delivery although a male doctor may be tolerated. The husband must be involved in any decisions for surgical interventions but he may defer a decision to the wife or female relatives. Multi-parous women do not like the interventions in the U.S. and may wait until late in labor to come to the hospital. C - sections may be refused in emergency situations.

Postpartum Practices •

Traditionally women rest in bed for 40 days postpartum and are attended by other women who prepare nutritious food and do housework. \

At the end of 40 days there is a celebration at the home of a relative or friend. This marks the first time the baby and mother have left the home since delivery. This celebration may

be combined with a naming ceremony for the baby. A woman carries a metal object (often a knife) with her at all times to prevent evil eye. Special teas, soups, and porridge are provided for the mother. Flaxseed porridge with honey is commonly given to mothers postpartum.

Breast feeding Practice

In many ways, breastfeeding is a universal practice, yet there are cultural aspects that vary considerably. In East Africa, practically all infants are breastfed. Breast-feeding is initiated in the second or third day of life when the mother's milk comes in. Prior to this, the infant is given fresh butter which "cleanses the gut; newborns are full of dark stool (i.e. meconium) and butter clears this out." Unpasteurized cow milk is often given as well, and is frequently continued past the first few days as a supplement to human milk. Formula is extremely rare for it can only be obtained in large cities and is prohibitively expensive.

The initial breast production of "yellow water" (i.e. colostrum) is viewed as nutritionally useless, "just like water". It is sometimes expressed and discarded, not fed to the infant. In general, Oromo people see water as void of nutrition and do not drink it. They seriously doubt the value of clear fluid diets for infants with gastroenteritis, which the American doctors advise.

Mothers feed infants on demand, rarely going far from the infant and sleeping with them at night. Breastfeeding is acceptable in all social situations, even a busy marketplace. However, breastfeeding women often keep their breasts covered when not feeding, fearing the lactating breasts are very susceptible to air-borne illness. Sometimes women breast feed infants who are not their own. This is particularly true when both mother and daughter have infants and are lactating. It is usually done for convenience, for example when one of the women is away from the village on an errand. Occasionally in situations of maternal illness, death, or failed milk supply, a relative or other village women assume breastfeeding responsibility. However, such infants are frequently just sustained on cow's milk.

It is rare for women to be unable to breastfeed. Practically all mothers breastfeed. It is almost unheard of for there to be significant breastfeeding problems except in the case of very ill mothers.

Infants are breastfed until two or three years of age. Prolonged breastfeeding is seen as nutritionally beneficial and recognized as a form of birth control. Solid foods are offered at a young age (around 2 months). If the infant shows interest, small amounts of soft food are continued. If not, solid foods will again intermittently be introduced until the infant appears ready.

"Despite this strong breastfeeding background, many, probably the majority, of Oromo women opt to formula-feed once they take up residence in the U.S."(10)

Nutrition and Food

Buddeena, (or bideenna, several spellings have been suggested), is a fermented flat bread made from teff flour and is commonly eaten by Oromos. It is eaten with stew (Itto). A spicy barley dish (Cuukkoo) mixed with butter is a special delicacy. Butter is added to most porridge (Marqaa) and stew or soup dishes. Meat is an important part of the diet, both smoked and fresh, but pork is not eaten. Milk and coffee mixed with milk are

common drinks. Traditionally food is eaten with the fingers of the right hand. Western utensils may now be used in Oromo homes. (5,8)

Housing, Employment and Education

Some of the determinant of health (e.g. Housing, income, and education) could have been assessed quantitatively. Due to lack of resources to do the study as well absence of data from previous studies it is difficult to say exactly the extent of the problem in this community. But from some studies done on the Ethiopian community in which the Oromos are included, some information can be inferred.

According to the study on Pathways and Barriers to Mental Health Care for the Ethiopians in Toronto, 80% of the sample were employed, however 60% of men and 50% of women are under-employed. According to the analysis of the 1996 census, unemployment in Ethiopians living in Toronto was 24.4%.

When it comes to the poverty, Ethiopians are the third poorest headed by Ghanaians and Afghans. Almost 70% of the Ethiopian families are below the statistics Canada's Low Income Cut-off. According to the study on the settlement needs for the Ethiopian newcomers in Toronto housing was one of the two most important concerns, preceded by a job. In the same study it was shown that only 5.9% of the Ethiopian own house while most of them live in rented house.

Educational level of the Ethiopians is still one of the lowest in Toronto. From the Ornstein report only 9.6% of the Ethiopians graduated from university while that of the general population is 22.7%.

Utilization of the health service is another factor that determines the health status of a community. In the study by the Ethiopian community done in 2000, they assessed the health service utilization by the family physician. In this study they found out that 89.1% have family physician during their first three years in Toronto and of those 61.2% go to Ethiopian physicians.

Stable Social Support

Stable family structure and social support is one of the important factors for health. This is very important especially in communities, which are used to live in an extended family structure. In the Oromo community extended family life part of their culture. An unstable Family and social system will affect the health of an individual. This has been documented in the studies done by the Ethiopian and Somali communities.

d) Ethiopian Community

Extended Families

Family structure includes the extended family. Family ties are, strong. Households in the Ethiopian community includes 1 to 6 six persons, half of who are children under age 10. The divorce rate is high and mothers have a hard time raising children as single parents. In times of crisis, the family will take full responsibility for the family member's problems, whether it 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.⁵

Marital problems are usually kept confidential and Ethiopians rarely seek counseling. If differences cannot be resolved, the wife goes to her parents. Family elders talk to the couple together and separately and permit a divorce if reconciliation is impossible. Ethiopian children are expected to have respect for their parents and older people, and obey their decisions. The male head of the family is the main decision maker; even adult children seek his advice.⁶

Related women and women within a neighborhood have very strong ties among each other in Ethiopia. The women have daily coffee ritual where each day in homes to share coffee and talk. This daily gathering of women established support networks for pregnancy, post-partum help, and child care.

The Ethiopian families in Canada are often separated from extended family and live spread out from each other in different neighborhood, therefore similar women's socializing has been hard to recreate.

It is also often difficult to maintain traditional Ethiopian values in Canada. The sort of communal responsibility that is traditional in Ethiopia is not possible in most Canadian neighborhoods. Most Ethiopian newcomers are young, single adults. Cut off from their families' support, they have to learn quickly how to adapt to Canadian life, where independence and competition replace the shared responsibility and mutual dependence of Ethiopian life.

Circumcision

Most people who are Muslims, Christians and Ethiopian Jews practice male and female circumcision.

⁵ <http://www.ethnomed.org> 11/20/2001

⁶ Ethiopia A Culture profile researcher/Writer: Berhnam Behnia

Pregnancy Practices Activity Level

Women usually work until delivery.

Food

- Women try to have good nutrition and particularly may increase meat in their diet.
- Flax seed flour is mixed with warm water before delivery and drunk by the woman to help produce an easy delivery.

Delivery

- Home deliveries with midwife or traditional birth attendant are the norm in Ethiopia. Some women from urban areas may have had a hospital delivery.
- Men do not participate in the delivery. Male interpreters are considered inappropriate in labor and delivery although a male doctor may be tolerated. Ethiopian women prefer female doctors and interpreters, especially for child birth
- Many think that Canadian 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.

Post Partum Practices

- Traditionally women rest in bed for 40 days post-par time and are attended by other women who prepare nutritious food and do housework. Because of school, work and other obligations, Ethiopian women in the Canada are not able to take the traditional 40 days of rest after childbirth.
- In some Ethiopian culture groups, a woman carries a metal object (often a knife) with her at all times to prevent evil eye.
- Special teas, soups, and porridge are provided for the mother. Flax seed porridge with honey is commonly given to mothers post-part time.

Infant Feeding, Care

In Ethiopia 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.⁷

They also 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.~

Mothers are unfamiliar with. pumping and storage of breast milk and need education about how to do this.

⁷ <http://www.ethnomed.org> 11/20/2001 ⁸
<http://www.ethnomed.org> 11/20/2001

Soft foods are offered starting at a few months of age and drinking from a cup is offered at 6-8 months of age.

Traditional Medical Practices

Illness is often considered 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 benefits and attitudes towards health.

Experience With Western Medicine In the Country of Origin

Where Western-style medical care is available, antibiotics are used frequently. Ethiopians who consult doctors usually receive a medication for every illness.⁹

Prerequisites For Health

The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic prerequisites. Good health is a major resource for social, economic, social, cultural, environmental, behavioral and biological factors can all favor health or be harmful to it.¹⁰

As per the Ottawa Charter for Health Promotion health is seen as a resource for everyday life, not the objective of living. Peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity are the determinants of health. Therefore these factors have to be fulfilled to reach a state of complete physical, mental and social wellbeing of an individuals or group.

Studies suggest that, added to the sufferings in the home country and/or the country of asylum, arrival and resettlement in a new country often involves a period of significant re-adjustment and stress~

Despite their need, immigrants use fewer services compared to Canadian born and immigrants that have come earlier. ¹¹

Part of the service utilization problem may stem from a mismatch between what service providers feel they are offering and what potential clients perceive as their needs and resources to meet those needs. Concerns about the growing needs of Ethiopian newcomers have been articulated at a number of community meetings hosted by the Ethiopian Association in Toronto. Hence, there are some initiatives in identifying the

⁹ <http://hywww.ethnomed.org>

¹⁰ The Ottawa Charter for Health Promotion, 1986, Copefihagen

¹¹ Canadian /council on Multicultural Health, 1989; Canadian Task Force, 1988 ¹²
Canadian Task Force, 1988

needs of Ethiopians in Canada such as the Federation of Ethio-Canada Association in 1996, the pathways and Barriers to Mental Health Care for Ethiopian in Toronto which is in progress and the Social and Health Taskforce Assessment in 1999."

The three main areas of services obtained by Ethiopian newcomers are on settlement, job and education related. Most Ethiopian newcomers obtained these services from friends followed by the Ethiopian Association and government agencies.

Although the great majority of Ethiopian newcomers to Toronto, 78.9 percent, had either relatives or friends at the time of arrival, significant number of respondents, 38.6 percent, reported that life in the first few months in Toronto were indeed difficult.

As far as employment is concerned 83.6 percent of Ethiopian newcomers worked during the first three years in Canada. Of those who had been working, 34.8 had two jobs in. striving to settle. 29.5 percent had changed their job at least in the three-year period of settlement. 47.8 percent Ethiopian got their job through family or friend, 26.1 percent from advertisement, 17.4 through agencies and the rest with other means. The level of satisfaction on the job is that 54.2 percent are dissatisfied. 25.0 percent are neither satisfied nor dissatisfied and 20.9 are satisfied. For 76.1 percent of Ethiopian newcomers, their jobs do not reflect their education level. ¹⁴

Housing accommodation as an immediate need on arrival is a major concern for newcomers. Most Ethiopian newcomers, 69.5 percent, stayed either with a relative or a friend, 13.6 percent in a hotel and 10.2 percent in a shelter. As a consequence of the housing problem, particularly for newcomers, the mobility of Ethiopians in the three years is high. While 11.9 percent are still living in the same address since arrival, 33.8 percent have moved one or two times and 38.9 percent have moved more than two

[times.js](#)

Ethiopian newcomers encountered various forms of family and social problems during the first three years of their stay in Toronto. These problems are indicators of the stress and challenges of the settlement process. The top five concerns of Ethiopian newcomers during the first three years in Canada are:

Major concerns with children

- difficulties at work or school
- trouble in housing
- trouble because of language and
- trouble with prejudice or discrimination

Findings from the key informant survey indicate that social and gender role reversal is one of the challenges Ethiopians have faced in Canada. In Ethiopia, men are head and breadwinners of the family while women are in most case homemakers. In Canada,

¹³ Settlement Service need for the Ethiopian Newcomers in Toronto ^{ia}
Settlement Service need for the Ethiopian Newcomers in Toronto ^{1'}
Settlement Service need for the Ethiopian Newcomers in Toronto

Ethiopian women are enjoying financial independence while many Ethiopian men are suffering from underemployment and expectation crises. In comparing the level of ° integration, Ethiopian women do integrate easier and faster than Ethiopian men do.

The difference in English language proficiency in a family has caused a communication gap. Children adapt faster to the Canadian way of life while parents are facing difficulties. Isolation, loneliness, mental illness and suicidal behaviors are the outcomes of the settlement programs for Ethiopian newcomers. One of the solutions in minimizing these problems is working towards family and social support systems. Family reunions and sponsorship is an important part in developing social support system. Therefore , the government should facilitate family reunion process. ¹⁶

The major issues raised among Ethiopian Women focus group were lack of timely information, proper orientation, high expectation, loneliness, weak financial management, issues related with children such as behavioral change and communication difficulty, and coping with the Canadian way of life which brings strange intra-family relationships to Ethiopian newcomer families. While children could adapt easier and faster to the Canadian way of life, parents could not cope with the rate of change and this caused misunderstanding and further conflict in the family.

Most Ethiopian mothers spend their time in the house and this has caused isolation, stress and very slow settlement and adaptation. Ethiopian families, particularly, with single mothers are facing multiple burdens and having no time to utilize the existing services. Developing a social support, network, meeting place and childcare service for Ethiopian women could have eased these burdens.

Ethiopians in Toronto appear to be exposed to most critical risk factors. An analysis of the 1996 census of Toronto residents showed that such risk factors as poverty and unemployment were highest among Ethiopians, as well as Ghanains and Afghani.

The following are some of data's collected from the study done by Samuel Noh, PhD, Ilene Hyman, PhD, and Haile Fenta, HO, MPH, PhD Culture Community and Health Studies Program Center for Addiction and Mental Health and Department of Psychiatry, University of Toronto In Cooperation with The Ethiopian Association in Toronto April 2001. (Pathways and barriers to mental health care for Ethiopians in Toronto)

Employment

Almost 80 percent of respondents were employed.

Of those employed, 84 percent were employed full time.

Although men were slightly more likely to be at work, a substantial proportion of women were in the labor force (64 percent)

Less than 6 percent were unemployed (being in labor market and actively seeking employment); 4 % among men and 8% among women.

However, almost 60% of men and 50% of women said they were "under-employed"

¹⁶ Settlement Service Needs for Ethiopian Newcomers in Toronto

This figures suggest Ethiopian immigrants' and refugees willingness, or necessity, to work under any conditions, and their ability to find work.

Perceived Racial Discrimination

About 65 % percent of the sample experienced one or more forms of discrimination in Canada because of their racial or ethnic background.

Close to 50 % of the sample reported at least one incidence of subtle discrimination (being looked down upon, expressed resentment, unfair treatment); more that forty percent said the were treated rudely in public.

Although the rates of overt discrimination were significantly lower compare to subtle forms of discrimination, one quarter of the sample said they received insulting remarks, and more than 10 percent were threatened because of their race, while 2 percent were physically abused or attacked.

Substantially greater proportions of male respondents reported the experiences of discrimination.

Over 20 %of male respondents and 3% to 14 % of female respondents reported experiences of racial discrimination from government agencies, media, and police.

Mental Health Problems

The lifetime prevalence of depression (Major Depressive Disorder or MDD) was 9.8 %. The lifetime prevalence of MDD was comparable to the rate in Ontario, but three times higher than the rate reported for Ethiopia (3.2%) by Awas, Kebede, and Alem (1999). In the general populations of the Ethiopia and Ontario, the prevalence was significantly higher for women than men. In our sample, we found little gender difference in depression. In fact, the rate was slightly higher for men (10.4%) than for women (8.4%). Indeed, in the present study, we found that the post-arrival (in Canada) incidence of MDD was more frequent in women (6.6%) than in men (5.4%). In addition, 3 percent and 5.8 percent of the current sample had generalized anxiety disorder and post-traumatic Stress Disorder (PTSD). Respectively. The PTSD was more prevalent among men (6.9%) than among women (4.3%), although the gender different was not statistically significant.

Living alone also constitutes a risk for depression. Non-believers ere also at risk. But, social support for emotional and instrumental needs were effective in preventing mental disorders. It seems church based intervention for single person may promote informal network to meet the emotional needs.

Traumatic events such as civil war and forced displacement may result in variety of psychological problems including depression, post-traumatic stress disorder and suicide (Boehnlein & Kinzie, 1995; McSpadden, 1987; Lin, 1986; Stein, 1986). Furthermore, resettlement in a new country often involves a period of significant re-adjustment and stress (Canadian Council oni Multicultural Health, 19S9; Wood, 1988; Canadian Task Force, 1988).

In this study, it was observed that many Ethiopi4n immigrants in Toronto experienced premigration trauma, refugee camps and post-migration stressful events, which are

known risk factors for the development of depressive disorder. However, the prevalence of depression among Ethiopian immigrants in Toronto was only slightly higher compared to the average rate of the Ontario population (9.8 % versus 8.3 %). This may suggest that Many of the Ethiopian immigrants have been able to cope with the stresses or they might have had a good social support network in the Ethiopian community.

The following information's are taken from focus group discussions summary done by The Ethiopian association in Toronto in collaboration with the Center for Addiction and Mental Health (Building Bridges and Breaking Barriers Access Project).

Ethiopians do not go to health services until the condition gets worse and it is late, although some say they go as early as possible. This behavior is mainly due to the experience and practice back home, which is preference to use traditional treatment and medicine prior to seeking care from the modern health system. One of the reasons for not using the health services among Ethiopian youths in Toronto is absence of specialist Ethiopian doctors, such as psychiatrist, with knowledge of the cultural and linguistic dimensions of illnesses Ethiopians are encountered with.

To most Ethiopians a mentally ill or a person with mental health problem is better expressed with the Amharic word "ibede" meaning crazy. The word is a very general term applied to the various types of mental health problems.

Mental health problems usually occur among well-educated people who are in a pressure of performing better in various activities but unable to accomplish their objectives. It also occurs among those who were in a higher status back home but fail to maintain their status in Canada. Mental illness also occurs due to lack of confidence.

Some of the mental health problems in the Ethiopian youth are stress and depression, which are caused by cultural change, weather, loneliness, isolation and problems of adoption

Ethiopian Women in Toronto use health services in general. However, due to lack of awareness, Ethiopian women do not use special services such as maternal and child health care and counseling services. They also usually do not go for check-up regularly.

Health service utilization among Ethiopian women in Toronto is often with difficulties. Some of the difficulties are language barrier, problem of locating the address of the service provider, lack of knowledge of specialized services, long waiting lists. From the part of the services providers lack of understanding and insensitivity to the culture elements of health and treatment are discouraging Ethiopian woman from using the services known to them. Most women in the community do not have the tendency to use free health care services.

First of all alcohol/drug problems are not considered as health problems in the Ethiopian Community. Taking alcohol is taken as fun or means of relaxation. The community does not have the belief that mental health problems could be handled with medical care.

On the other hand, although there is awareness to some of the services for mental health or alcohol/drug problems, there is a tendency not to use the services due to the stigma attached to the population. People do not want to be labeled as alcoholic or drug addicts.

Generally Ethiopian women feel comfortable going to female physicians. Some feel comfortable going to Ethiopian family physicians for ease of expressing themselves. Others prefer going to non-Ethiopian physicians due to fear of confidentiality or being identified.

Some of the general concerns of the focus group are:

Canadian health professionals should be oriented with the cultural norms, related to the health matters, of the Ethiopian community.

Producing a booklet that illustrates and explains the various body parts and diseases both in English and in Amharic would help women and children understand and describe their illnesses to Canadian health professionals. And it would also help health professionals to explain the outcome of the diagnosis to their Ethiopian patients.

There is lack of understanding both by service providers and members of the community on the issue of child abuse. For an Ethiopian parent punishing a child when committing fault or misbehaving is culturally and socially accepted way of disciplining. However to Canadian law the extent of punishment applied by an Ethiopian parent is taken as child abuse.

The following shows the conclusions of Ethiopian community survey of the mental health needs of Ethiopian immigrants in North America by Samuel Noh, PhD, Ilene Hyman, PhD, and Haile Fenta, HO, MPH, PhD Culture Community and Health Studies Program Centre for Addiction and Mental Health and Department of Psychiatry, University of Toronto In Corporation with the Ethiopian Association in Toronto. April 2001.

In this study, it was observed that many Ethiopian immigrants in Toronto experienced pre-migration trauma, refugee camps and post-migration stressful events, which are known risk factors for the development of depressive disorder. However, the prevalence of depression among Ethiopian immigrants in Toronto was only slightly higher compared to the average rate of the Ontario population (9.8 % versus 8.3%). This may suggest that many of the Ethiopian Immigrants have been able to cope with the stresses or they may not have had a good social support network in the Ethiopian community.

The lifetime prevalence of depression among Ethiopian immigrants in Toronto was found to be 3 times higher than the lifetime prevalence of depression in Ethiopia. This difference could be due to the fact that many Ethiopians in Toronto had been exposed to numerous risk factors for depression during their migration and resettlement process

The results of this study also suggested a higher prevalence rate of depression among younger adults, males, currently unmarried individuals, the unemployed, and those with a low level of education. Although statistically significant evidence was lacking, due to a

small study size, the findings confirm well-known epidemiological **risk** factors for depression. The higher depression rate among male compared to females, which was the opposite pattern in Ethiopia, may suggest that males were less likely to accept changes in occupational roles and felt more threatened by changing gender roles. Furthermore, in our sample males were more likely to have experienced factors associated with depression than females.

The results of this study also showed a statistically significant relationship between the prevalence of depression and the well-known risk factors, including experiences of living in refugee camps, motive of migration, and post migration stressful events. These finding suggest urgent needs for developing mental health intervention programs, particularly for those who experienced pre-migration trauma, refugee camps, and stressful life events.

IV. Major Health Issues a)

Eritrean Community

Family

Most Eritreans live in rural areas in an extended family, with parents, uncles, aunts, cousins and grandparents all under one roof or in the same compound. Eritreans have a strong sense of family unity, and this familial feeling extends even to strangers. It is common for an Eritrean to greet a stranger using terms like brother, sister, grandfather or grandmother. At the same time, an Eritrean adult would readily discipline or correct the behavior of other people's children. The children are expected to respect the adult's words. The elderly have a special place in Eritrean society, where they are treated with great respect and sought for advice. Families usually desire elders' approval for most major family decision. Elders also settle household and community conflicts or other disputes.

Children

Most Eritreans believe children are the gift of God and will have as many children as they can, even if resources are scarce to support the family. Family planning is not commonly practiced in villages and in most towns and major cities. Most Eritrean parents do not talk about sex with their children. Girls hide menstruation. Pregnancy before marriage is absolutely unacceptable to most Eritreans. It is considered morally wrong and a disgrace for the family and the village. Influence of the culture and tradition is very much alive in the Eritrean community in Toronto. Most families who are newcomers to Canada are faced with challenges of raising their children in this culturally and linguistically different environment. They find it very hard to accept most of the Canadian cultural values their children embrace as a result of growing up in a Canadian environment. Because of these cultural and linguistic gaps between the parents and their children, communication becomes nearly impossible. Consequently, the cultural and linguistic gaps create an atmosphere that is not conducive to openly discuss issues that are central to youth, such as, alcohol, drugs, youth violence, sexually transmitted diseases (STDs) and HIV/AIDS.

Workshops that help narrow the communication gap between parents and their children are strongly recommended after generational conflict can be addressed by creating an atmosphere where parents and children can discuss their challenges and share each other's worlds for better communication.

Social System

The Eritrean society is a patriarchal society with the exception of the Baza people, the only matrilineal group among the Eritreans. Baza women head families, and only people from a mother's side of the family are considered relatives. The nine ethnic groups have their own social system and values generally following their religious beliefs. For instance, a Muslim man may have as many as seven wives. However, all nine groups give respected social standing to religious leaders and elders. Elders in all ethnic groups play a decisive role as leaders, problem-solvers and transmitters of culture. They handle

disputes and have authority over marriages and divorces in their families. The governing body of most villages is usually composed of older people.

Therefore, it is essential to remember that religious leaders and the elders have an important role to play in communality peace building, health promotion and corn in unity based conflict resolution.

Gender Roles

Eritrean society is largely patriarchal. The division of male and female roles, and the accompanying prejudices are common. Husbands and fathers head their families, wielding incredible amounts of power. They oversee family resources and determine the futures of their spouses and children. Males are raised from birth to fulfill these positions. Women have always held a subservient status. They are looked upon as daughters, as wives and as mothers. Their duties are domestic, such as, cooking, cleaning and care giving.

In post-independence Eritrea the situation for women is slightly better. However, much of society remains traditional and patriarchal, and most women have an inferior status to men in their homes and communities. The law provides a framework for improving the status of women, but laws are implemented unevenly, because of a lack of capacity in the legal system and ingrained cultural attitudes. In practice, males retain privileged access to education, employment, and control of economic resources, with more disparities in rural areas than in cities.

In the Diaspora, the old values still persist and many men in the Eritrean community find it very difficult to reverse the roles. In many families, although the men and women both work for economic reasons, it is mostly the woman who comes home and prepare the meals as well as cares for the house. Traditionally, the girls are taught to share in household tasks, but with family roles changing, some families expect boys to help out with housecleaning and dishwashing. Traditionally, it is common for men as they approach 35 to 50 to do very little to help out in the duties of the home such as dishwashing and cleaning. However this, too, is changing, as many of the women need to work outside the home. The transition is not a smooth one, however. The issue of changing roles is enough to insinuate violence at home and family break down.

Workshops or forum on effective communication, on how to deal with familial conflict and support group for fathers would help reduce violence and enhance understanding.

Privacy

Eritreans are not comfortable taking off their clothes for physical examinations. Both men and women prefer to be cared for by same sex health providers. Particularly, women prefer to be treated by a female health care provider and to have a female interpreter. It is very uncomfortable for most Eritreans women to answer questions about sexual activity.

V. Recommendations

Mainstream Health Care Professionals

1. Health personnel should be aware that *not* all modern medical practices are familiar to many Horn of Africa communities (HADCs)
2. Health care providers should ask patients if they are using any traditional medicines or healing practices for their illness.
3. For new immigrants, provide interpreter services at clinics and hospitals.
4. Provide educational seminars and workshops about the prevention of disease and the importance of seeing family doctors for regular check ups.
5. Provide information about family planning
6. Encourage parents to talk with their children about sex, drugs, alcohol, STDs and other problems and provide information that will help them in these discussions (ethnomed).

Governments, Board of Education, Community Agencies

1. Dropping the waiting period for Landing status to alleviate the suffering of Somali refugees in Canada.
2. Encourage and assist to establish collaboration among HADCs-based agencies to provide effective initial settlement programs, services materials and developing cultural training for staff and frontline workers
3. Public schools should initiate programs and homework clubs to help students from the HADCs achieve their potential.
4. Somali Agencies should sponsor educational, recreational, traditional and Islamic studies in addition to regular academic programs in the schools.
5. Extensive educational programs are needed for the communities to understand the school system and how the Boards of Education operate.
6. Providing day care for young mothers from the HADCs is essential to enable them upgrade their educational skills (like computer literacy and other meaningful skills to compete in the Canadian job market).
7. HADC agencies in collaboration with other mainstream agencies should enhance and further develop strategic programs to raise their awareness of and usage of services in different areas of the city, and should advocate on to ease the housing problems faced the community.
8. HADC agencies in collaboration with mainstream agencies and health service providers need to create culturally sensitive programs to educate the community about *mental illness*.
9. HADC-based agencies; in partnership with public health, need to increase their efforts to educate the community about STD and HIV/Aids.

Research and Training

1. HADC should increase research project initiatives to narrow the gap in information scarcity about the different health issues in the community.
 2. Research should be participatory and should enhance the capacity of community-based agencies to engage in on-going knowledge-generation and utilization.
 3. Collaborative research among different HADCs should be encouraged to leverage more resources and promote inter-agency cooperation.
 4. Joint training of HADC agencies and volunteers will enhance the capacity of community agencies in the areas of program planning, evaluation, research, advocacy, etc.
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5. HADCs agencies should develop effective student placement programs to enable HA-DC students in colleges and university gain community experience and at the same time contribute to their own communities.
6. Partnership with Community Health Centres and other mainstream social service Organizations should be encouraged in order to access existing expertise and support systems.
7. A network of community development and health professionals from HADCs is an effective way of exchanging new and researched information, and may be a platform for generating project ideas and joint initiatives in the area of health promotion and community building.
8. Dissemination of new information and practices is essential. HADC agencies and their partners should consider translating key documents in HADCs languages for wider community use and access.
9. Research collaboration and sharing of experiences and practices should not be limited to HADCs in Toronto only; there is a growing body of knowledge within Canada and other countries where there are sizable Horn of Africa Diaspora communities.
10. The current body of knowledge on HADCs reveals scarcity in information on a number of communities not considered in this project and in two communities that were part of the project. These are the Eritrean and Oromo communities.

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VII. Appendix - Community Peace building & Health Promotion Program

Info Sheet

Program Goal

To promote the well being of the Heights' Horn of Africa Communities through a peace building and health promotion program.

Populations of Interest: Horn of Africa Communities in Toronto

Objectives:

1. To develop a community peace building and health promotion program at Lawrence Heights CHC in consultation with identified members of the Horn of Africa communities and partners working in the area of health promotion, peace building and conflict resolution.
2. To build and document knowledge and information about community-based conflict resolution, peace building, major health issues confronting Horn of Africa communities and relevant health promotion strategies.
3. To increase greater understanding of the commonalities among Horn of Africa communities and devise confidence and trust building program activities.
4. To forge local, national and international linkages with organizations, groups and individuals that have experience and resources related to health promotion, community-based conflict resolution and peace building.
5. To raise awareness on a specific health issue(s) and challenge(s) and enhance the capacity of the Horn of Africa communities to address the challenges.

Strategies & Activities

1. *Stakeholders Identification* : recruit 6-8 members of the Horn of Africa communities who are able to act as advisors and resource people for the program
2. *Partner Identification & Linkages*. -
 - a) network and collaborate with 2-3 Community Health Centres interested in health promotion pertinent to communities coming from war-torn countries
 - b) , establish a working relationship with 10 Toronto-based, national and international organizations, groups and individuals that have experience and resources related to health promotion, community-based conflict resolution and peace building
3. *Knowledge Build-up*:
Compile and document information about community-based conflict resolution, peace building, major health issues confronting Horn of Africa communities and relevant health promotion strategies
4. *Information Dissemination*: disseminate information to stakeholders through E-Bulletins, workshops, forums, etc.
5. *Community Harmony (Confidence and Trust Building)*:
 - a) implement a *peer model* with a group of 20 teens from Horn of Africa communities to promote greater understanding of the commonalities in cultures and challenges facing them as newcomers to Canada
 - b) work with a group of 20 women from the Horn of Africa communities to understand and share information about health and parenting and build confidence and trust building program activities.

6. Specific Health Issue:

- a) compile status of mental health and suicide prevention in Horn of Africa communities b) explore and compile information on culturally-appropriate resources and expertise to enhance the capacity of the Horn of Africa communities to address suicide and promote mental health
- c) disseminate information to Horn of Africa community groups and partners through workshops, print and electronic tools.
- d) engage in similar activities for other issues as identified by the Advisory Committee

Program Structure

An Advisory Committee (see terms of reference) will act as a consultation body, both collectively and individually to the Program Manager on various aspects of the program's design and implementation, dissemination of information and evaluation. Four Project Support Staff from Horn of Africa communities will work closely as *a team* under the program manager to develop, implement and evaluate the community peace building and health promotion program. The team of project support staff will work with eight Youth and Women Peers in their community outreach activities.

What the Program is Not

The community peace building and health promotion program is a community development initiative that aims at building individual and community capacity in communities coming from war-torn countries. It is not a political conflict resolution program. The promotion of community harmony and improvement in inter-community relations is however a medium to long term goal of the program.

History and Accomplishments of the Somali Immigrant Aid Organization

1986: The Somali Immigrant Aid Organization starts as working group, with support of Parkdale Community Legal Services, to facilitate awareness of refugee needs and promote understanding of the impacts of domestic laws and practices on refugee relief.

1988: SIAO incorporates as a non-profit organization.

1989: SIAO opens first office at 11 St. Joseph Street.

1990: SIAO joins the Ontario Council of Agencies Serving Immigrants,

1991: The size of the Somali community in Greater Toronto reaches 60,000, and numbers continue to grow. Illiteracy and low educational levels among newcomers strain the capacity of existing settlement organizations.

1993: Government of Canada funds English Language for Newcomers, recognizing the urgent need in the Somali-Canadian community for English language and Canadian cultural exposure. Government of Canada funds family reunification in separate organization (Mideynta Qoyska). Government of Ontario funds SIAO under Jobs Ontario Training initiative. SIAO celebrates, Somalia's Independence Day and Canada Day, June 30, 1993. Somali Women's Network formally established.

1994: Focus on Housing, with support from the Metropolitan Toronto Housing Authority and Lantana.

1995: Focus on Health, including comprehensive community health needs assessment and implementation of nutrition programs, and health information workshops.

1996: Reorganization to support stabilization of funding and comprehensive settlement service for those most in need. Aggressive volunteer recruitment campaign to revitalize services.

1997: Move to premises at 1778 Weston Road, to address needs of the community more effectively. Strategic analysis of needs and resources leads to **Small Business Development Plan** focusing on increased community self-reliance.

1998: Initial Phases of Small Business Development plan funded by the May tree Foundation, resulting in skills development for 7 community trainers.

SIAO Capacity Building

Our plans to 2000 focus in 3 main directions:

- a continuation of our settlement services,
- community economic development, and
- research and development of further integration opportunities for the Somali Newcomer community into Canadian society.

Challenges

There are many challenges to the social integration and participation of Somali Newcomers in the diversity of Canadian society, in particular:

Immigration:

- * Complex process of refugee determination, Documentation difficulties that leave many Somali Newcomers in a legal and economic limbo,
- Landing fees prohibitively high.

Employment:

- Recognition of professional qualifications and experience,
- Few opportunities for language and skill upgrading,
- Few employment opportunities in mainstream labour market.

Other Social Issues

- Community economic development
- Affordable Housing
- Healthy lifestyles