Ethiopian Parents' Perception of Their Children's Health: A Focus Group Study of Immigrants to Israel

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Abstract

Background: The recent influx of Ethiopian immigrants to Israel has created challenges for healthcare workers. Qualitative research methods have proven to be of value in providing useful data in cross-cultural medical settings.

Objective: To learn about Ethiopian immigrants' perception of the health of their children.

Methods: Ethiopian parents of children under age 3 registered with a family medicine clinic in Jerusalem were invited to participate in two focus groups. Transcripts of the group discussions were analyzed to reveal themes relating to children's health.

Results: Analysis of the transcripts revealed five themes relating to the health of children in two domains: the intra-familial and the extra-familial. Specific themes that emerged in the intra-familial domain were the role of traditional medicine, gender-specific roles in child care, and decision-making in seeking extra-familial medical help. Themes in the extra-familial domain were recognition of illness and the meaning of symptoms, and notions of prevention and resistance to illness. The collected data found application in the daily clinical work of the researchers and enriched understanding of their patients.

Conclusions: Ethiopian immigrants to Israel share special perceptions of their children's health that differ from prevailing beliefs in Israel. Focus groups provide health workers with a wealth of data on these beliefs that will enable them to offer more culturally sensitive care.

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The arrival of large numbers of Ethiopian immigrants to Israel has presented challenges to healthcare workers. Problems in care include treatment of acute and chronic illnesses unfamiliar to clinic staff, language difficulties and culture shock for both patients and staff. Initial attempts to collect clinical and research data in classical quantitative ways, such as routine history taking and health surveys, have proved difficult and have not provided all the data needed for comprehensive care of the population in a family medicine setting. Further difficulties are encountered in a young population (with 50% under the age of 15 years) in which clinical information passes from young patients, to parents, to translators and finally to medical staff.

There is evidence that application of the model of patient-centered care improves process (compliance with treatment) and outcomes (resolution of symptoms), with increased understanding of patients' explanatory models of illness and expectations of care [1]. Exploration of patients' explanatory models may require the use of qualitative research methodology. Based on the experience of others in obtaining clinically relevant information from parents on their children's health in a relatively short period [2], we chose to use focus groups of parents in our clinic population. Focus group methodology has found numerous applications in family medicine research and has been described by Morgan [3,4]. The present study was undertaken as part of a comprehensive program of clinical care and assessment (including a health survey and other elements of survey research) in a group of Ethiopian immigrants to Israel receiving care in an urban family practice.

Materials and Methods

The study sample was drawn from a population of 650 immigrants to Israel who had arrived from Ethiopia in August 1991 and were housed initially in a Jerusalem hotel that had been converted into an immigrant absorption center. Family doctor-nurse teams provided the primary healthcare for this population in the hotel and in a local community health center. The teams provided care of acute and chronic illness and preventive care (mother and child health and immunizations). A special nurse-run clinic in the hotel provided initial care of acute problems, dispensing of medicines for special chronic problems such as tuberculosis, and triage of problems for additional care at the health center. The age-gender distribution of this population was found to be similar to that of the total population of Ethiopian immigrants to Israel in 1991 and similar to that of the general population of Ethiopia. All patients were registered for care at the Family Medicine Unit of the Kiryat Hayovel Community Health Center, a teaching practice of the Department of Social Medicine of the Hadassah Medical Center in Jerusalem.

The idea for a focus group study was first raised in the research forum of the Family Medicine Unit to complement the data obtained in clinical interviews and a health survey of the community. A working group consisting of two physicians, a nurse, a social worker and an anthropologist met to discuss the

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study method, selection of participants, and possible guiding questions for the focus groups. Following these initial meetings, parents of children under the age of 3 were invited to participate in a group discussion of their children's health. A list of potential participants was drawn from hotel residents known to the clinic translator and medical staff. Participants were approached at the hotel by one of the clinic doctors accompanied by the translator and the purpose of the study was explained. All participants who were invited accepted and the lists were completed when five couples had agreed to participate. The sample size was a result of convenience in drawing the sample within a short time and the space constraints of the hotel housing the immigrants. Separate groups were held for men and women, based on information obtained from community members and other experts that women would be unlikely to speak freely about family matters in front of other men from the community. Similarly, couples were chosen to increase the likelihood of obtaining consent from women once their husbands had given their consent to participate. All participants were from Gondar, which is an agricultural province in northwestern Ethiopia. One couple came from the Tigre region.

The focus groups were held in a meeting room of the hotel over 2 days, 1 week apart. They lasted approximately 90 minutes. Interviews were conducted by a family physician and social worker from the clinic, assisted by an Ethiopian medical translator fluent in Amharic, Hebrew and English. After explaining the purpose of the meeting, permission was obtained from the participants for recording the proceedings. Participants were asked to describe the last time their child was ill in Ethiopia, how they knew that the child was ill, and what they did for the child. The guiding questions for the focus groups were: "Tell me about the last time your child was ill in Ethiopia. What happened? What happened when your child was ill in Israel?" Brief translations of replies were provided to the interviewers to allow them to track the discussion. An attempt was made to get all participants to speak and interact with each other. Questions from the participants to the facilitators were encouraged throughout.

Following the interviews, the clinic translator made a tape-recorded translation of the interviews and transcribed them. Errors in grammar and vocabulary were left in the transcript to retain authenticity of the text. Transcripts were brought for discussion to an analysis forum consisting of two physicians and a nurse. Two transcripts of 26 pages each were obtained. They were analyzed initially to identify specific passages relating to children's health. Selected passages were then labeled to identify them as representative of key concepts in the discussion. Key concepts were then assembled to look for underlying themes. Work was done independently by members of the team and notes on the transcripts were compared at meetings of the analysis forum. Clinical experience with this population and data from the health survey were also used to interpret the transcripts. The translator attended meetings of the forum to clarify and confirm observations. A record of proceedings of the analysis forum was also kept and used in writing the final report.

Results

Five themes evolved from the analysis of the focus group transcripts. These were grouped into two domains: the intra-familial domain and the extra-familial or professional domain. The intra-familial domain included the role of traditional medicine in the care of children, gender-specific, and other family roles in the care of children and decision-making in seeking outside help when ill. The extra-familial domain included recognition of illness in children and the special meaning of common symptoms, and notions of prevention and resistance to illness. These themes will be presented with supporting quotes from the transcripts.

The intra-familial domain

- ***Treatment and the role of traditional medicine***

Many statements concerned the treatment of childhood illnesses within the family context. Rich descriptions of traditional therapies were provided, as in the following example of *garafta* (pneumonia).

> "Traditional treatment of course is given and traditional medicine is prepared by the healers. They bring certain type of leaves. They boil the leaves and let the child breathe the steam that comes out. The sick child sweats a lot and then falls asleep. As a result, by the way, diagnosis is made by looking at this specific result; (the next day) the water in which the leaves were boiled and onto which the child breathed would be blackened. And this is a telltale sign that the child has had *garafta*. If the child could be treated this way or if he is seen to be feeling better there is no need to take the child to a doctor but if the child's cough is long lasting that is cannot be treated by hot steam or if he is being wasted then these are indications which tell that the child should see a doctor."

Participants described the preparation and use of traditional medicines.

> "There is a traditional medicine that is used to treat burns. The healer brings the leaves from a desert mixes them with water and takes out the extract and puts the extract on the area of the skin that is eaten by the burn and amazingly enough the burn heals."
>
> "(A drug) against *kmo*. The Amharic word for inflammation of the tonsils is *kmo*. They mix *achuch* (an unidentified herb) and garlic and put that mixture in the house and when the child gets sick he is led to take a little bit of that mixture and he gets better and this mixture helps until the child is taken to the *awaki* (traditional healer)."

Participants distinguished between conditions that were best treated by traditional medicine and those that required referral to other forms of therapy.

> "There are four occasions whereby modern medicine can't help and only traditional medicine is able to cure. When a snake bites you, when you have rabies, when a scorpion

bites you and when there is anthrax. In these four cases there is no way out but go and ask for traditional medicine. And they give you a root to chew and you are cured by it."

The traditional practice of uvulectomy illuminated many of the issues involved in the meeting between medical systems.

"An example of such a situation is a swollen uvula or *anka*". There were few of us that used to go to modern doctors for this specific complaint. We used to have the child's uvula cut. It helps the child suck better and if not cut the child is likely to die.... Most babies undergo cutting of the uvula and it is few that don't.... It is cut in most people. But in some people it is not cut because there is a family drug against swollen uvula so they don't have to cut it.... When we were in Ethiopia I used to have the uvula cut for my children and soon after my children were born at about the third day we used to take them to local healers and have their uvulas cut maybe because of fear of danger happening to them. They used to come down with fevers, loss of appetite and changed behavior. For example soon after my last baby was born we were very worried thinking that if we are not going to cut the uvula for him then he will die. So we took him to a hospital and there they said he is all right. At first we were afraid. We thought that something is lacking for this child. But now we are happier."

- ***Decision-making in seeking outside help***

A process of recognition of illness followed by attempts at self-help, assessment of response to treatment, consultation with family members (especially elders), consultation with village "pharmacists" in Ethiopia (usually shopkeepers dispensing medications over the counter), and a subsequent decision regarding the need to seek additional help was delineated.

"All the time it is known that the elders know better than us so we approach them and ask and consult with them. For example if it is my first child, then I approach and consult with my mother who gave birth enough times. She explains to me how to take care of the child. What to do so that he won't be ill."

Several participants mentioned the pharmacist as an important resource for primary healthcare in Ethiopia. In addition to diagnosing illness and providing medication, the pharmacist would also advise families when hospital care was required.

"We take our children to private pharmacies (in Ethiopia) if their situation is not that critical. But if the situation is or looks serious then we take them straight to the hospital."

"Allow me to say what differences I see between the healthcare system in Ethiopia and the healthcare system in Israel. Here in Israel if somebody is very sick, even on the verge of death and is taken to the hospital, then the doctor examines him and writes him a prescription. The person who brought that patient to the hospital is supposed to look for the medicine and go to the pharmacy. If pharmacies are closed then he has to stay until whatever time until the pharmacies are open. But in Ethiopia the doctor examines the patient and if he has the appropriate medicine he injects him or gives him to swallow. Or if that medicine is not accessible at the hospital then he sends the person who brought the patient to go and look for that specific medicine."

- ***Gender-specific and other family roles in child care***

Participants differed over the roles of mothers and fathers in the care of sick children.

"The women take the child to the doctor and it is not the women who make the diagnosis or decide on the treatment. ... Yes we do the caring my wife and me. Fifty-fifty, we do the caring for the healthy children or for the sick as well in equal proportions."

"Because of the fact that it is the mother that takes care of the child or looks after him and notices any behavioral changes, she is the one to notice any disease and take the child to any health care system. So it is more a job of the mother rather than a job of the father."

"Obviously women stay at home while men or the husbands spend a lot of time outside working. And if the child's disease is in our ability to get it cured, then we take the child to wherever is necessary. But if not we ask for the husband's or the men's help. So in a related way, if the place is very far that we were going to take the child to or if the child is supposed to stay overnight in the hospital or in a health center, then we ask for the husband's, the men's help."

The extra-familial or professional domain

- ***Recognition of illness and the meaning of symptoms***

Significant portions of the discussions were concerned with recognition of illness in children. Changes in behavior such as refusing food were interpreted as signs of illness.

"He was well until a certain time when he came down with weight loss and he started refusing food. Whatever he eats, he vomits it out and then diarrhea followed and repeatedly until a time when he became very thin and lost weight."

Common symptoms in Israel, such as diarrhea, vomiting and fever are assigned special meaning by Ethiopian parents.

"So he came down with diarrhea of many different colors like yellow or green, etc., and we thought it was malaria. As the days went by his body started to become wasted."

Parents were able to identify specific illnesses based on their etiology and presentation.

"I can tell you about *garafta* which means infection of the lungs. It develops when a child is exposed to cold wind or cold air and the sick child comes down with high fever which is very typical."

Parents were also able to classify the severity of certain symptoms and decide what action needs to be taken.

"This was a different type of cough. This was a deep cough.

> There is a certain type of cough which the doctor shouldn't see then there is a certain type of cough which the doctor should see."

- ***Prevention and resistance to disease***

The participants expressed clear notions of hygiene and resistance to disease. Experiences from Addis Ababa and exposure to the American Joint Distribution Committee clinic were recalled. In response to the question "What other things were done for the health of children in Ethiopia?" the following is a typical observation:

> "Parents feed the children good foods, and the other is cleanliness and the third thing is prevent the children from going astray, not to fall and hurt themselves, not to come near fire. But it all depends on how much the parents know."

The concept of communicability of diseases was explored through quarantine practices, which appear to be well developed.

> "There is a sort of quarantine called *kasa* where you put the sick family not only the sick kids."

> "This is a special type of *kasa*. We just made our own children live in a *kasa* which is practically within our house but has different routes of entry and is very much isolated from even the same house. We opened another door to them and somebody goes in the morning, puts the meal on the door and goes back and they were isolated."

Discussion

This study has proved useful to the researchers on two levels: the content of the focus group discussions, and the process of focus groups and their analysis. This discussion will focus on these two major areas.

The information obtained in the focus groups points to the rich world of health beliefs and practices among Ethiopian immigrants to Israel. Although of intrinsic interest by themselves, the attitudes and experiences of these people have practical implications in their contacts with healthcare workers. Whether one adopts Kleinman's anthropological model of care [5], Engel's biopsychosocial model [6] or the patient-centered care model [1], basic information on the patient's explanatory model is required for adequate primary care. In the meeting between two medical cultures, both parties undergo socialization. Specific findings from this study may facilitate this process.

Common symptoms in Israel, such as fever and diarrhea, may have special meaning for Ethiopian patients and suggest life-threatening illnesses like malaria. Careful attention to these symptoms, reassurance when indicated, and alternative explanations to parents may aid in the transition to a new environment. Patients carry with them a medical lexicon that may be radically different from that of their helpers. Awareness of terms such as *kmo* (probably corresponding to tonsillitis) and *garafta* (pneumonia) may help build bridges between staff and patients, even if the exact meaning of terms is not understood. Unique health practices such as uvulectomy are a potential source of conflict. Again, awareness of the practice and respect for the belief in its usefulness, while suggesting other acceptable alternatives, may cement relationships. The role of family members and others such as pharmacists in making health-related decisions has been presented here. Families and other team members may be seen as an important resource in the care of individual patients, and their mobilization should be considered. The status of the doctor (*hakim*, literally "wise one" in Amharic) is privileged and respected and can be used effectively in socialization of patients.

The findings of Reiff et al. [7] from their study of illness and treatment perceptions of Ethiopians in Israel support our findings. They stress the importance of medical staff understanding culturally specific symptoms and adequate translation to provide more effective healthcare for the immigrant population.

Findings in our study are similar to those in Irvine and Cunningham-Burley's interview study of 54 Scottish mothers [2]. Hundreds of recorded observations of sleep patterns, eating habits, irritability and positive behaviors were found to be the basis of mothers' assessments of illness and normality in their children. The authors stress the importance of health workers' sensitivity to mothers' concerns in enhancing effective and satisfying professional relationships. Demonstration of "common ground" and of a shared understanding and valuing of parents' knowledge and attitudes in an immigrant population may be of great value in their adaptation to the host culture.

The use of focus group methodology had a marked effect on members of the research team as researchers and clinicians. It represented a departure from the traditional survey methods of community-oriented primary care by which the health center was known. Group discussions before, during and after the focus groups themselves had a team-building effect. Mutual consultations among team members and daily clinical observations with citations from the study transcripts have strengthened impressions of the validity of our conclusions. During the process of discussing transcripts, much time was spent discussing areas of ignorance in the light of fascinating questions raised by the text. Ideas for several more exploratory studies on issues such as quarantine, family function in times of illness, and patient expectations of caregivers were generated in this way.

The use of focus group methodology in this study was the key to obtaining relevant clinical data in a short time. Given the sample size, the issue of generalizability of these findings is relevant to the quantitative paradigm but less so here. Although specific observations from this study may not be generalizable to the whole Ethiopian immigrant population (such as the division of responsibility for childcare between men and women), some observations are of critical importance. Deeper, culturally determined attitudes, such as fear of death of a child if uvulectomy is not performed, constitute important knowledge for clinicians caring for Ethiopian patients. Validation of observations was attempted by triangulation (discussion with other health professionals involved with this community) and

member checking (feeding back observations to members of the community during clinical encounters). In this way we learned, for example, that traditional healers are still active in the Ethiopian community in Israel and are still performing uvulectomies. These observations will also be measured against findings from a quantitative community health survey and the survey of uvulectomy beliefs and practices. Observations presented in this report are not meant to be representative of all Ethiopians in Israel. However, they are of value in sensitizing healthcare workers to issues that merit further study and may find daily clinical application. The focus groups were useful in teaching us our patients' vocabulary. The major disadvantage is the time and effort required for the analysis of the transcripts and the validation of interpretations. There is no substitute for careful reading and re-reading of the text, which is the primary source for interpretations. The initial arduous work of transcribing the tapes by the principal investigator (4 hours per hour of tape) was time well spent in immersion in the material. Group discussions were also a time-consuming but creative part of the process.

Support for the use of focus group methodology in this population may be found in Rosen's exploration of Ethiopian Jewish culture through its proverbs [7]. He states "... the discussion of any serious topic requires subtlety of speech rather than direct statement. In fact what is most essential about conversation, what constitutes its 'play' component, are the ways in which words and expressions can be used to hide real intentions or to reveal deep meanings through suggestion and allusion."

The political stance implied by the use of focus groups may be in conflict with traditional Ethiopian views of the medical profession. Young has described the *debtera*, traditional healers in Ethiopia who monopolize magical knowledge and actively exclude laymen from their secrets [8]. However, our attempts to share our knowledge with our patients and value their knowledge, attitudes and beliefs seem to have met with acceptance by participants in our focus groups.

The problem of language must also be addressed. Interviews were conducted in Amharic and responses were translated into English for the transcripts. Although the study employed a highly skilled medical translator, the passage of statements through an additional filter adds shades of meaning that may be unknown to the researchers. Ideally, subjects and interviewers (or doctors and patients) should speak the same language to ensure effective communication without intermediaries, but current reality dictated that conduct of the study would replicate one of the major problems in clinical encounters with Ethiopian patients in Israel today.

Kleinman views translation as the "essence of ethnographic research" [9]. Cross-cultural medical research is feasible if we are able to grasp the central medical concepts of another culture and incorporate them into our future inquiry of that population. This may help us to create valid and reliable research instruments that survey research may be unable to provide at present.

Members of the research team involved in the analysis who were not present at the interviews commented on the loss of non-verbal information in the transcription. Videotaping of the interviews would have enriched the interpretation with data on individual behavior and group interaction.

Despite the limitations of findings from focus group research, this study may have practical application for other practitioners working with Ethiopian immigrants in Israel. Attention to specific attitudes and practices discussed here may help to improve the relationship between the community and health professionals. Focus groups may be attempted in the primary care setting to explore other issues unique to specific subgroups of this population. As expected, the 40,000 Jews of Ethiopia, scattered over wide areas, have unique features in different regions. Cultural differences have been found for example among those from the Gondar, Tigre and Addis regions, but these distinctions have not been explored here. Wider application of focus group methodology in family medicine may further enrich medical practice by increasing our understanding of our patients' experience of health and disease.

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