CASE REPORT

Ethiopian-Israeli community

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SUMMARY

The Ethiopian-Jewish community in Israel is an immigrant population numbering 131 400 as of 2012. Many arrived from 1980 to 1992 by airborne operations coordinated by the Israeli government. Immigration was prompted by Israeli recognition of the community's Jewish citizenship eligibility status. This period in Israel's history saw the First Lebanon War, the First Intifada, the Gulf War and the beginning of Soviet Jewish immigration. The Ethiopian community faced difficult integration, cross-cultural misunderstandings and the development of chronic disease, due to lifestyle changes and differences in cultural beliefs. These factors significantly affect the community's health. Governmental and non-governmental organisations have sought to improve the quality of life for Ethiopian Israelis through empowerment and education. Enhancing societal integration, augmenting cross-cultural communication and understanding and instituting community-based health projects are essential in improving the health of this community. Successful healthcare intervention requires a biopsychosocial model of analysis and usage of a culturally appropriate context.

CASE PRESENTATION

The Ethiopian-Jewish community in Israel is a unique segment of the Israeli population that largely immigrated in waves from 1980 to 1992. Approximately 50 000 Ethiopian Jews arrived in Israel during this period.[1] In 1984, many Ethiopian Jews traversed from Ethiopia to Sudan under demanding and deadly circumstances in hopes of reaching Israel.[2 3] Those who had escaped famine in Ethiopia and survived the journey to Sudan faced malnutrition in Sudanese refugee camps. Many succumbed to illness.[4] Earlier in 1975, the Chief Rabbinate of Israel ruled that Ethiopian Jews were eligible to immigrate to Israel under the Law of Return, Israel's Jewish immigration policy. The Rabbinate has influence in certain political and social functions of Israeli government, as they relate to traditional orthodox religious law.[5] The ruling, coupled with reports of fatalities in the refugee camps, prompted Israel to covertly exfiltrate Ethiopian Jews to Israel in a mission called Operation Moses.[2] The second large-scale airborne operation that brought Ethiopian Jews to Israel, titled Operation Solomon, was conducted in Addis Ababa, Ethiopia, in 1991. This operation occurred concurrently with the start of the wave of Soviet Jewish immigration.[6] Throughout this period of Ethiopian immigration, Israel faced the First Lebanon War, the First Intifada and the Gulf War, when scud missiles fell in Israel.[7] In 2003, a resolution to the Law of Return granted citizenship eligibility for Ethiopian Christians who had matrilineal Jewish roots. These individuals were unable to legally immigrate to Israel until this resolution.[8] Concerns regarding the Jewish character of this group and political pressure on the Rabbinate prevented their earlier absorption with other Ethiopians.[2] According to a 2012 census, the Ethiopian-Israeli population in Israel reached 131 400 members.[9]

During the waves of Ethiopian immigration, Ethiopia harboured environmental, political and social turmoil; famine in Ethiopia led to food insecurity in the region.[5] Militant rebel groups led a violent insurrection to overthrow the Marxist Ethiopian government. Prior to Operation Solomon in 1991, the militant groups marched towards and sought to conquer the government-controlled area around Addis Ababa, where many Ethiopian Jews happened to be located. The Ethiopians (as well as members of other minority groups) experienced marginalisation by the ruling regime and faced restrictions on religious worship. With these conditions and the threat of continued violence, the Ethiopian-Jewish community sought to leave Ethiopia in hopes of a better life. Israel, the embodiment of modern Zionism and a democratic state harbouring Jewish values, became the clear destination.

Differences in cultural beliefs and practices posed challenges for integration into Israeli society and high-quality provision of healthcare. The immigrant Ethiopian-Israeli community presented with symptoms of illness and perceptions of health, hygiene and medication that varied from the Israeli biomedical norm.[10] Western medicine was an unfamiliar concept to the Ethiopian immigrants.[5] These issues, coupled with the difficulties experienced by Israeli clinicians in recognising health concerns and treating Ethiopian patients, highlight the value of effective cross-cultural communication and understanding. The prevalence of diabetes, a result of stark changes in physical exertion and dietary conditions, was shown to be markedly higher within the Ethiopian-Israeli community in comparison to the greater Israeli population.[11] The overall health of the Ethiopian community changed on immersion into Israeli society.

GLOBAL HEALTH PROBLEM LIST

- Challenges in societal integration
- Cross-cultural misunderstanding
- Diabetes and chronic disease

GLOBAL HEALTH PROBLEM ANALYSIS

Challenges in societal integration

The difficulties encountered by Ethiopian-Israeli citizens are indicative of challenges faced by

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immigrants, refugees and communities that have undergone a dramatic shift in their geographical and cultural context.[1]

The change in lifestyle from Ethiopia to Israeli absorption centres and cities led to culture shock and social upheaval in the community.[11] The extended family support structure that existed in Ethiopia shifted into the nuclear family model, cultural rifts emerged between younger and older generations of Ethiopian Israelis and traditional physical and dietary habits eroded. Ethiopian men, who historically performed agricultural work in Ethiopia and were considered the head of the family in the traditional Ethiopian patriarchal system, became unemployed or worked in low-income jobs.[10] The absorption centres, coordinated by the Israeli government, sought to orient Ethiopians to Israeli society and address health concerns such as infectious diseases.[6] Ethiopian Jews were sent to these centres on arrival in Israel.

Efforts were made to further integrate Ethiopian Jews into Israeli society, with variable success.[5] The Israeli government promoted settlement into apartments and permanent living facilities following a period in the absorption centres. In order to prevent clustering and ghettoisation of Ethiopian Israelis in specific locations, and in the hopes to better integrate the Ethiopian community within the broader Israeli society, the government encouraged settlement in various cities and provided grant and lone incentives. However, likely due to the Ethiopian population's strong family and community structure, extended families tended to settle together in the same location. This highlights the issue of governmental integration efforts in conflict with immigrant community structure and psychosocial health. On one hand, the distribution of Ethiopian Israelis among non-Ethiopian Israelis may promote and hasten immersion into Israeli society, with increased interaction with presiding Israelis and greater familiarisation of cultural nuances. On the other hand, disruption of the traditional Ethiopian community structure, undoubtedly a protective factor in mental health (which can influence the success of integration), may aggravate the psychosocial distress that accompanies immigration. Mitigating between these two factors in opposition may lead to more optimal conditions for successful and healthy integration.

Children of secondary-school age were required to attend state religious schools for at least the first year of their education. In some cases, this presented challenges for local school systems in absorbing high numbers of new students and tending to the unique educational needs of these children, whose academic background varied from that of native Israelis. Additionally, some Ethiopian-Israeli children needed to travel great distances to attend the required state religious schools.

In cases where the Hebrew competency of Ethiopian children surpassed that of their elders, transformation of traditional family roles occurred, as children acted as the Hebrew-speaking representatives of the family. A preparatory programme was established for Ethiopian Israelis interested in pursuing higher education. This governmental initiative demonstrated the young Ethiopian population's motivation for higher education and ability to succeed academically. The promotion of army service through youth programming heightened draft rates among the Ethiopian community as well as male recruitment into combat units. Vocational training provided tools for successful independence in Israeli society and heightened Ethiopian employment rates.

The Ethiopian community's Jewish identity was questioned when Israel's religious ruling body sought to coordinate ritual conversion of community members to Judaism.[2] Although the Israeli Rabbinate ruled that the Ethiopian-Jewish community was eligible for immigration under the Law of Return, the emphasis on conversion was an attempt to fully embrace the community as Israeli Jews, as the Israeli orthodox religious sect specifically perceives Jewish identity.[2 5] Tension soared when the public discovered that from 1984 to 1996, blood donations from Ethiopian Israelis were being eradicated by the Magen David Adom (MDA) Israeli blood bank. According to MDA, the goal was to protect donation recipients from infectious blood-borne diseases that were prevalent in Ethiopia. Many in the Ethiopian community felt as though they were perceived as second-class citizens that posed a danger to Israeli society. Efforts to conceal the practice of blood donation rejection added insult to injury. Initiatives to successfully integrate Ethiopian Israelis into all levels of Israeli society while encouraging the maintenance of Ethiopian heritage and identity are crucial.

Despite successes with efforts to integrate Ethiopian Jews into Israeli society, socioeconomic gaps still exist.[12] Statistical data were collected by the Joint Distribution Committee and presented in a 2012 report on the status of Ethiopian Israelis. Discrepancies in economic, educational, employment and family status between Ethiopian Israelis and the greater Israeli population were prevalent. This leaves room to strengthen pre-existing initiatives and create novel programmes that address these issues.

Determinants of health of the Ethiopian community in Israel

Social determinants of health

Shavu Banim is an Ethiopian cultural centre in Beer Sheva, Israel, that provides social and cultural services to the Ethiopian-Israeli community.[13] This organisation seeks to celebrate and preserve Ethiopian heritage, bring together and empower the Ethiopian community in Beer Sheva and enhance the integration of Ethiopian Israelis, all of which can be supportive in individual and community health. The centre was established in 1994 as a joint project of The Beer Sheva Municipality, The Jewish Agency for Israel, Keren Hayesod, The Sacta-Rashi Foundation, Beer Sheva Ethiopian residents and private donors. A community centre, synagogue, and *mikveh* (ritual bath) comprise the three buildings of *Shavu Banim*. In 1998, Project PACT (Parents and Children Together) was implemented at *Shavu Banim* by the Joint Distribution Committee and the Beer Sheva Municipality Department of Welfare to promote well-being and educational growth in young Ethiopian children. This initiative seeks to close the gaps between these children and the greater Israeli population by supporting child development. Activities for parents and children occur three times a week for 2 hours at a time. The first hour consists of play and homework assistance, and the second hour encompasses structured programming in various topics, not all of them health-related. There is also structured and unstructured programming for the Ethiopian-Israeli elders multiple times a week in the mornings and afternoons. This includes a community gardening project, hobby-related courses, nutrition and health workshops, technological skill seminars and engagement in religious affairs. Elderly Ethiopian-Israeli immigrants have faced changes in social status and self-worth with the transition to Israel. Programming that offers space for these individuals to learn and grow may stimulate empowerment.

Social capital is described by the Office for Economic Co-operation and Development (OECD) as "networks together with shared norms, values, and understandings that facilitate co-operation within or among groups."[14] Social capital can be present between individuals in shared (bonding) or different

(bridging) social identities. Significant social capital exists in the *Shavu Banim* community. The constant programming held for people of all ages creates social bonds and stimulation—essential components of mental health. The *Shavu Banim* synagogue encourages participation in Jewish activities and social events. Bonding social capital exists within the members of the Ethiopian-Jewish community in Beer Sheva, especially among members of *Shavu Banim*. Bridging social capital is demonstrated by the non-Ethiopian *Shavu Banim* social worker, the non-Ethiopian project coordinator, the *Sheirut Leumi* (national service) women who perform service in this institution and the Ethiopian-Israeli members of *Shavu Banim*. Integration into Israel is the essential upstream social determinant of health for the Ethiopian-Israeli community. The downstream social determinants of health include competency in Hebrew among Ethiopian-Israeli elders, knowledge of affordable and nutritious food options, education, employment and economic burden. The upstream and downstream social determinants of health are key factors in physical and mental well-being, and addressing these issues may improve the health of the Ethiopian-Israeli community.

Mental health

The process of immigration and integration is associated with significant stress and increased prevalence of psychological health problems.[15] A higher prevalence of suicide was discovered in the immigrant Ethiopian-Israeli population as compared to the general Israeli population; the suicide rate for Ethiopian-Israeli community in 1984 was 25:100 000, whereas the overall suicide rate in Israel was 6:100 000.[16] Causes of this phenomenon may include the scope of preimmigration trauma, poor diagnosis of psychiatric disorders due to cultural manifestations of mental illness that were unrecognised by Israeli physicians, the introduction of cultural tendencies and technology that was unfamiliar to the Ethiopian community, erosion of the traditional Ethiopian family and community structure and discrimination.[15–17]

Israel and Ethiopia

Israel is considered a high-income country and Ethiopia a low-income country, according to WHO.[18 19] Table 1 displays 2014 and 2015 health indicators from these two countries, as collected by WHO.[18–21] In comparison to Ethiopia, Israel has a longer life expectancy, as well as lower rates of mortality under 5 years of age and mortality due to HIV/AIDS.[20 21] However, Israel has a higher mortality rate due to diabetes.[19 20] Collecting data that illuminate the health indicators for the Israeli Ethiopian community, as well as other recent immigrant groups in Israel, would allow a more comprehensive examination of this population's current health status.[22] This may pave the way for targeted health outreach programmes.

Table 1 2014 and 2015 health indicators from WHO

	Israel	Ethiopia
Income classification	High	Low
Life expectancy	82	64
Under 5 mortality rate (per 1000 births)	4	64
Mortality due to diabetes	5.7%	1%
Mortality due to HIV/AIDS (per 100 000)	0.4	54.6

Cross-cultural misunderstanding

A 1999 study by Marian Reiff, Havah Zakit and Michael Weingarten examined the perceptions of treatment by Israeli doctors and Ethiopian-Israeli patients.[1] This study illuminated differences in perception and satisfaction of the care between both groups. The cultural manifestation of stress in illness, as an example, was understood differently between Ethiopian-Israeli patients and their physicians. This prompted different views of the quality of care. The study highlights the importance of cross-cultural understanding and recognising various beliefs and presentations of illness. In addition to the use of qualified translators, the degree of care between immigrant patients and physicians may be improved by cross-cultural education and communication workshops for both parties. The difference in belief systems of new immigrant populations, and the way in which western biomedical practitioners approach these beliefs, may greatly affect care.

Diabetes and chronic disease

On arrival to Israel, the lifestyle habits of the Ethiopian community diverged from common practices in Ethiopia.[11] With the new use of public transportation around the country, walking became less of a necessity and less commonplace than it was in Ethiopia. The diet of the Ethiopian community formerly consisted of fresh, healthy, independently grown food, and it was considered an essential component of Ethiopian culture and pride.[11 17] With the presence of high carbohydrate and fatty options, and the availability of food at local stores, the diet of the community changed. The quality and prevalence of dining on traditional dishes changed following immigration to Israel due to the high cost of this food.[10] Diabetes in the Ethiopian-Israeli community increased to a significant degree following the waves of immigration.[10 11] The prevalence of type 2 diabetes expanded from 0.4% to 8.9% from 1985 to 1987.[10 23]

Tene Briut, a community-based project that 'promotes culturally appropriate prevention, detection and management activities', was developed to improve the health of the Ethiopian-Israeli community. The project was created in 1998 and has focused on health education programming. *Tene Briut* has used Ethiopian community members, knowledge of cultural practices and beliefs and a culture-specific approach in their activities. *Tene Briut's* train-the-trainer approach used 15 Ethiopian nurses with specialised training during the programme's inception, garnering participation from within the Ethiopian community. Community support has persisted throughout the creation, maintenance and outcomes of the programme. A diabetes education initiative compared insulin's relationship to the body with water's relationship to the cultivated greens found in Ethiopia.[11] Type II diabetes and other lifestyle-directed chronic diseases were unfamiliar concepts in the immigrant Ethiopian community's understanding of health.[10] The emphasis on elements that are essential to life and the Ethiopian community's strong connection to agriculture make this an excellent demonstration of conveying a western biomedical concept through a culture-specific understanding of health and the world. *Tene Briut* notes its successes in creating awareness of chronic disease in the Ethiopian-Israeli community, empowering community members to take leadership positions in the organisation and developing methods for community-specific health intervention. *Tene Briut* can serve as a model for further outreach in the Ethiopian-Israeli community, in other Israeli immigrant and refugee populations, and throughout the world.

Learning points

- As an immigrant population, the Ethiopian-Israeli community faced difficult integration and health inequities on arrival.
- A keen understanding of the immigrant population's culture can enhance state and non-governmental organisation-sponsored efforts for successful integration.
- Educational programming for medical decision-makers, healthcare providers and the Ethiopian-Israeli community can mitigate cross-cultural misunderstandings and may optimise care.
- Successful healthcare intervention requires a biopsychosocial model of analysis and usage of a culturally appropriate context.

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