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THE EMBRACE UK PROJECT

**The Ethiopian Migrants, their Beliefs,
Refugeedom, Adaption, Calamities, and
Experiences in the United Kingdom**

**Edited by
Irena Papadopoulos and Alem Gebrehiwot**

May 2002

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Foreword

HOME OFFICE

I am pleased to have the opportunity to comment on this research. I recognise that this a project that has involved many members of the Ethiopian community and a great deal of hard work by committed individuals. I congratulate them all on their efforts.

This report highlights some of the difficulties that Ethiopian arrivals have faced in trying to settle successfully in the UK. I hope that we at the Home Office can play a part in making that process easier, through our refugee integration strategy. We are committed to ensuring that those who come to the UK through a genuine fear of persecution be given the opportunity to rebuild their lives and fulfil their potential.

This report also makes clear that these new arrivals bring with them a whole range of skills and experiences that can potentially benefit the UK. I want to endorse that view, and would like to take this opportunity to recognise the constructive contribution to the UK that has been made by Ethiopian migrants and refugees.

I do hope that service providers, both statutory and voluntary, find this report useful as a source of information, and indeed that all who read it have a greater understanding of, and empathy toward, the Ethiopian community in the UK.

Best wishes,



DAVID BLUNKETT

Foreword

This is an important and powerful report.

It shows how the events that have forced so many Ethiopians into exile combined with the many challenges they face adapting to life in the UK have taken a heavy toll on their health.

However, we know that the Ethiopian community has an enormous amount to contribute to the UK and the obstacles that prevent them from doing so to their full potential are a huge wasted opportunity.

Community organisations such as the Ethiopian Community Centre in the UK (ECCUK) play the major part in supporting their community. This report is just one example of how ECCUK combines its practical work with constructive and authoritative representation of the community's needs.

The report contains a wealth of important information and helpful recommendations that the Refugee Council, and I am sure, other organisations that assist Ethiopian refugees, will do their best to implement.

Finally, I would like to reiterate my thanks and appreciation to the ECCUK both for this report and for the tremendous work they do all year round. They are an inspiration and model for all organisations working with refugees.



Nick Hardwick
Chief Executive
Refugee Council

Who Is Who In The Study

- 📖 Dr Irena Papadopoulos conceived the study and wrote the research proposal with the help of Mark Newman.
- 📖 Alem Gebrehiwot agreed on behalf of ERAH (The Ethiopian Refugee Association in Haringey) now ECCUK (Ethiopian Community Centre in the UK) to collaborate in the study.
- 📖 Dr Irena Papadopoulos and Alem Gebrehiwot jointly directed the study.
- 📖 Dr Irena Papadopoulos and Mark Newman prepared and delivered the training programme for the research assistants who collected the interview / survey data.
- 📖 Dr Irena Papadopoulos devised the data collection instruments.
- 📖 Abebe Gellaw, Bethlehem Haile, Hirut Assefa Haile, Kumneger Tilahun, LishanTennagashaw, Mekibib Dawit, Mentenot Mengesha and Sagni Duftu collected the interview / survey data, provided advice regarding modifications to the data collection instruments and offered views regarding the emerging themes. Lishan Tennagashaw and Mekibib Dawit also assisted in the back-translation process.
- 📖 Sagni Duftu and Mentenot Mengesha contributed in the literature searching, data analysis and in the writing of some of the chapters
- 📖 David Harries provided administration support, assisted in the quantitative data analysis and created the study's web-page.
- 📖 Dr Irena Papadopoulos, Shelley Lees and Margaret Lay, conducted the data analysis and authored chapters for the study.
- 📖 Dr Irena Papadopoulos and Alem Gebrehiwot edited the final report.
- 📖 The study was overseen by a Steering Committee chaired by Yosias Tadesse
The members of the Steering Committee are as follows:

Yosias Tadesse, Chair of ECCUK (previously ERAH)

Alem Gebrehiwot, Project Co-Director, (Manager of ECCUK)

(I)Rena Papadopoulos, Project Co-Director, (Head, Research Centre for Transcultural Studies in Health)

Mark Newman, Research Fellow, Middlesex University

Shelley Lees, Research Fellow, Research Centre for Transcultural Studies in Health

David Harries, Project Administrator (Research Centre for Transcultural Studies in Health)

Lord Toby Harris, (Chair of the Metropolitan Police Authority)

Sasha Acimovic, (Health Officer, Refugee Council)

Caroline Lowdell, (Health of Londoners Programme)

Chukwunyere Kamalu, (Evelyn Oldfield Unit)

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- ♥ All the members of the Steering Committee especially Yosias Tadesse who chaired it.
- ♥ The staff of ECCUK (Ethiopian Community Centre in the UK) former ERAH (Ethiopian Refugee Association in Haringey).
- ♥ The Home Secretary the Right Honourable David Blunkett MP, and Nick Hardwick Chief Executive, Refugee Council, for kindly providing the forewords for this report.
- ♥ Finally, to the National Lottery Charities Board for providing the funds to enable this important study to be undertaken.

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The EMBRACE UK Study

Executive Summary

Aims and background of the study

There are no systematic arrangements in place in the UK to deal with the health and social problems of refugees and asylum seekers. There is also a lack of information on the demographic characteristics of different refugee groups, their health problems and health and social welfare service use.

It is estimated that there are 25,000 - 30,000 Ethiopian refugees most of whom are in the London area. This study aimed to investigate and describe the health and social care needs of Ethiopian refugees and asylum seekers in the UK in the context of their ethno and migration histories.

The study was funded by the National Lottery Charities Board and was undertaken in partnership between the Research Centre for Transcultural Studies, Middlesex University and the Ethiopian Community Centre in the UK - ECCUK. It commenced in November 1999 and was completed in December 2001.

Objectives of the study

The specific objectives were to:

1. Describe the ethnohistory of Ethiopia and relate this to the Ethiopian people's reasons for refugeedom: their history, geography, demography, religion, politics, and the Ethiopian social structure.
2. Describe the health and social welfare systems of Ethiopia.

3. Describe the migratory experiences of Ethiopian refugees and asylum seekers: Their experiences of war/conflict/ persecution, and the process and experience of flight.
4. Describe the Ethiopian refugees' and asylum seekers' beliefs, values and customs in relation to health and social welfare.
5. Describe the ways in which Ethiopians refugees and asylum seekers have coped with and adapted to their new environment.
6. Provide information that voluntary and statutory service providers and policy makers require to help them meet the health and social welfare needs of this community.

Methods

The study used a multi-method participatory model whereby members of the Ethiopian community worked closely with the researchers at Middlesex University. They were involved in every stage of the research process.

A combination of snowball and quota sampling was used. Semi-structured interviews were conducted with 93 key participants, 8 expert participants and 5 with a history of mental illness. Each interviewee was also asked to complete a survey questionnaire. Additional data were collected through informal conversations with experts and through documentary analysis.

In order to understand the UK society's attitudes towards Ethiopian refugees and the impact this may have on their experiences in the UK, we explored how they were portrayed in the U.K. national press (The Guardian and The Sun in February 2000 and 2001).

Characteristics of participants

Almost equal numbers of females as males participated in the study. Age groups were broken down by stages of life relevant to the Ethiopian life cycle. There were very few in the youngest and oldest age groups (Table 1).

| Table 1: Age Group | Number | % |
|---------------------------|---------------|--------------|
| 12-15 | 10 | 9.4 |
| 16-25 | 34 | 32.1 |
| 26-59 | 60 | 56.6 |
| 60+ | 2 | 1.9 |
| Total | 106 | 100.0 |

Most participants were single, one-quarter were married and none reported being widowed. There was no difference in marital status between men and women. Just over one-quarter had child or spouse dependants.

In Ethiopia, the Oromos are the largest single ethnic group, comprising over one-third of the total population. The Amharas make up almost another third. In our sample, over one-third (37%) described themselves as Amhara; 12% were of mixed ethnic origin of Amhara and another ethnicity principally Oromo; 23% described themselves as 'black African'; and 10% Oromo. Others included Gurage, Tigre, and 'Ethiopian'.

In our sample, Amharic was the mother tongue of 82%, 10% Oromiffaa, and the rest spoke Tigrigna, Guragena, Wolaikan or English. Amharic is the language of government, commerce and education.

Of the sixty-three (59%) of participants who stated their religion, over half (55%) were Orthodox Christian, 25% were Christian, 10% Protestant, 8% Muslim, 2% Jehovah's Witness'.

Two-thirds (65%) reported that they had lived in the UK for over five years, 24% less than a year, and 11% between one and five years.

Of those (100/ 106) who answered the question regarding their immigration status, 36% reported that they had temporary admission, 40% indefinite leave to remain

(ILR) and 12% had exceptional leave to remain (ELR). Those with refugee status constituted the smallest group (7%). The rest (5%) had British citizenship, were awaiting deportation, or their status was unspecified.

FINDINGS

Media analysis

Analysis of two national daily newspapers showed that the 'Sun' (a tabloid) tended to be openly hostile to refugees and asylum seekers, whereas the 'Guardian' (a broad sheet) provided more facts and was generally sympathetic. Most of the Guardian stories dealt with the problems which refugees face or the problems they create. Negative portrayal may create or reinforce the negative stereotyping of asylum seekers as 'bogus' and 'scroungers'. Thus the Ethiopian refugees not only have to overcome the trauma of their past experiences but often also have to cope with hostility in the UK. This may hamper their attempts to integrate and make a useful contribution to the country.

Reasons for leaving Ethiopia and modes of escape

Many reasons were given for leaving Ethiopia and seeking asylum in the UK but they amounted mainly to a desire to avoid imprisonment, injury and death.

Of the 98 participants who were asked to recount their reasons for leaving Ethiopia, 19 reported that they had left predominantly because of fear of, or following imprisonment of themselves or family members for political reasons. Some of those who had been political prisoners reported that they had been detained in dark, overcrowded and 'suffocating' conditions. Some (n=7) said they had been beaten up and / or tortured. Others said that their family and friends had been killed and they feared the same fate.

A considerable proportion (n=18) reported that they had left for 'political' reasons, to escape what was described as an 'oppressive' and 'undemocratic' political regime. The oppression was said to impact on everyday activities to such an extent as to deny people any sense of freedom. Such a lack of freedom of expression in Ethiopia was a frequently given reason for leaving, as was harassment by the authorities such as the police. Coercion into joining allegiance with the ruling political group was also described.

Several reported that they or their family had left as a direct result of the war between Ethiopia and Eritrea, or because of civil war. None of the participants said that famine or starvation was one of the reasons for them leaving Ethiopia. Five male (n=5) participants left the country to avoid conscription into the army or were sent away in childhood for this reason. Conscription was perceived as being likely to cause injury or death.

Six participants (n=6) had won scholarships to study in the UK and others came here to be educated. Two young men described how during their time here in education, the political situation in Ethiopia had worsened and they were afraid to return, so they sought asylum.

Another six (n=6) reported that they had left Ethiopia for economic reasons, because there were few occupational opportunities in Ethiopia. They wanted to find good jobs to support themselves, their families and sometimes their country, rather than directly because of war or conflicts.

Gaining entry to the UK by legal means for non-European Union citizens is not easy. Illicit means of escape were the only choice for those whose life was endangered and a quick exit was necessary. Modes of escape commonly included false travel documents and staying beyond the duration permitted by a visa. Some managed to get visas from British Embassies in other countries. Those who obtained illegal travel documents did so at great cost. Someone who came via Kenya said he paid about 10,000 dollars. Others altered existing documentation.

Bribing officials was said to be necessary to get through the process of seeking refuge. Sometimes a 'middle man' was involved. Getting to the UK was invariably expensive and the financial support of family and friends was often necessary. The church was reported to have helped in two cases.

Fifteen (n=15) participants reported that they had come to the UK via another country, most commonly via Bulgaria (n=4). Other countries in which they had spent time prior to coming to the UK include India, Russia, Kenya, Nigeria, Sudan, Saudi Arabia, France, and Austria where frequently they were working or studying. Others were actually working in the UK legitimately when the political situation in Ethiopia changed and it became dangerous for them to return. Only one participant reported that he was enabled to stay in the UK through marriage.

In several cases, the interviewers did not ask the participants how they had come to the UK. In other cases the participants were reluctant to answer or were non-specific. The participants were not pressurised into answering, so data on this subject is incomplete. However, it is clear that the decision to leave was often difficult, the reasons were strong, and the cost both financially and in human terms was often high.

Adapting to the UK

One of the major transitions for the participants on arrival to the UK was losing their status as citizens and becoming a 'foreigner' and an asylum seeker. The stigma of this was compounded by the food voucher system. The sense of alienation from the host culture was compared to various other negative situations. For example, one of the participants said that being in prison was preferable to a life in exile.

Some participants had explicit aims to integrate by learning about British culture. Others wished to retain the positive aspects of Ethiopian culture. Difficulty with adapting to British culture was said to be a cause of stress, depression and poor health. The degree of integration or adaptation was recognised by many as being partially dependent on the host society.

Religion was a central part of many participants' cultural identity. It was an important aspect of life that they did not want to lose as it gave them hope, guidance, continuity, familiarity, and much needed support.

Women were said by some participants to adapt better to life in the UK than men, as they had equality of opportunity here. Men on the other hand were believed to be more likely to experience negative effects such as loss of self-esteem, which could impact on their ability to integrate. These variations were said to be dependent on age, duration in the UK and whether they originated from a rural or urban location.

Variation in adaptation among different age groups was also reported whereby young people often felt they adapted more quickly, picking up the language and accent better than older people do. However, young people described problems adjusting to living independently of parents as in Ethiopia the family carries responsibility for their children until they marry. They needed to learn to budget, cook, clean and make decisions for themselves as well as having to cope with the psychological impact of estrangement from family.

Settling in the UK

Asylum seekers and refugees in the UK are presented with a set of problems that are shared by many other marginalised groups in British society, such as high levels of unemployment, poor housing, racism etc. However, they also suffer the additional stress caused by their asylum status, separation from family, uncertainties about their future, and the need to adapt to a new culture. The following aspects of settling in the UK were of most significance to the participants.

Experiences with the UK Immigration Department

Convincing the immigration department that an application for asylum was genuine was reported to be extremely difficult. Obtaining evidence of severe danger whilst still under threat of it can be particularly problematic. This appears to be compounded by the psychological consequences of political persecution in Ethiopia creating insecurity and fear of authority. Ethiopians also tend to be shy and unassertive,

particularly women and children. The shyness manifests itself in avoidance of eye contact as a sign of respect. Lack of assertion was reported to be so extreme that in some cases it was a threat to life: if an asylum seeker is unable to convince the immigration authorities of their need for asylum, they risk being deported back to a dangerous situation.

In 1999, the average length of time the Home Office took to process applications for asylum was eighteen months. Some of our participants had been waiting for a decision in the UK for over 5 years and this was a significant source of stress.

Experiences with employment

Just over one-third (n=37) of participants reported that they were students back home. Of the forty (n=40) who described their occupation in Ethiopia, many had been professionals such as lawyers and accounts. We do not have explicit data on unemployment in Ethiopia for our sample to compare with the UK.

One-third reported that they were employed in the UK (Table 2), just over a quarter were unemployed, and over one- third were students.

| Table 2: Employment Status | Number | % |
|-----------------------------------|---------------|--------------|
| Student | 40 | 37.7 |
| Employed/self employed | 35 | 33.0 |
| Unemployed | 28 | 26.4 |
| Volunteer only | 2 | 1.9 |
| New arrival | 1 | 0.9 |
| Total | 106 | 100.0 |

Employment was found to vary within certain sub-groups: those who had been in the UK for less than 5 years were twice as likely to be students and were least likely to have a job than those who had been here 5 or more years (9% versus 44%). Employment status and immigration status were also associated: those with ELR being most likely to be unemployed, those with temporary admission to be students, and those with refugee status to be employed.

Finding work that was comparable to what the participants had in Ethiopia was often difficult. Coming to the UK as an asylum seeker caused significant downward social

mobility for many and often caused considerable distress. Employment on the other hand was reported to help them to settle in the UK and to gain a sense of belonging and citizenship.

Participants gave the following barriers to finding work in the UK:

| Table 3: Biggest Problems in Getting Work | % |
|--|----------|
| Little or no work experience in the UK | 40 |
| Need more qualifications | 38 |
| Immigration status | 29 |
| Poor English | 27 |
| Discrimination | 27 |
| Qualifications not valid in UK | 27 |
| Other problems (specified) | 17 |

Other reasons given included a lack of money to travel to look for work, health problems, no affordable childcare support, and not understanding the employment system. Women refugees may not have a family member who can look after their children. Employers may be confused about refugee and asylum seekers' entitlement to work and their status.

Those who reported that poor English was a barrier to employment were more likely to be unemployed than those who had no reported problem (50% versus 21%; $p < .05$). Many of the participants were, or had been working towards removing the barriers to (suitable) employment through English language, vocational and other courses. Some were disappointed that even with (extra) qualifications they could not find appropriate work. Some went into education as an alternative to employment.

More than a quarter of the participants felt they had experienced discrimination and racism when seeking employment through for example, having foreign names and accents.

Not having a network of contacts or mentors was also perceived as a disadvantage as was the Ethiopian tendency to be modest. Others said the energy needed to adapt to a new culture and language made it harder to succeed academically or with employment.

It was suggested that the inability of asylum seekers to work as a means of improving their financial circumstances might lead some into illegal working, or other criminal activities.

Educational attainment and experiences in Ethiopia and the UK

Fifteen percent of participants had no educational qualifications, 19% had a Bachelor degree or higher degree, 10% had diplomas or professional or vocational qualifications. Many said their qualifications were not valid in the UK. This sudden invalidity of qualifications was reported to be a source of stress.

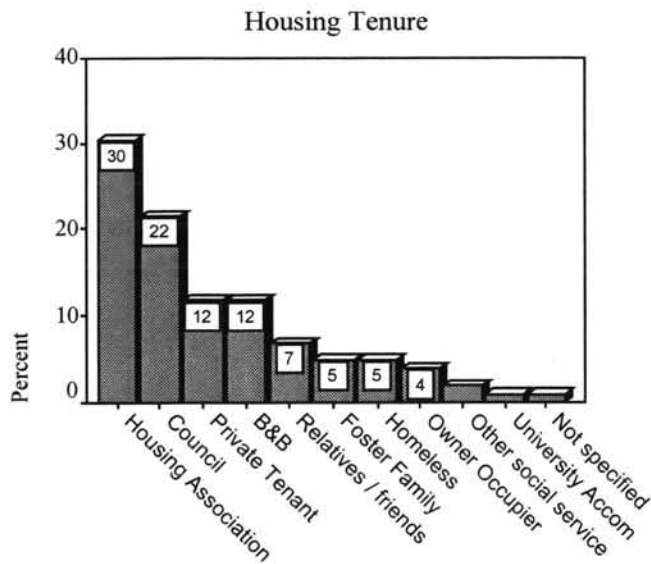
Just over half (57%) were currently studying in the UK. A quarter of these said they were engaged in university courses (14% of total). Education and fluency in English language are primary predictors of success in the labour market and in level of hourly pay; another 14% were currently studying English as a second or other language. However, financial hardship and having to move home frequently created barriers to taking up or completing educational opportunities. Living in half-board accommodation also posed barriers when meal times coincided with courses. Some participants reported lack of appropriate advice about what courses they should take. Stress, such as that caused by waiting for the Home Office decision about their asylum application caused difficulties concentrating on studies. Unaccompanied minors may be particularly disadvantaged in terms of achieving their educational potential by the negative effects of being apart from their families.

Experiences with housing

Most of the participants lived in Greater London, most commonly in Haringey, then Islington and Westminster. Those participants who reported living outside Greater London came from Liverpool and Leeds.

A third of the participants were housing association tenants (Figure 1), and a quarter were council tenants, all of whom had been in the country for 5 or more years. One-third said they lived in one room (excluding kitchen and bathroom).

Figure 1. Housing Tenure of participants



Half of the participants lived alone (three-quarters of them were single, widowed or separated). Those who lived with others most commonly lived with their spouse or their spouse and children. Five participants were minors living with foster families.

Almost half the participants said they were not satisfied with their current accommodation. Private tenants, and those living in bed and breakfast accommodation, or with relatives or friends and those who were homeless were least likely to be satisfied (Table 4). Reasons for dissatisfaction are summarised in Box 1.

| Owner-Occupier | Housing Assoc. | Council | Private Tenant | B&B | Relatives/ friends | Foster Family | Home-less |
|----------------|----------------|---------|----------------|------|--------------------|---------------|-----------|
| 3/3 | 17/29 | 15/21 | 3/12 | 4/12 | 1/6 | 4/5 | 0/5 |
| 100% | 58.6% | 71% | 25% | 33% | 17% | 80% | 0% |

- Box 1: Reasons for dissatisfaction with housing**
- Lack of space and privacy (and not being allowed to have guests)
 - Lack of personal safety and security
 - Damp, dirty, cold or unsafe housing conditions
 - Noisy or hostile neighbours
 - Having to share a home with incompatible people
 - Insecure tenancy
 - 'Bad' neighbourhood or inconvenient location
 - Not having an Ethiopian community nearby

Lack of space and lack of privacy were the most common housing problems reported and included having to share a kitchen and bathroom with several other people. Other issues revolved around the poor conditions of the building, noisy or hostile neighbours, insecurity of tenancy, and problems with the location. Lack of safety was also a problem for some. For example, an unaccompanied 17 year-old girl was afraid because she had to share accommodation with a number of unknown adult males of varying nationalities. Some females were said to be afraid of unannounced visits from their landlords.

Material security

The financial support that the participants were entitled to in the UK depended on their immigration status and personal circumstances. Over one-third (n=35/101) said they were not in receipt of any benefits at all, or the question was not applicable. A quarter (n=28) received income support - usually accompanied by housing benefit. Few participants said they received unemployment benefit (n=8) or food vouchers (n=7). This voucher system was stopped in April 2002 and replaced by vouchers exchangeable for cash.

Some reported that they had experienced difficulties when trying to claim benefits, including not being entitled, delays in processing claims, and protracted and complicated procedures.

Ethiopians were described by one of the expert participants as 'proud people' who liked to be self-reliant and able to support others. Being unable to work and being reliant on government support was a common complaint of the participants and some described feeling ashamed or embarrassed by this.

One- third of participants said they were struggling financially. Only two-fifths said they were at least reasonably well off. These were generally people who had found work, although they often also reported financial difficulties.

Many participants described how their relative poverty severely restricted their lives. For example, some said they could not afford the bus or train fares to travel to find work or to attend courses. This created a barrier to finding a way out of poverty.

Lack of money was a cause of feeling ill for about half the participants. It also resulted in social isolation which was hard for many; social life to Ethiopians is an extremely important part of their culture and was inexpensive and accessible in Ethiopia.

Having a low income also prevented many from getting enough nutritious food and one-sixth of participants said that poor diet made them ill. Lack of money was also the main reason for not being able to eat culturally appropriate food (particularly for those in receipt of vouchers), or to be able to afford accommodation with adequate cooking facilities. Those living in half-board accommodation were often given little choice about what food they ate. This created difficulties for those of Christian Orthodox or Muslim faiths who do not eat pork or who have to fast.

Expectation and disappointment

Several participants described disappointment with life in the UK and this seemed to be partially dependent on the expectations they held. Several participants believed that success was possible in the UK if they worked hard. However, some reported that the energy needed to succeed in the UK was diverted by anxiety about their application for asylum, learning about the British culture, and dealing with racism and discrimination. Despite the difficulties they faced in living in the UK as asylum seekers and refugees, some participants retained a positive outlook and praised the UK government for the support it was giving them.

Experiences with statutory social welfare services

Almost two-fifths said they were in contact with a social worker. This compared with around a quarter that had had contact with an Ethiopian community organisation. Housing services were also frequently used, particularly the Homeless Person's Unit which was used by one-quarter of the participants. Half of those who had used housing services gave negative comments about them such as 'daunting'; 'unhelpful staff'; a 'poor service'; and 'long waiting lists'. The remainder gave positive

comments such as 'satisfied' and 'very good'. Day services such as nurseries and day centres were very infrequently utilised by the participants.

One of the reasons given for their low use of formal support agencies was Ethiopians' reluctance to seek help from strangers and to fully express their needs when they do. This was particularly the case for women and children. Compounding this reluctance was the experience of social services not always being sensitive to their plight. Ethiopian community organisations often played a crucial role in advocating for people to help them access statutory services. Having a more personal relationship with their support workers rather than a distant and impersonal one generally appeared to have been preferred by the participants.

Over one-third had sought help from a solicitor or from other formal services, and a quarter sought help from interpreting services.

Experiences with Ethiopian community organisations

Two-fifths had been in contact with Ethiopian community organisations in the UK. The following main reasons were given for this:

- to seek help and advice for housing or financial problems;
- help with accessing education and training;
- to socialise with other Ethiopians;
- and to read Ethiopian newspapers and other reading materials.

The community organisations' linking role with statutory or legal services was felt to be important.

The most common comment given about the Ethiopian community organisations was that they were 'supportive'; support being felt to be particularly important for new arrivals and unaccompanied minors. Some wished to see an expansion in their service provision, such as in areas of health and more youth activities. A few found it difficult to trust Ethiopian organisations because they feared a lack of confidentiality. Suggestions for improvements were made such as advertising the organisations more, producing an Ethiopian newsletter and helping Ethiopian youth become more

independent and self-confident. Some improvements have already been implemented such as outreach work in other cities.

The importance of friends as a source of support

Most said their friends were the main source of support when feeling unhappy, whereas considerably fewer turned to a relative or their spouse. Many participants did not have relatives in the UK but those who were married would still often seek the support of friends rather than their spouse. Most participants reported they would also look to friends for help with health or social welfare problems. Many felt socially isolated and they may be particularly at risk of having unmet social and emotional needs.

Social experiences

Over a quarter said that social life was better in Ethiopia than in the UK. People in the UK were felt to be too busy earning a living and the pace of life was perceived to be too fast to have time for social life. In Ethiopia families and neighbours as well as friends were reported to be very important; neighbours were frequently described as being like 'one big family'. Consequently many found it difficult to adjust to the British life-style which was perceived as 'private' and 'individualistic'. Attempts to recreate neighbourliness in the UK were often thwarted by a fear of being misunderstood. This led to some participants isolating themselves.

Friendship in the UK was seen as having many benefits such as supporting one another in illness or helping financially: in this way it also compensated to some extent for lack of family. However, some felt Ethiopians were not as supportive of one another in the UK as in Ethiopia. This was often attributed to a lack of trust and suspicion caused by ethnic division in Ethiopia. Not only were Ethiopians in the UK seen as being less supportive but they were also reported to be less likely to seek help from fellow Ethiopians as they had before. The risk of suicide was believed to be increased by this.

Beliefs and experiences of health and sickness

Ethiopian asylum seekers' and refugees' beliefs about what an individual requires to be healthy and what indicates that the individual is healthy include (in order of importance):

- happiness;
- ability to fulfil material needs and ambitions;
- harmonious relationships;
- personal qualities/attributes;
- physical, mental and spiritual well-being;
- and a healthy environment.

Happiness was the most important prerequisite and indication of health: to Ethiopians healthiness *is* happiness and happiness *is* healthiness. Looking happy also indicates that a person is healthy. Happiness to them means fulfilling dreams; ambitions and basic needs; harmonious relationships; not being depressed, stressed or worried; and physical and mental well being.

Over a third of the participants described healthiness as being physically able, being physically fit, doing physical exercise, and being alive and vibrant. Being able to eat and sleep properly were also important to being healthy. If a man and a woman fail sexually they are considered ill.

The participants described health in holistic ways and did not separate physical health and mental health. For many, spiritual well being was also important. Health was seen as a 'gift of God' or 'the will of God'. Many of the explanations offered are clearly linked to their belief that their religion helps keep them healthy.

A clean environment, clean air and good personal hygiene were also seen as important to health.

Sickness causation

The participants held a number of beliefs about sickness causation and these may be influenced by their experiences both in Ethiopia and in the UK. Whilst happiness is the primary ‘cause’ of health, disease is the primary ‘cause’ of sickness. The beliefs about the causes of sickness are presented below in order of importance:

- Disease (germs and viruses spread through blood, air, food and water, lack of cleanliness and sanitation etc)
- Food (eating the wrong foods or eating contaminated food)
- Climate and environment (pollution, flooding, swamps with malarial mosquitos, weather changes, cold weather, too much sun)
- Accidents
- Poor socio-economic conditions (inability to afford to eat a balanced diet, keep clean, pay bills, and find suitable shelter)
- Depression and stress
- Unhealthy behaviours (unprotected sex, drinking alcohol, taking drugs, smoking cigarettes or not taking exercise).
- Social isolation/loneliness
- Supernatural causes (God, Satan or evil spirits, magic, the evil eye)
- Other causes (included self-neglect, inherited disease and iatrogenic causes such as the bad effects of traditional medicines).

Sickness prevention

Participants suggested that sickness could be prevented by avoiding addictive or harmful substances such as alcohol or cigarettes, avoiding stress, adhering to HIV prevention practices, eating a balanced diet, and having knowledge about healthy lifestyles.

Sometimes contradictory beliefs were held simultaneously, as indicated by discrepancies between expressed belief and actual behaviour. Many of the participants were probably from urban regions where beliefs and behaviours may vary from those from rural regions. However, educated urban Ethiopians living abroad may hold traditional Ethiopian beliefs, or revert to them in times of illness.

Health status and Ethiopian refugees

Most of the participants described their health as very good or good in the last year, although half had experienced a physical health problem since arriving in the UK, such as headaches, migraine or colds. The most frequent causes of illness for the participants were stress/worry, lack of money, housing problems, boredom, family problems and unemployment. The major mental health problem was depression.

Health care seeking in Ethiopia

The participants had sought a variety of health care in Ethiopia depending on their illness, the cost, their health care beliefs and the availability of services. The availability of modern health services varies greatly between rural and urban areas.

Over half the participants said they had used traditional medicine, including consulting spiritual or traditional healers such as bonesetters. Slightly fewer had used a hospital or a doctor; over a quarter had used self-care, and the same proportion had sought health care or advice from family or friends. Traditional medicines were mainly used in Ethiopia for minor illnesses such as influenza, colds or tapeworm. For many illnesses (including serious ones) some participants prayed and bathed in or drank holy water (*'tsebele'*). These remedies may have been used in conjunction with Western medicines.

Almost half the participants said they would have visited a hospital or medical doctor in Ethiopia. For some this would only be if they had a serious illness or following failure of traditional medicine or self-care, whilst for others it would be the first service sought.

Self-care involved taking traditional medicines and eating special or healthy food. Family and friends were a source of informal care, providing health advice, physical care and psychological support.

The main negative experiences of health care in Ethiopia were shortages of healthcare facilities, unsanitary conditions at the facilities; and shortages of drugs, equipment and well-trained professionals. Some had problems, or had heard of problems with traditional healers including wrong dosage of medicine and side effects, delayed

treatment for serious illnesses, and ineffective or wrong treatment. A few said they never used traditional medicines, some believing they were dangerous.

Health care seeking in the UK

The health care sought in the UK was reported to depend on the type or seriousness of the illness. Three-quarters said that they had or would visit a GP (table 5) and it was often the first service sought. Some said they would consult friends or family first.

| Table 5: Health care sought in the UK | Number of participants who sought this service |
|--|---|
| General practitioner (GP) | 74 |
| Hospital | 34 |
| Self-care | 34 |
| Family or friends | 12 |
| Traditional medicine | 12 |
| Pray to God | 12 |
| Complementary treatment | 2 |

Self-care such as using ‘modern medicines’ or eating ‘good’ or traditional foods was frequently reported to be the first action in minor illness. Most participants would use western medicine in the UK combined with some traditional remedies. Religious practices such as praying were also seen to be important healing acts.

Experiences of health care in the UK

There appeared to be a good level of knowledge about how to access GP and hospital services, although there was wide variation probably associated with length of time in the UK and degree of acculturation. Three-quarters found the UK health services easy to use. However, some participants did not seem to understand the primary care system or method of referral. Difficulties communicating due to a lack of interpreters was the main problem and this was reported to have had serious consequences for some.

Other negative experiences of the UK health care services were the (usual) waiting times at hospitals and GP surgeries. Others said they experienced prejudice and racism that manifested as poor or inappropriate treatment. It is not clear whether this was due to prejudice and racism or simply bad medical practice.

Nearly all the participants were registered with a GP. However, only one-third had used dental services in the UK.

There remains a lack of knowledge among some refugees and asylum seekers about their rights to free health care in the UK. Some healthcare professionals may also be unaware of the rights of this group.

Comparisons between health care seeking in Ethiopia and the UK

Traditional remedies were more likely to be sought in Ethiopia and the GP's help was more likely to be sought in the UK.

Most participants acknowledged that the UK had more health care facilities, drugs, equipment and health professionals than Ethiopia. However, more than a quarter of participants felt there was less informal support and care given by family, friends and neighbours in the UK than in Ethiopia and traditional Ethiopian remedies in the UK were generally not available.

Mental health

There is some evidence that a higher proportion of Ethiopian refugees commit suicide and self-harm than other African communities from a similar geographical background. One in six participants said they had suffered a mental health problem such as stress, depression or 'mental illness' since coming to the UK. When participants were asked what made them feel ill, two-thirds said stress /worry did. Almost half said they felt sad or unhappy for long periods of time.

Participants were asked what mental health means to them. Their responses are listed in the boxes below:

Box 2: Mental health in behavioural terms means:

- responding sensibly
- being reasonable
- not imposing ones ideas on others
- communicating well
- interacting with others
- integrating and adapting
- fulfilling one's needs or desires
- taking responsibility
- being independent
- overcoming problems
- being able to handle a crisis
- being able to talk about problems and to listen
- being able to analyse situations

Box 3: Mental health as a subjective state means:

- not having mental illness
- being free of stress
- avoiding stress
- having a clear bright mental state
- having mental strength
- knowing right and wrong
- viewing things in a balanced way
- thinking for ones health and wellbeing
- having mental satisfaction
- not having a trauma
- being mentally well
- being confident
- being mentally active

The participants indicated vulnerability to new or 'Western' mental health problems when they came to the UK. Some said that depression was unknown in Ethiopia because the social structures and support there prevents loneliness. Loneliness was seen to be a major cause of depression. Stress and depression were in turn reported to be major causes of ill health.

Explanations of 'madness' and mental health problems

The stress of being an asylum seeker or refugee was seen as being likely to lead to emotional problems. Ethiopians in this study distinguished between these 'normal' reactive emotional problems and 'mental illness' in that the latter would be called 'madness' in Ethiopia. Mental illness or 'madness' carries a stigma in Ethiopian culture. It is believed to be the work of the devil and a punishment for the sins of the patient or a person close to them. Madness is also thought to be due to spirit possession such as by 'Zar' spirits. 'Buda' (evil eye) is also believed to cause mental illness. Depression is perceived as having both natural and supernatural causation and remedies. The stigma of madness and even of depression leads Ethiopians to be secretive about mental health problems.

Several psychosocial causes of mental health problems were identified for Ethiopian refugees; these included traumatic events in Ethiopia such as persecution, having to endure many losses on migrating to the UK, and loneliness.

Help seeking and coping with mental health problems in the UK

None of the participants mentioned anti-depressants as a cure for depression or tranquillisers as a remedy for stress. Political and social solutions for problems that caused stress were seen to be the answer for some, such as reducing social isolation. Whereas drinking or bathing in holy water (*tsebele*) and prayer was a solution sought to eradicate madness when it was believed to have been caused by supernatural forces.

The participants described the following ways that they coped with stress: praying, crying, talking to friends, exercise, music, TV, smoking, drinking, trying to be strong, thinking problems over, sleeping, eating, keeping busy, expressing feelings, spending money etc. Very few mentioned seeing a counsellor or their GP. However, three-quarters said they would like to talk to someone trained in working with refugees about their feelings. Having fun and laughter were seen as important to maintaining happiness and mental health, but some found this difficult in the UK.

Ethiopian migrants who are socially isolated may be particularly vulnerable to suicide, especially as they are reluctant to admit they have mental health problems or to seek help from health and social welfare agencies. Another barrier to receiving prompt mental health care is the assumption by some asylum seekers that they are not entitled to free healthcare in the UK.

Recommendations

| Immigration issues | Solutions / recommendations | Suggested agencies for action |
|--|--|---|
| <ul style="list-style-type: none"> ▪ Negative attitude to Ethiopians including racism and discrimination. | <ul style="list-style-type: none"> ▪ Dispel myths through informing the public of reality. ▪ Support Ethiopian media. | <ul style="list-style-type: none"> ▪ Media. ▪ Educational establishments. ▪ Ethiopian community organisations. |
| <ul style="list-style-type: none"> ▪ Ethiopians may have difficulty convincing immigration officials of genuineness of application. | <ul style="list-style-type: none"> ▪ To be aware of Ethiopian tendencies to be shy and unassertive and of the corresponding body language. | <ul style="list-style-type: none"> ▪ Immigration Nationality Directorate and Officers |
| Employment issues | Solutions / recommendations | Suggested agencies for action |
| <ul style="list-style-type: none"> ▪ Poor English language skills. | <ul style="list-style-type: none"> ▪ Improve accessibility to courses e.g. packed lunches for those in hostels on courses. ▪ Childcare facilities in educational establishments. | <ul style="list-style-type: none"> ▪ Half-board housing providers. ▪ Colleges of Further Education and other educational providers. |
| <ul style="list-style-type: none"> ▪ Lack of knowledge about the employment system. | <ul style="list-style-type: none"> ▪ Information & advice in English and Amharic on how to get work. | <ul style="list-style-type: none"> ▪ Employment services. |
| <ul style="list-style-type: none"> ▪ Lack of valid qualifications. | <ul style="list-style-type: none"> ▪ Fast track courses /special schemes. | <ul style="list-style-type: none"> ▪ Universities and colleges. ▪ Professional bodies. |
| <ul style="list-style-type: none"> ▪ Discrimination and racism. | <ul style="list-style-type: none"> ▪ Individuals can seek advice but need to know how. ▪ Workplace monitoring and reporting of violations. | <ul style="list-style-type: none"> ▪ Commission for Racial Equality. ▪ Ethiopian community organisations. ▪ Employers and employees. |
| <ul style="list-style-type: none"> ▪ Immigration status (Exceptional Leave to Remain) causes problems in finding work. | <ul style="list-style-type: none"> ▪ Incentives for employers to take on people with Exceptional Leave to Remain. | <ul style="list-style-type: none"> ▪ Dept. of Employment. ▪ Employers. |
| <ul style="list-style-type: none"> ▪ Exploitation as illegal workers and ignorance about the | <ul style="list-style-type: none"> ▪ Advise asylum seekers how to claim permission to work six | <ul style="list-style-type: none"> ▪ National Asylum Support Service. ▪ Ethiopian community |

| | | |
|--|---|---|
| <p>Law pertaining to the employment of refugees and asylum seekers.</p> | <p>months after application.</p> <ul style="list-style-type: none"> ▪ Employers to be aware of the Asylum and Immigration Act 1999. | <p>organisations.</p> <ul style="list-style-type: none"> ▪ Employers. |
| <p>Education issues</p> | <p>Solutions / recommendations</p> | <p>Suggested agencies for action</p> |
| <ul style="list-style-type: none"> ▪ Lack of advice re appropriate courses or training. | <ul style="list-style-type: none"> ▪ Advice in Amharic. | <ul style="list-style-type: none"> ▪ Local Education Authorities. |
| <ul style="list-style-type: none"> ▪ Poor 'pay off' for additional qualifications/ upgrading. | <ul style="list-style-type: none"> ▪ Advise regarding risk of poor pay-off and what are the alternatives. | <ul style="list-style-type: none"> ▪ Careers Advisory Services. |
| <p>Housing issues</p> | <p>Solutions / recommendations</p> | <p>Suggested agencies for action</p> |
| <ul style="list-style-type: none"> ▪ Low levels of satisfaction with housing for those in private accommodation (dirty, overcrowded, unsafe etc). | <ul style="list-style-type: none"> ▪ Housing standards to be monitored in private hostels, hotels and Bed and Breakfast accommodation. Action taken if violated. | <ul style="list-style-type: none"> ▪ Environmental Health Dept. ▪ Housing Officers ▪ Social Workers. |
| <ul style="list-style-type: none"> ▪ Inappropriate housing e.g. mixed sex/ ethnicity households /hostels/B&B. Minors accommodated with foster parents of inappropriate ethnic or religious group. | <ul style="list-style-type: none"> ▪ To take account of religious and cultural background of person. Ask minors what their preferences are regarding the ethnicity and religion of foster parents. ▪ Awareness of Ethiopian ethnohistory. | <ul style="list-style-type: none"> ▪ Social Workers. ▪ Housing Officers. ▪ Housing Agents. |
| <ul style="list-style-type: none"> ▪ Lack of money for deposits and for rent on being granted Refugee status or Exceptional Leave to Remain leading to homelessness. | <ul style="list-style-type: none"> ▪ Establishment of a loan scheme. ▪ Other solutions to be investigated. | <ul style="list-style-type: none"> ▪ Local authorities. ▪ Establishment of a new body? |
| <ul style="list-style-type: none"> ▪ Intrusion of landlords/ladies into accommodation without notice. | <p>Tenants to be made aware of their rights and landlords aware of rights of tenants.</p> | <ul style="list-style-type: none"> ▪ National Asylum Support Service. ▪ Housing Officers,. |

| Finance issues | Solutions / recommendations | Suggested agencies for action |
|--|--|--|
| <ul style="list-style-type: none"> ▪ Many refugees and asylum seekers struggling financially. | <ul style="list-style-type: none"> ▪ Help younger migrants with budgeting skills. ▪ Improve employment outcomes. | <ul style="list-style-type: none"> ▪ Ethiopian community organisations. ▪ Employment and educational advisors. |
| <ul style="list-style-type: none"> ▪ Cannot open a bank account with asylum seeker's documentation: leads to problems with potential employers and getting loans. | <ul style="list-style-type: none"> ▪ Alternative(s) to be investigated. | <ul style="list-style-type: none"> ▪ National Asylum Support Service. ▪ Refugee Council. ▪ Banks & building societies. |
| Social welfare service issues | Solutions/ recommendations | Suggested agencies for action |
| <ul style="list-style-type: none"> ▪ Inappropriate treatment of asylum seekers by some service providers due to lack of understanding of their culture and the law. | <ul style="list-style-type: none"> ▪ More attention to cultural issues and needs and rights of asylum seekers in training of professionals. | <ul style="list-style-type: none"> ▪ Universities and other educational establishments. ▪ Social services in collaboration with voluntary organisations. |
| <ul style="list-style-type: none"> ▪ Some asylum seekers /refugees unaware of Ethiopian community organisations / leaflets not in Amharic. | <ul style="list-style-type: none"> ▪ Information leaflets in Amharic about sources of support and advice provided on entry into UK. | <ul style="list-style-type: none"> ▪ Refugee Council. ▪ National Asylum Support Service. ▪ Ethiopian community organisations. |
| Health issues | Solutions/ recommendations | Suggested agencies for action |
| <ul style="list-style-type: none"> ▪ Health problems related to poverty, unemployment and bad housing. | <ul style="list-style-type: none"> ▪ See Finance, Employment and Housing issues | |
| <ul style="list-style-type: none"> ▪ Health problems related to poor nutrition/culturally inappropriate food. | <ul style="list-style-type: none"> ▪ Information on Ethiopian foodstuff suppliers. ▪ Nutritional advice. ▪ Provision of culturally appropriate food in full/half board accommodation. ▪ Cash for food. | <ul style="list-style-type: none"> ▪ Ethiopian community organisations. ▪ Dept. of Health. ▪ Private hostels, Bed and Breakfasts, and reception centres. ▪ Home Office |
| <ul style="list-style-type: none"> ▪ Lack of knowledge among health workers regarding | <ul style="list-style-type: none"> ▪ Information for health care workers on traditional healing | <ul style="list-style-type: none"> ▪ Research Centre for Transcultural Studies in Health. |

| | | |
|--|---|--|
| Ethiopian traditional healing practices. | practices. | <ul style="list-style-type: none"> Ethiopian community organisations. |
| <ul style="list-style-type: none"> Information about the NHS needed in Amharic. | <ul style="list-style-type: none"> Information leaflets in Amharic to be available on arrival in UK. | <ul style="list-style-type: none"> Home Office. Refugee Council. Ethiopian community organisations. |
| <ul style="list-style-type: none"> Inappropriate care and treatment due to language/communication barriers. | <ul style="list-style-type: none"> Provision of professional interpreters who speak Ethiopian languages. | <ul style="list-style-type: none"> Dept. of Health in collaboration with other organisations. |
| <ul style="list-style-type: none"> Culturally insensitive health and social care services. | <ul style="list-style-type: none"> Cultural competence training for all health workers (including NHS Direct) and social care workers. | <ul style="list-style-type: none"> Experts in cultural competence. |
| <ul style="list-style-type: none"> Poor utilisation of dental services. | <ul style="list-style-type: none"> Information leaflets concerning dental health and services in Amharic. | <ul style="list-style-type: none"> Dept. of Health. Ethiopian community organisations. |
| Mental health issues | Solutions / recommendations | Suggested agencies for action |
| <ul style="list-style-type: none"> Stress and depression caused by socio-economic circumstance, disadvantage, racism, discrimination, difficulties adapting to new culture, immigration status etc. | <ul style="list-style-type: none"> Attention to above recommendations. Greater recognition of the psychosocial and cultural needs of asylum seekers and refugees through training in cultural competence. | <ul style="list-style-type: none"> Centre for Transcultural Studies in Healthcare. Health and social care providers. |
| <ul style="list-style-type: none"> Social isolation and loneliness leading to stress and depression. | <ul style="list-style-type: none"> Reduction in social isolation by increasing employment, English language skills and contact with Ethiopian organisations. | <ul style="list-style-type: none"> Home Office. Dept. of Employment. Ethiopian community organisations. |
| <ul style="list-style-type: none"> Stigma about mental illness among Ethiopians leads to lack of help seeking. | <ul style="list-style-type: none"> Encourage more openness and sharing of problems. Service providers to be aware of the stigma. Provision of specialist refugee counselling services. | <ul style="list-style-type: none"> Ethiopian and other media. Health and social welfare providers. Ethiopian community organisations. |

Chapter 1

The EMBRACE UK Study: An Introduction

Aims of the study

This report details a research study which aimed to investigate, describe and analyse the health and social care needs of Ethiopian refugees and asylum seekers in the U.K, in the context of their ethno and migration histories and the impact of these factors on their culture, values and beliefs. It is hoped that the findings presented in this report will enable policy makers and service providers to address the needs of this marginalised group in more effective and culturally competent ways.

The study commenced in November 1999 and was completed in December 2001. The study was funded by the National Lottery Charitable Board.

The purpose and rationale for the study

There is a growing recognition that health and social care services need to respond to the increasing cultural diversity within society. There is also a growing recognition of inequalities in health status and health provision and how these impact on the experiences of minority ethnic communities (Ahmad 1993, Smaje 1995, Nazroo 1997, Acheson 1998, Alexander 1999, DoH 2001). It is important to understand cultural diversity in order to provide effective health care in a multi-ethnic society. However, practitioners and policy makers also need to understand the complex way in which historical, political, social and economic influences interact and impact on the experiences of minority ethnic communities as these are key determinants of health related behaviour, health status, response to and use of health and welfare services (Papadopoulos et al, 1998).

The experience of cultural uprooting confronts all migrants whether refugee or not, but takes different forms. By virtue of being refugees individuals are often lonely and isolated; confronted with enforced separation from family and friends; thrust into a society which is usually very different to their indigenous one and often discriminatory; frequently, they have no means of making their existence, let alone their needs, known (Huka, 1996).

General problems that affect refugees include homelessness, unemployment, downward occupational mobility, the reversal of social roles where men are unable to obtain employment, similarly the reversal of traditional family order as young people adapt to new situations more quickly and may drift away (Taylor and Gair, 1999). Even after comparatively longer periods of resettlement refugees can still experience problems of coping with learning a new language, adapting to a new culture and trying to develop a new social identity (Clinton Davis and Fassil, 1992). It has also been argued that, Ethiopian refugees due to lack of contact with any colonial powers, are less able to cope with the British social and institutional systems and other colonial legacies such as racism (Huka, 1996).

At present there are no systematic arrangements in place in the U.K. to deal with the health and social problems of refugees and asylum seekers. As a result there is a lack of systematic information or data on the general demographic characteristics of different refugee groups, their physical and mental health problems and their entitlement to health and social service provisions. It is therefore difficult to provide a well-informed picture of the health and social problems of refugees in the U.K. (Clinton Davis and Fassil, 1992). It is essential to increase understanding of the immigration experience through illuminating the lived experience of resettlement for any particular migrant group (Baker et al, 1992).

It is estimated that there are 25,000 - 30,000 Ethiopian refugees and asylum seekers in the U.K the majority of whom are concentrated in the London area. There are over 80 different ethnic groups in Ethiopia and the composition of the refugee community varies accordingly. There are some whose English is only functional and who have a high school level of education, and others who are highly educated. Despite these differences, anecdotal evidence and localised studies suggest that health and social

problems including severe mental health problems -manifest in higher than expected levels of suicide- are common amongst all Ethiopian refugees. There is therefore an urgent need to carry out systematic, ground level, qualitative exploratory research into the effects of trauma and exile on Ethiopian refugees in the U.K (Gamaledin-Ashami 1993, Huka 1996, Bariso, 1997).

Therefore, this research aimed to increase understanding of the lived experiences, and of the health and social care needs of Ethiopian refugees and asylum seekers. It is important to increase the understanding of service providers and policy makers of the ways in which the Ethiopian community interpret health and how they cope with and change to adapt to their new environment, in order to inform appropriate practice (Muecke, 1992).

The study was a partnership between the Research Centre for Transcultural Studies, Middlesex University and the Ethiopian Refugee Association in Haringey (ERAH) (now known as the Ethiopian Community Centre in the UK - ECCUK). Its multi - method design followed a participatory research approach by involving members of the Ethiopian community in all stages of the research process, not only in providing information but also as active collaborators and paid researchers, thus allowing them to express their own needs, all of which are important processes contributing towards empowerment and capacity building for this community group.

Project management

The day to day management of the project was provided by the joint Project Directors (I.P and A.G).

A Steering Committee was set up to oversee the project with a remit to provide advice and support to the project team, and to help with the dissemination of the findings to policy makers, service providers and the Ethiopian community. The Steering Committee had representatives from the Refugee Council, the Association of London Government, the Health of Londoners Project, and the Evelyn Oldfield Centre. Unfortunately neither the Metropolitan Police representative, nor the General

Practitioner who were invited to join the Steering Committee were able to attend any of the meetings.

Dissemination of information about the study

A quarterly project bulletin was produced and distributed very widely to numerous organisations, health and social care key providers, and to targeted individuals. The bulletin was also placed on the study's web-site for wider access. As a result many interested individuals and organisations contacted the project directors requesting further information about the study or expressing an interest about the findings.

In addition to the bulletins and project leaflets which were distributed widely, the Ethiopian community were kept up-to-date with the progress of the study through broadcasts on Negat Radio Ethiopia, and through presentations at the annual Ethiopian cultural day organised by ERAH (now ECCUK).

To date, members of the research team have presented the project at two national conferences; further, one chapter has been written for an American book due to be published in 2002.

It is hoped that in the near future it will be possible for the project team to produce educational materials for health and social care workers -who form the focus of the study- such as doctors, nurses and social workers, but also for teachers, employment and housing officers, probation officers and the police, based on the findings as well as other information gathered during the study, alerting them to the needs of this community.

Papers will also be prepared for the academic community to be published in peer reviewed journals, presented in conferences and via the Internet.

Overview of the Report

Chapter 2 provides a detailed description of the methodology used for this study.

Chapter 3 presents an ethnohistorical account of Ethiopia. This is considered important background knowledge for all public service providers as they strive to understand the needs of Ethiopian refugees and asylum seekers. By discussing the geographical position of Ethiopia, its demographic and ethnic make up, the religions of its people, its history, and its politics, the chapter aims to illuminate the reasons for the refugee exodus from Ethiopia.

Chapter 4 outlines the health and social welfare profile of Ethiopia. It specifically focuses on social structures, the family and the role of women in Ethiopia. The chapter also discusses the implications of these structures on the health care system.

Chapter 5 details many cultural and self-care health beliefs and practices in Ethiopia. This is considered important there is evidence to indicate that people continue to hold their traditional beliefs even when they no longer live in their country of origin. In fact cultural beliefs and practices continue to exist within migrant communities for at least three generations albeit in modified forms. It is therefore important for health and social care practitioners to have some cultural knowledge about the Ethiopian migrants.

Chapter 6 provides information about the Human's Rights legislation specifically as it applies to the British legal system. It details the process of asylum seeking in the UK and the role of the National Asylum Support Service. A brief discussion on the implications of the Immigration and Asylum Bill (1999) is also included. Such factual information is considered crucial for the reader of this report.

Chapter 7 deals with another important social factor affecting refugees and asylum seekers; that of the mass media representation of their plight.

Chapter 8 discusses the reasons for, and the ways used by the informants of this study, to leave Ethiopia.

Chapter 9 describes the trials and tribulations of the Ethiopian refugees and asylum seekers, as they try to adapt to their adopted country.

Chapter 10 provides details about the experiences of Ethiopian refugees and asylum seekers with the UK immigration department, the statutory and community welfare agencies, with trying to find employment, housing, and education. It discusses their difficulties and the resultant stresses, exclusion and poverty.

Chapter 11 describes the social experiences of the informants as they relate to their settling in the UK, and compare and contrast these experiences to their social experiences in Ethiopia.

Chapter 12 explores the beliefs and experiences of health and sickness of Ethiopian refugees and asylum seekers in the UK. The analysis is divided into a number of sections detailing the informants' views on: the prerequisites and indications of health, the causation and prevention of sickness, the informants' self reported health status and their health seeking behaviours.

Chapter 13 is totally devoted to mental health. It reports on the informants' beliefs about 'mental health' and 'mental illness', their explanations of mental health problems, their expressions of 'mental illness' and distress, their help seeking behaviours and their experiences with mental health services in the UK.

Chapter 14 provides the conclusions of the study along with a number of recommendations.

Chapter 2

Methodology

Introduction

This chapter will detail the following:

- The objectives of the study
- The participatory study design
- Sampling and sample size
- The data collection methods
- The data analysis and validation
- Ethical issues related to the study
- The socio-demographic characteristics of the study participants
- Language, style and notation system

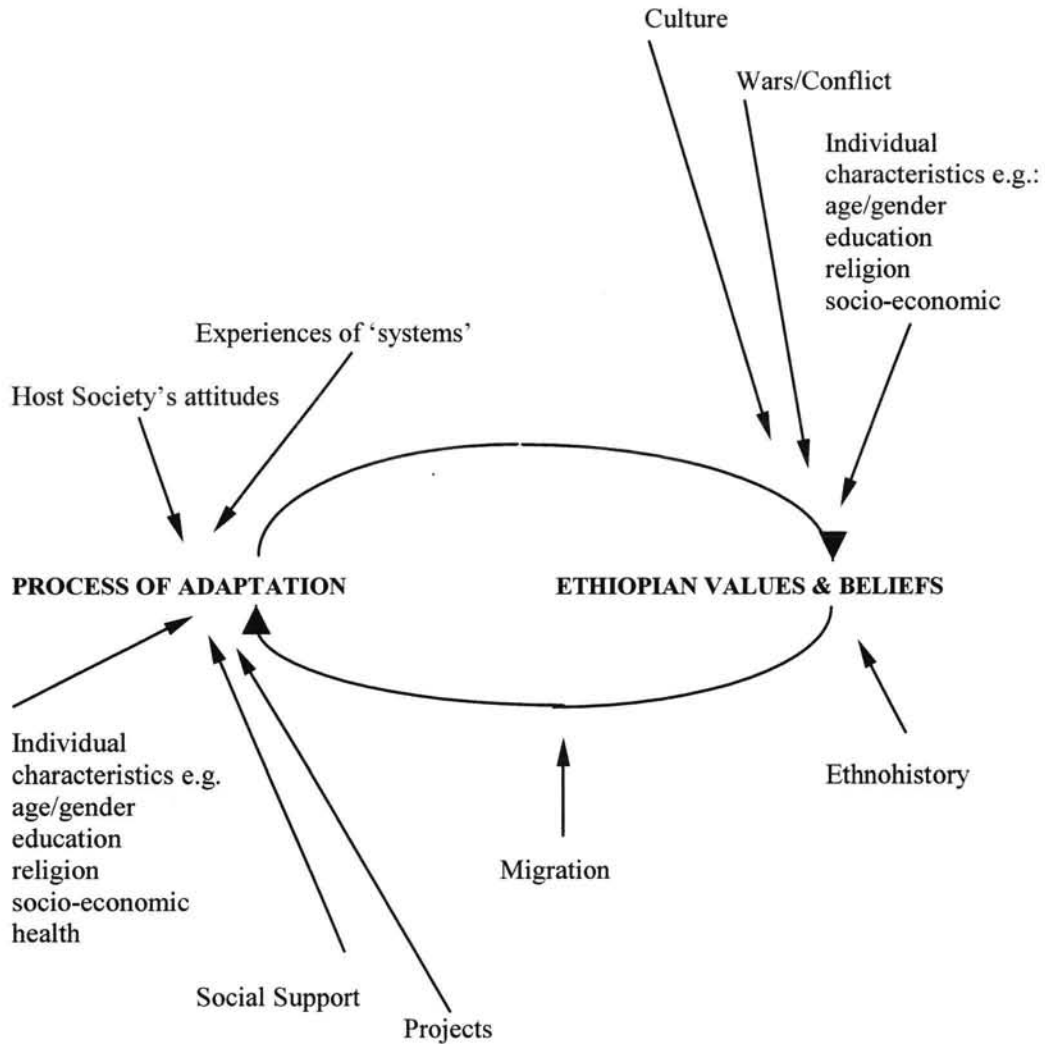
The objectives of the study

The overall aim of the study was discussed in the introductory chapter. A conceptual representation of the study is given in figure 2.1. This illustrates the research objectives and their interrelationship. The specific objectives are:

1. To describe the ethnohistory of Ethiopia and relate this to the Ethiopian peoples reasons for refugeedom:
 - History
 - Geography
 - Demography
 - Religion
 - Politics
 - Social structures

2. To describe the health and social welfare systems of Ethiopia.
3. To describe the migratory experience of Ethiopian refugees and asylum seekers:
 - Experience of war/conflict/ persecution
 - The process and experience of flight
4. To describe the Ethiopian refugees' and asylum seekers' beliefs, values and customs, focusing in the areas of health and social welfare *specifically*:
 - Nature of health
 - The nature of sickness and its causes
 - The roles and responsibilities of individuals, families, communities and society in relation to the maintenance of health, 'care/cure' of sickness, and social welfare
 - Traditional practices and customs related to health and social welfare
 - Expectations regarding the provision of health and social welfare services
5. To describe the ways in which Ethiopians refugees and asylum seekers have coped with, and adapted to their new environment.
6. To provide information that voluntary and statutory service providers and policy makers require in order to help them meet the health and social welfare needs of this community.

Fig. 2.1: A conceptual representation of the project



The participatory study design

The study used a multi-method participatory model. Members of the Ethiopian community worked closely with the researchers at the Research Centre for Transcultural Studies in Health, Middlesex University. They were involved in every stage of the research process from design to dissemination of findings. This participation developed as follows (Box 2.1):

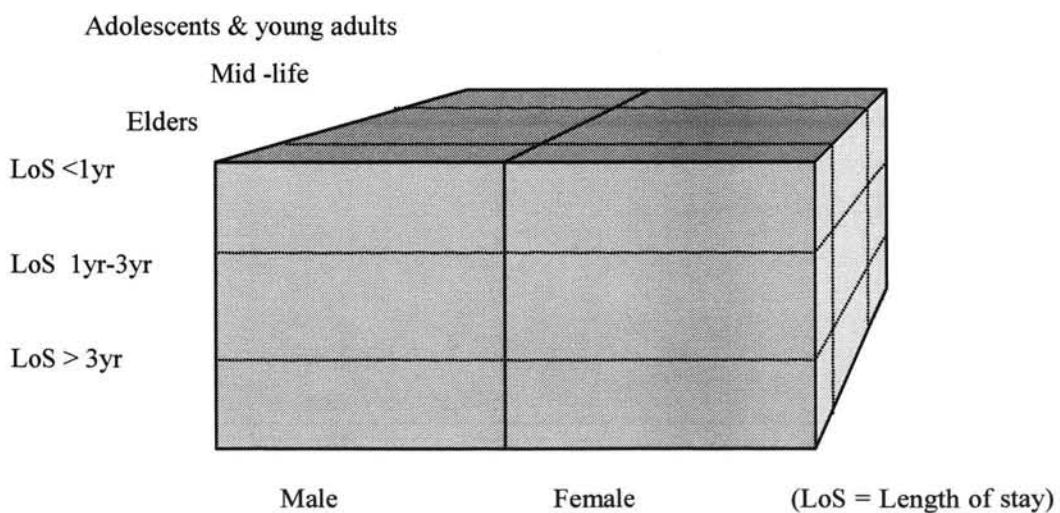
Box 2.1: Nature of user participation

- Collaboration in the development and submission of the research proposal
- Joint direction of the study
- Collection of interview and survey data
- Transcription and translation of interviews
- Provision of advice regarding modifications to the data collection instruments and offering of views regarding the emerging themes.
- Backtranslation.
- Contribution in the literature searching
- Contribution in the writing of some of the chapters
- Steering Committee membership
- Chairing of the steering committee
- Assisting in the editing of the final report
- Assisting in the dissemination of the study's findings

Sampling and sample size

A combination of snowball and quota sampling was used. Key stakeholders of the various sample groups were identified by the research assistants. These key informants were used to gain access through snowballing to the sub groups of the Ethiopian refugee community of which they were members. The study's sampling matrix is set out below (Fig 2.2).

Fig. 2.2: The sampling matrix



The categories outlined above were identified by the Ethiopian staff of ERAH (now ECCUK) as potential key markers of different experience amongst the Ethiopian refugee community. The suggested framework for the age related categories was:

- ◆ Adolescents and young adults **12 -25** School/ early adulthood, normally a time of entering work and forming adult relationships.

- ◆ Mid-life **26 – 59** Consolidation of significant adult relationship, development of own family, consolidation and development of career.

- ◆ Elders **60 +** Finishing paid work, second generation of own family (grandparent), experience of illness and death amongst family and friends.

It was anticipated that a minimum of 100 Ethiopian refugees and asylum seekers would participate in the study. The ideal sample would consist of equal number of men and women, and equal number of people from each age group. Ideally, each age/gender sub-group should include participants from all three 'length of stay' categories. In reality, given the size of the Ethiopian community in London, the size of the desired sample did not present any difficulties although the age and length of stay categories did. In particular, it was recognised very early that the desired sample size for the over 60s would not be achieved, this being a relatively young migrant community (please see characteristics of sample below).

As the study progressed two significant sampling sub-groups emerged: a) those suffering from mental health problems and who had been given a mental illness diagnosis, and b) those who had specific knowledge about the Ethiopian community in the UK as a result of their work and/or voluntary involvement with this community; such people were called 'expert informants'.

Data collection methods

Data were collected using a number of methods:

- a) Semi-structured individual interviews
- b) Survey
- c) Documentary analysis
- d) Informal conversations with experts

a) Semi-structured individual interviews were conducted as follows:

- ◆ 93 Key informants
- ◆ 8 Expert Informants
- ◆ 5 Informants with history of mental illness

Eight Ethiopian research assistants were recruited and worked on a sessional basis. Most of the interviewees were matched with an interviewer of their gender and age group. All interviews were taped recorded (with the consent of interviewees).

b) Survey

Each interviewee was asked to complete a **questionnaire** which provided additional quantitative and qualitative data.

Training of research assistants

With the exception of two research assistants, the rest had some research knowledge acquired during their higher education studies. Some had participated in other community studies so they had experience of interviewing and/or helping people complete questionnaires. However, they all attended a structured training programme to enable them to familiarise themselves with the project, develop or extend their interviewing and other research skills (see Appendix 1 for the training programme).

The supervision process

The research assistants received individual on-going support and supervision by one of the study directors (IP). This enabled them to discuss any problems they

encountered and to explore together solutions or alternative ways. At the early stages of the study the research assistants offered invaluable insights and made practical suggestions which facilitated the improvement of the data collection tools.

The research assistants' fieldnotes

The research assistants were asked to keep notes about the interview encounter. Each recorded the place and time of interview, and the context within which it happened. For example, if the interview took place in a person's home, they were asked to describe the physical surroundings paying particular attention to any cultural symbols; they were also asked to note whether anyone else was present during the interview, whether there were any interruptions, whether anything unusual happened, and to note other observations which they considered significant. This helped their supervisor to gain a better insight of the interview content (second best from actually being there) and if need be asked them to clarify any points which may not have made full sense on reading the transcripts.

Transcribing, translating and back translating the interview data

The majority of the interviews were conducted in Amharic. Part of the research assistants' role was to transcribe the interviews in the language they were given and where necessary to translate and transcribe them in English. In order to assure the quality of translations, a randomly selected translated transcript from each research assistant was backtranslated to Amharic by a different research assistant. One of the study directors (AG) compared the two Amharic versions of each research assistant and was able to confirm their accuracy. It was found that although some expressions differed the conceptual meaning remained true to the original transcript.

c) Documentary analysis

In order to address the research objectives which related to the adaptation process of the Ethiopian refugees and asylum seekers and of the host society's attitudes towards them, it was decided to examine the way in which the British national press projects their issues. Two newspapers were selected for this purpose: The Guardian, and The Sun. All issues of both newspapers in the month of February 2000 and 2001 were analysed (please see chapter 7).

d) Informal conversations with experts

One of the study directors (IP) conducted numerous 'conversation sessions' with two of the research assistants who had worked in the health and social welfare field in Ethiopia, in order to explore the traditional and self care practices of Ethiopian people, and to formulate an accurate and reality anchored picture of the nature of the health and social care system operating in Ethiopia. Such background information would help health and social care professionals in Britain make sense of the needs and behaviours of Ethiopian refugees and asylum seekers. Furthermore, the information gathered and presented in chapters 4 and 5, also proved essential in the analysis of the interview and questionnaire data.

The pilot study

The pilot study was used to:

- ◆ Test the research instruments
- ◆ Enable the interviewers to apply and develop their interviewing skills
- ◆ Explore the practical issues of language use and tape recording of interviews
- ◆ Explore different strategies for obtaining access

The pilot study constituted of the first interview and completed questionnaire by each of the eight research assistants. As already discussed on-going feedback during this stage and a meeting with the research assistants resulted in some changes to the questionnaire and assured the study directors that both the approach to, and the data being collected were appropriate to the research aims and objectives. At this early stage it became evident that it was unlikely to meet the desired number of study participants who were aged 60+.

Data analysis and validation

The qualitative data

Data collection and analysis are intertwined in qualitative research. A constant comparative process of defining and redefining any emerging themes in the light of new data was utilised. The emerging themes were then elaborated conceptually both

from the data and by using theoretical and empirical constructs from the literature (Patton 1990, Tesch 1990). The initial analysis of the interview data was performed by the research assistants who conducted the interviews. They were asked to document their views regarding the important issues and themes after each interview. These were discussed with the study supervisor (IP). At the same time all transcripts were being transferred into a qualitative data analysis software programme (NUDIST) and coded using as a guiding coding framework the *a priori* themes and the emerging themes from the initial analysis.

When the first twenty transcripts were completed, a random sample of three transcripts were printed out and two of the researchers (IP and SL) undertook an independent manual analysis. Their analyses were then compared for similarities and differences and a new, more refined coding framework was developed. This was used to code the remainder of the transcripts as they became available. The views of the research assistants continued to be taken into consideration and any new emerging issues were added to the coding frame. By the time all the interviews were completed a new researcher (ML) was employed to help with the final analysis. At this point, all the data were reviewed by the three researchers (IP, SL, and ML) who were able to agree on the final coding frame and identify the major emerging themes.

Validation of the interview analysis

The validity of the analysis of the interview data was achieved through researcher triangulation, and through comparisons with published literature. Furthermore, the preliminary findings were presented at two peer review conferences which provided an opportunity for discussion, reflection and validation. Given the methodological rigour which is described in this chapter, and the advantages of a research team which included both 'insiders' (Ethiopians) and 'outsiders' (non-Ethiopians), the research team is confident that the findings have truth value (credibility), are dependable (reliability) and are applicable to the rest of the Ethiopian UK community (generalisability).

The quantitative data

Quantitative data collected via the questionnaire were entered onto the SPSS (statistical software programme for social scientists). Simple descriptive statistical

analysis was performed and where possible relationships and associations were explored. Any that were found significant are reported in the relevant findings (chapters 8, 9, 10, 11, 12, 13).

Documentary analysis

This consisted in summarising the articles carried by the selected newspapers on: a) Ethiopian refugees and asylum seekers, and b) refugees and asylum seekers in general. For further details please see chapter 7.

Informal conversations with experts

The health and social care, as well as the self-care data collected from the experts were simply collated in chapters 4 and 5. They have been verified against the available literature and by one of the study directors and co-editors of this report who is an Ethiopian (AG).

Ethical issues

The study gained ethical approval by the ethics committee of the School of Health Biological and Environmental Sciences, Middlesex University. The guiding ethical principles were those advocated by the 'Belmont Report (1978)' which are: a) the principle of beneficence, b) the principle of respect for human dignity, c) and the principle of human justice.

The principle of beneficence includes three important dimensions: freedom from harm, freedom from exploitation, and risk/benefit ratio. In this study, none of the participants were exposed to any physical harm. However, it was anticipated that the issues which were to be covered during the interviews would provoke feelings of extreme discomfort in participants. Therefore the research assistants were trained to respond appropriately in such situations. All participants were offered follow up support and advice from ERAH (now ECCUK). Freedom from exploitation means that any information gained from the study will not be used against the participants in any way. This is particularly relevant when dealing with such vulnerable people. It was therefore important that all participants were fully informed of the aims of the

study and the extent of their involvement. With regards to the risk/benefit ratio the researchers and the study's steering committee agreed that such a study will provide important data which will ultimately benefit the participants.

The principle of respect for human dignity includes the right to self-determination, the right to full disclosure, and the right of informed consent. A person's right to self-determination means that the person decides voluntarily and without any coercion to be involved and to terminate his/her involvement at any stage s/he wants without incurring any penalties. This right is closely linked to the rights of full disclosure and informed consent. The participants of this study were provided with written information about the study in both English and Amharic, and their consent was ascertain prior to any involvement. Participants were assured of their anonymity and of the confidentiality of any information they provided. They were also offered the opportunity of being interviewed by one of the non-Ethiopian members of the study team if they so wish.

The principle of human justice includes the rights to fair treatment and privacy. The research assistants were told that they must ensure fair and non-discriminatory selection of participants based on the requirements of the research and not of their own convenience, or the gullibility of certain individuals. The existence of a semi-structured interview schedule and the common training given to the research assistants aimed at fairness by ensuring that similar information was collected from each participant in a similar way. The right to privacy means being courteous and respectful when people allow the researcher into their homes, and give their time for an interview. As mentioned earlier, all participants were informed that any information they provide would not be divulged to anybody, which would be linked directly to them.

Socio-demographic characteristic of participants

All of the interviewees including the 'expert' informants (N=106) were asked to complete a questionnaire. In this they were asked a number of questions to ascertain their socio-demographic characteristics.

Sex and Age

Almost equal proportions of the respondents were male (51: 48%) as female (55: 52%). The respondents were asked what age group they belonged to. The age groups were broken down by stages of life relevant to the Ethiopian life cycle. The groups represent those of school age, post-school age /early adulthood, mid-life, and the elders (sixty and over). Just over half (57%) were aged twenty-six to fifty-nine, one-third (32%) were aged between sixteen and twenty-five. Just less than one-tenth were minors (9%) and even fewer (1.9%) were aged sixty or over (Table 2.1).

Table 2.1: Age Group of Respondents

| Age Group | Number | % |
|--------------|------------|--------------|
| 12-15 | 10 | 9.4 |
| 16-25 | 34 | 32.1 |
| 26-59 | 60 | 56.6 |
| 60+ | 2 | 1.9 |
| Total | 106 | 100.0 |

Marital Status and Dependants

Nearly three-quarters (68%) of the respondents were single and a quarter (24%) were married, the rest were divorced or separated. None reported being widowed (Table 2.2). There was no difference in marital status between men and women.

Table 2.2: Marital Status of Respondents

| Marital Status | Number | % |
|----------------|------------|--------------|
| Single | 72 | 67.9 |
| Married | 25 | 23.6 |
| Divorced | 3 | 2.8 |
| Separated | 3 | 2.8 |
| Data missing | 3 | 2.8 |
| Total | 106 | 100.0 |

Just over a quarter (28%) said they had dependants and these were few in number, mainly one or two (Table 2.3). The dependants were mostly children only or children and spouse (Table 2.4).

Table 2.3: Total number of dependants

| Number of dependants | Number | % |
|----------------------|------------|--------------|
| 0 | 75 | 70.8 |
| 1 | 11 | 10.4 |
| 2 | 9 | 8.5 |
| 3 | 2 | 1.9 |
| 4 | 1 | 0.9 |
| Data missing | 8 | 7.5 |
| Total | 106 | 100.0 |

Table 2.4: Relationship of dependant

| Relationship of dependent | Number | % |
|---------------------------|------------|--------------|
| Children | 16 | 15.1 |
| Spouse | 3 | 2.8 |
| Spouse and children | 3 | 2.8 |
| Brother | 1 | 0.9 |
| Sister | 1 | 0.9 |
| Not applicable | 75 | 70.8 |
| Data missing | 7 | 6.6 |
| Total | 106 | 100.0 |

Country of Birth & Ethnicity

When asked in which country they were born, the vast majority (96%) said Ethiopia, three percent (3%) said the UK, and one percent said Saudi Arabia. Five respondents did not answer this question. Ninety-two percent (92%) reported being of Ethiopian nationality, one percent (1%) Eritrean, five percent (5%) were of dual nationality, and two percent (2%) were British. When asked what their ethnic origin was, just over one-third (37%) described themselves as Amhara; this was the largest ethnic group (Table 2.5). A further twelve- percent (12%) described a mixed ethnic origin of Amhara and another ethnicity, principally Oromo. The second largest ethnic group described themselves as black African (23%), followed by Oromo (10%). The smallest ethnic groups in the sample were Gurage, Tigre, and 'Ethiopian' (Table 2.5). One of the reasons for this diversity and somewhat confusion was due to the fact that the original questionnaire asked respondents to define their ethnicity without giving them any predefined ethnic categories. It is safe to assume that all those who defined themselves as 'black African' are Ethiopians as only known Ethiopians were approached (by the research assistants who were all Ethiopians) to participate in this study. However, it is not known of which specific ethnic grouping they belong.

Similarly, some participants were simply defining themselves as 'Ethiopian' in the early stages of the study when the original questionnaire was used. After viewing the early results and following the advice of some of the research assistants the questionnaire was amended to include specific ethnic categories plus the 'other: please define' category.

Table 2.5: Ethnic Origin of Respondents

| Ethnicity | Number | % |
|-------------------------|---------------|--------------|
| Amhara | 39 | 36.8 |
| Black African | 24 | 22.6 |
| Oromo | 11 | 10.4 |
| Amhara and Oromo | 7 | 6.6 |
| Ethiopian | 5 | 4.7 |
| Gurage | 5 | 4.7 |
| Tigre | 5 | 4.7 |
| Amhara and Arabic | 2 | 1.9 |
| Amhara and Tigre | 2 | 1.9 |
| Amhara and Gurage | 1 | 0.9 |
| Amhara, Oromo and Tigre | 1 | 0.9 |
| Ethiopian and Eritrean | 1 | 0.9 |
| Oromo/Black African | 1 | 0.9 |
| Oromo/Gurage | 1 | 0.9 |
| Oromo and Sidama | 1 | 0.9 |
| Total | 106 | 100.0 |

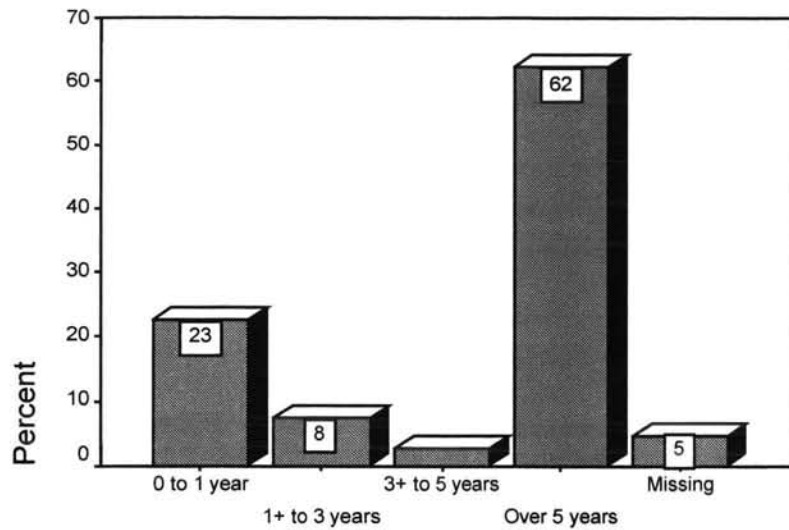
Language

When asked what their mother tongue was, the vast majority replied 'Amharic' (82%), ten percent (10%) said 'Oromiffaa', and the rest said 'Tigrigna' (3%), 'Guragena' (2%), 'Wolaikan' (1%), and two percent (2%) said 'English'. Amharic is the language of government, commerce and education. Two informants said they had two languages as their mother tongue. Eighty-one percent (81%) said they also spoke English.

Length of Time Resident in UK

Respondents were asked to indicate how long they had lived in Britain. A large majority (65%) of those who responded reported that they had lived in the UK for over five years, one-quarter (24%) had been here less than a year, and only eleven percent (11%) had lived here for between one and five years (Fig. 2.3).

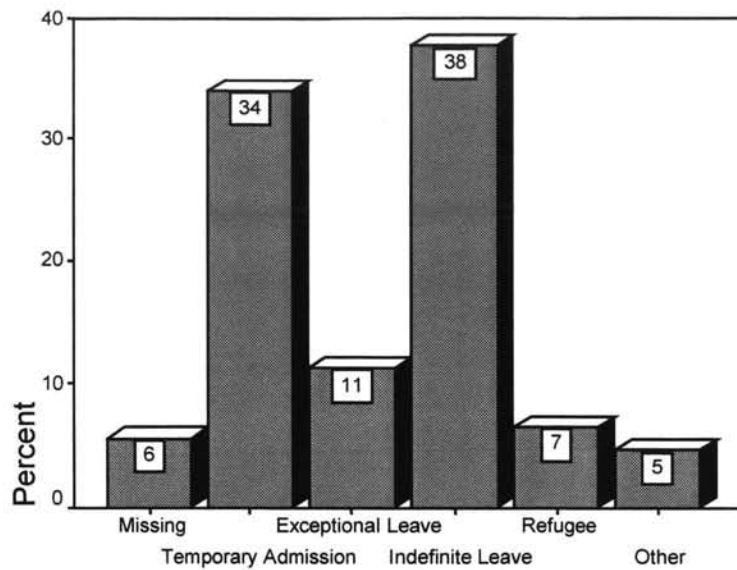
Fig. 2.3: Duration of Residency in Britain



Immigration Status

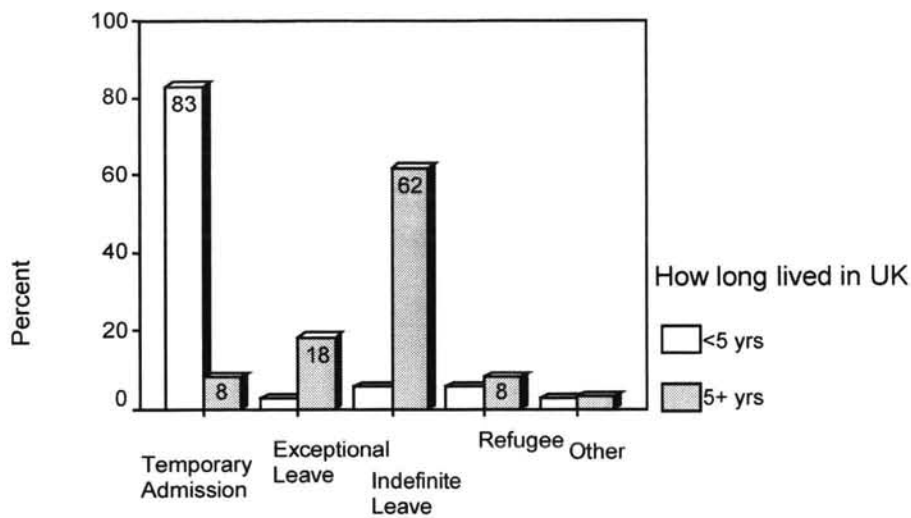
Of the one hundred and one (n=100/106) respondents that answered the question regarding their immigration status, one-third (36%) reported that they had temporary admission, two-fifths (40%) had indefinite leave to remain, and twelve percent (12%) had exceptional leave to remain (Fig. 2.4). ‘Refugees’ constituted the smallest group (7%). Five percent of respondents had another status either specified, including British citizenship, or holding a deportation order, or one that was not specified.

Fig. 2.4: Immigration Status



Percentages in columns include the missing values (n=6)

As would be expected, immigration status varied by the length of time spent in the UK. Figure 2.5 illustrates that those who have been in the UK less than five years are much more likely to have temporary admission (83%). Those who have been here five or more years are most likely to have indefinite leave to remain (62%). It also shows that some of those who had been in the UK more than five years still only had temporary admission rights (8%). Missing values have been excluded from the analysis ($p < .001$).

Fig. 2.5: Immigration status by length of time in the UK

Language, style and notation system

In order to help the readers navigate their way through this report, it may be useful to point out a number of philosophical and stylistic issues. Firstly, as an earlier section of this chapter explained, the methodological approach of this study is firmly located within a participatory philosophy. Accordingly, it is hoped that the language of this report reflects this approach. For example, the term 'participant' is the preferred term when referring to all those people who provided data for this study. However, readers may find references to 'respondents', interviewees and informants. These terms are used only when the term 'participant' felt clumsy or confusing within the context of the specific sentence or paragraph.

The authors of chapters 8, 9, 10, 11, 12 and 13, begin by identifying the major themes and then go on to present the findings prior to discussing the significance of them. When direct quotes from the interview transcripts are used these are identified by the number of the participant, his/her gender, and the number of the first line of the quote to be found on the transcript. Thus (015m: 235) indicates that the quote comes from interview number 15, given by a male participant, and it begins at line 235 on the

transcript. When the quote is identified by a number and gender (e.g. 019f) but no line numbers are given, this indicates that the quote source is the questionnaire survey.

Relevant quantitative findings are mixed with the qualitative findings to provide a complete picture of the theme. Where possible, qualitative findings have also been quantified in order to provide a sense of magnitude or measure given to a theme or sub-theme by the participants. Finally, although the themes are based on findings which are repeated by a number of participants until they are saturated, individual views which may contradict or question the consensus or may raise issues not identified by others are also presented.

Chapter 3

The Ethnohistory of Ethiopia

Introduction

This ethnohistorical review of Ethiopia will concentrate in identifying the main reasons for the persistent of refugee exodus from a country known as Ethiopia. Refugees begun to flow as a consequence of regime changes and the extreme radicalism of the regimes that came consecutively to run or mis-run Ethiopia. During the long imperial Government with a benevolent traditional authority in power, the refugee outflow was relatively small compared to when a particularly odious military-Stalinist regime climbed the ladder of power by imposing a reign of terror on the population. With the latter's overthrow, some would argue that the country was taken over by forces who lacked an integrated understanding of Ethiopia.

Refugees left the country when the imperial system was overthrown to continue staying outside Ethiopia along with the new influx from the overthrow of the military regime known as the Derg. Subsequent regimes have been experienced by the Ethiopians more as a burden than a help to forge their working lives. Consequently the country has been a victim of a permanent state of violence, poverty, war and famine. At the heart of the refugee exodus is the ontological insecurity of Ethiopians. Ethiopians will continue to be forced out until a rule of law infuses the social contract with principles of ethics, morality and political accountability which should govern public life.

The origin of the name 'Ethiopia'

Ethiopia's name is said to have been coined by the Greeks. In the way the Greeks used the term Ethiopia, it connotes the place of "sun- burnt faces". Many Ethiopians

in the outside world are confronted with the other name of Ethiopia called 'Abyssinia'. In the Arab world Ethiopians are invariably called "Habesh", the name apparently came "from one of the tribes that inhabited the Ethiopian region in the pre-Christian era" (Zewde, 1991:1).

The age of Ethiopia

The most contested matter about Ethiopia is the dispute on its age. As one young historian put it: "*Ethiopian history is as old as one wants it to be*" (Tibebu, 1995). Ethiopia is one of these countries which fate and irony have conspired to make it as ancient as 6,000 years old or as young as "eleven years old", so aged due to the new territorial arrangement after the 1991 events when Eritrea parted away from Ethiopia. This age, in fact, is said to have been claimed by Ethiopia's Speaker of the House of the current regime as reported by the monthly opposition newspaper 'Tobia'. Ethiopia was not only redrawn as a consequence of Eritrea's exit from what has been defined as the Ethiopian map but also the rest of the country has been divided into ethnic-vernacular political entities with the formal recognition that these vernacular states are free to pursue foreign and domestic policies potentially different from the Ethiopian national state.

Geographical position

The Federal Democratic Republic of Ethiopia has an area of 1,133,380 sq km and lies in northeastern Africa otherwise known as the Horn of Africa. The latter name designates the horn shaped tip of the region which marks off the Red Sea from the Indian Ocean. Ethiopia has been land-locked since the independence of its former province of Eritrea on the Red Sea coast in May 1993. The neighbours of Ethiopia have changed throughout history depending on the territorial arrangement which the various internal and external influences brought about Ethiopia's spatial shape and geography. Currently it is bordered by Eritrea and Djibouti to the north, Somalia to the east, Kenya to the south and Sudan to the west.

The largest city is the federal capital Addis Ababa (population 2,112,737 in 1994). Other important towns are Dire Dawa, Harar, Jijiga, Nazret, Gondar and Dessie.

Ethiopia including Eritrea is located between longitude 33° and 48°E and latitude 3° and 18° N. It lies near the equator but is known for its rather temperate climate. This is due to the elevated nature of its highlands which rise to over 1500 meters which balance its tropical location with a cooler climate. The highlands of Ethiopia have a considerable number of river valleys. The largest of the valleys is the Rift Valley which cuts across large parts of eastern Africa, including Kenya and Tanzania. Ethiopia contains some of the highest mountain ranges in Africa, with Rash Dashen over fifteen thousand feet above sea level, and the lowest depression on earth (Mesfin Wolde-Mariam, 1972). It is one of the oldest places known to practice agriculture (Ehret, 1979).

Size of population, ethnic make up and languages spoken

Ethiopia has approximately sixty million people. This makes it the third populous country in Africa, after Nigeria and Egypt. Forty six percent (46%) of the population are between 0-14 years old, 51% are between the ages of 15-64 years, and 3% are over 65 years. The current net migration rate stands at 1.3 migrants per 1000 population.

There are over 80 different ethnic groups in Ethiopia, referred to officially as 'nationalities'. The Oromos are the largest single group, comprising over one third of the total population. The Amharas make up almost another third. Other important population groups are the Tigreans (or Tigrayans), Somalis, Shankella and Afars.

The official language is Amharic but many other languages are spoken such as Tigrinya, Orominga, Somali, Arabic and English. The latter is used widely in official and business circles.

Religion

Ethiopia is the second oldest Christian polity in Africa. It was converted to Christianity in the 4th century AD. Coptic Egypt is perhaps the oldest African country to adopt Christianity. Ancient historians call “Ethiopia” the mother of ancient Egypt; and the history of Egypt with Ethiopia has been tied with religion and the waters of the Nile. It has a considerable portion of its population engage in pastoralism and nomadism. Ethiopia has been described as a museum of cultures, religions, and modes of production (Pankhurst, 1992).

Ethiopia has been home to three Abrahamic faiths: Judaism, Christianity and Islam. The majority of the people are deeply religious. Religion is in many ways the most important ingredient in the lives of Ethiopians. Wherever Ethiopians live they create two things first: their cuisines and then their church. Even in Denmark in a little town called Årus, there is an Ethiopian Church where there are no more than twenty or twenty-five Ethiopians! Religion may in fact provide in most cases their primary cultural identification.

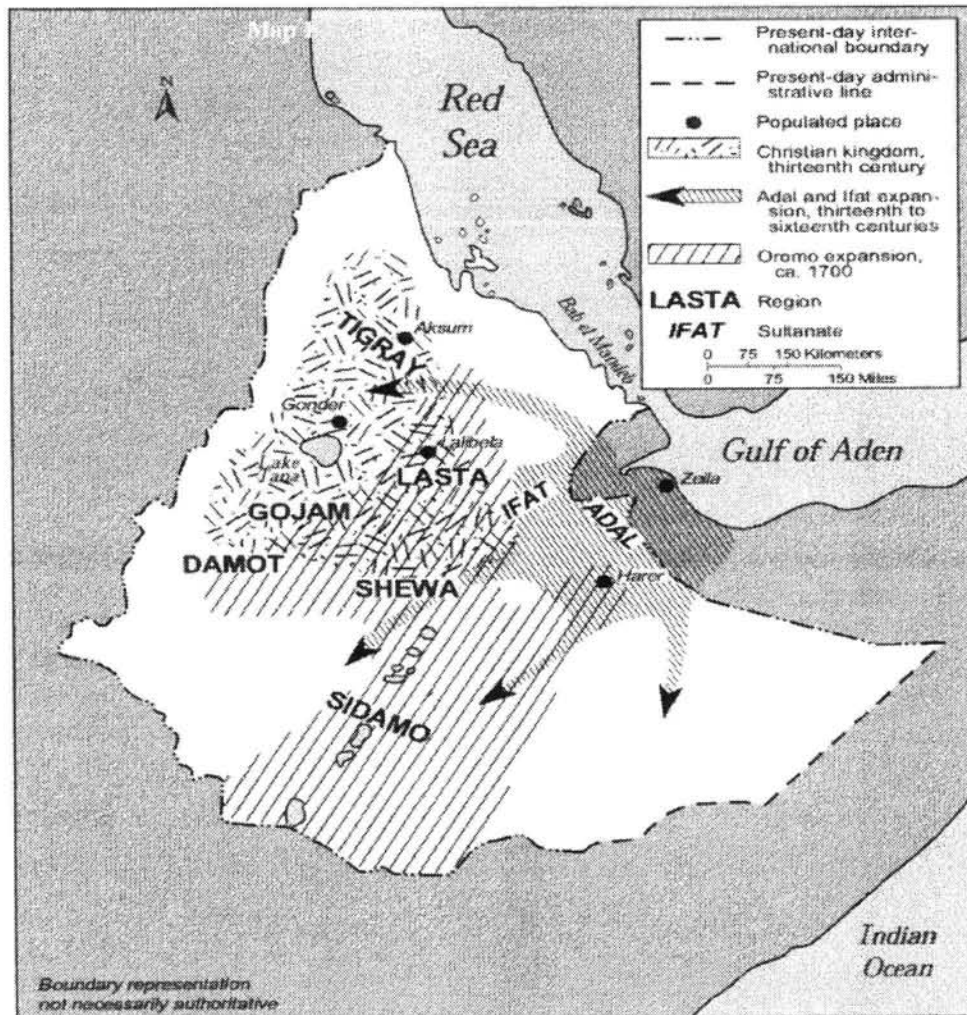
The ‘Kibre Negest’ - meaning Glory of the Kings - is a national epic written in the fourteenth century which linked or twinned formally the Ethiopian state with the Christian Orthodox church. Prior to that since the fourth century until 1974, when according to legend the last of 225th of Solomonic Dynasty, Emperor Haile Selassie, was overthrown, the relationship between church and state was like “shield and sword”.

Approximately 45% of Ethiopians are Orthodox Christians, 35% are Sunni Muslims, and the rest are of other religions including Catholics, Ethiopian Evangelists, and the Jewish Falasha people (Ethiopian Embassy 2001).

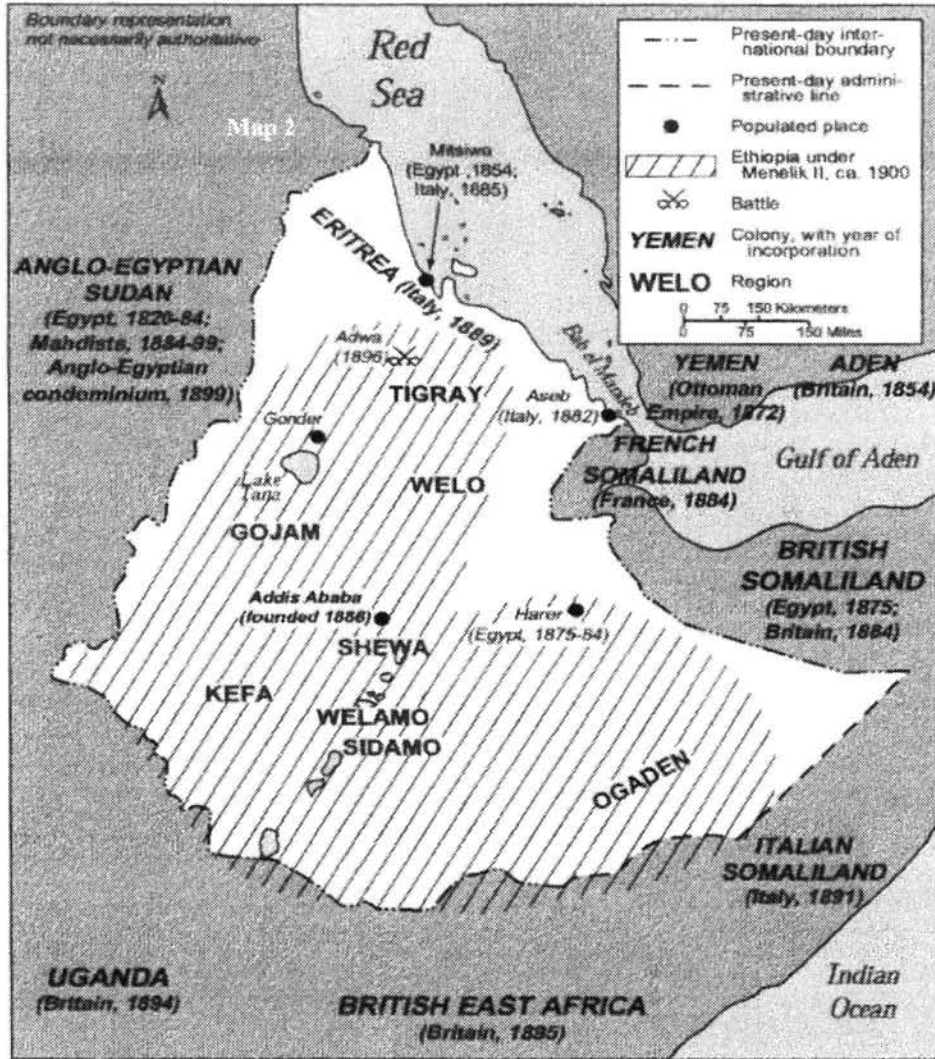
History

There are five distinct versions of Ethiopia's history:

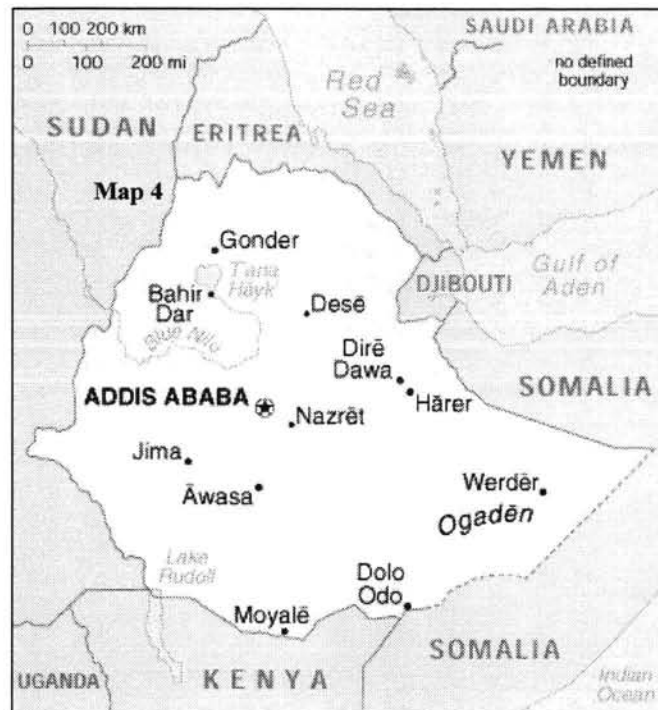
1. The first is what may be described as "Ethiopia as the cradle of human beings "
2. The second is Ethiopia's emergence as an independent state (Map 1)



3. The third is Ethiopia's boundaries in the aftermath of the European scramble for Africa (Map 2).



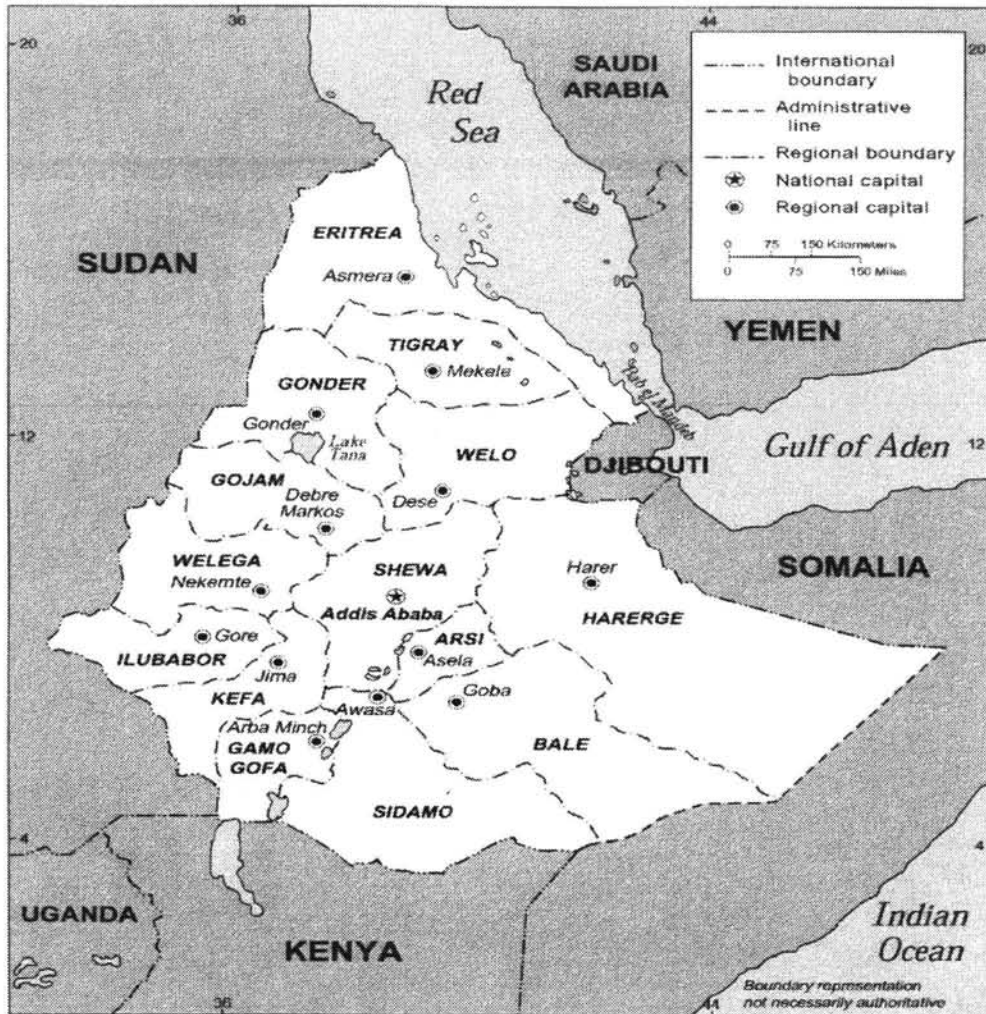
5. The fifth is the shrinking of Ethiopia after Eritrea's secession from Ethiopia (Map 4).



Ethiopia is the birthplace of humankind. Archeological studies in the late 1960s and 1970s claimed that Ethiopia is the origin of Homo sapiens. The name of the female human remains found in Ethiopia is called “*Dinqenesh*” (literally How Wonderful You Are or the marvelous one!). Dinqenesh has been known to the West by the Beatles song “*Lucy*”. The discovery of Lucy on the basis of scattered remains was in Hadar, Afarland in Eastern Ethiopia on November 30, 1974 (Johanson and Maitland, 1981). Her scientific name is “*Australopithecus Afarensis*.” As the oldest human ancestor Dinqenesh was reported to be as old as 3.5 million years. “*The problem is that Dinqenesh did not have an Ethiopian passport*” (Tibebu, 1995: p.xii). “*In the Omo valley in the South West, too, human fossils dating from one to two and half million years ago have been found*” (Zwede, 1991:7).

The second version of Ethiopian history is related to the myth of origin which dates back to 3000 years. This is related to the story enshrined in the country's mythology

4. The fourth is the enlargement of Ethiopia with the inclusion of Eritrea (Map 3).



in the form of the “*Kibre Negest*,” (Glory of the Kings), where the first king of kings of Ethiopia, “*Menelik the First*” was issued from a visiting Queen of Sheba and the wise king of Israel, Solomon. This visit was supposed to have taken place in the tenth century BC -hence the confirmation of Ethiopia’s reputedly 3000 years of age.

In some cases this 3000 years has been doubled into 6000 years with the association of prehistoric culture with the domestication of plants and animals. Historians are studying the states in the Ethiopian region associated with the development of sedentary agriculture which existed before the mythology of the Solomon - Sheba encounter which connected Ethiopia to the house of Israel and provided legitimisation to imperial rule.

The third form of Ethiopia is related to the emergence of Ethiopia after the victory of Adwa over Italy in 1896 and the subsequent expansion of the Ethiopian Empire to the south under Menelik II. (see Map 2)

The fourth form of Ethiopia is related to the territorial extension (not to be confused with expansion) of Ethiopia to the north by the federation of Eritrea in 1952.

The fifth form of Ethiopia is related to the territorial contraction of Ethiopia by the secession of Eritrea (1991-93).

There are other periodisations of Ethiopia’s history specially related to making sense of its much-contested modern history. During the 18th century reign of the era of the princes, parcellised authority suppressed central authority. Ethiopia was virtually decomposed into autonomous regions where the “*King of Kings*” was rendered more as a puppet. The era of the princes was challenged by a fiery and highly visionary Emperor called Tewdros. The latter hoped to do what Garibaldi did to Italy or Bismarck to Germany, but unfortunately Tewdros failed, unable to withstand the internal and external forces he wished to control, to carry out his visionary reforms. His coronation as emperor in 1855 is said to mark modern Ethiopia. Phase I of modern Ethiopia, lasted from the emperor’s coronation to the Battle of Adwa (1855-1896). Phase II extended from the Battle of Adwa to the Italian occupation (1896-

1936). Phase III lasted from 1936 to 1974, when the imperial system was overthrown in 1974. Phase IV lasted from the ascendancy of the military to the emergence of a regime which made ethnicity, the ethical, moral, political and intellectual foundation of governing Ethiopia. The social arrangement has been constitutionally anchored in dividing Ethiopia as vernacular - political spaces with fractured sovereignties and identities.

Politics

In 1974 Emperor Haile Selassie was deposed in a military coup led by radical elements in the armed forces, who established a military Stalinist system of government. The latter was overthrown in 1991 by the Ethiopian Peoples' Revolutionary Democratic Front (EPRDF), a coalition party comprising the Tigray Peoples' Liberation Front (TPLF), the Ethiopian Peoples' Democratic Movement (EPDM) and the Oromo Peoples' Democratic Organization (OPDO). The new government established a "*federation of ethnic-regional states*" called The Federal Democratic Republic of Ethiopia.

Under the monarchy, power derived from providence and the ideology stated that fear of god is the beginning of wisdom; the politics was based on the alliance of two pillar institutions - the monarchy and the orthodox church- whilst the economic system was based on feudal social relations. The society was on the snail's pace of modernisation committed as it were to preserving the feudal traditions.

The military Stalinist system changed all that in one fell swoop. Power was recognised to come from people and not providence. Church and state were formally declared separate. Fear of God was replaced formally by submission to Soviet style dogmatic Marxism-Leninist ideology. Politics was based on the alliance between Ethiopian soldiers and the Soviet leadership. Land was declared to be the state property of all the people. Society fell into drastic change and all opposition was dealt with a crude and simple response: violence!

When political power fell into the hands of the Tigrean Peoples Liberation Front (TPLF) in 1991, the TPLF imposed a new ideology/dogma which most academic commentators have designated as ethnic federalism. The Ethiopian people, nation and country lost their composite configuration and were fractured into the metaphysics of "*nations, nationalities and people*" without any care or bother to describe this new recasting and social re-engineering from any credible empirical consideration and reality. The group right of nations, nationalities and peoples was declared primary and the individual right of the Ethiopian citizen is either secondary or insubstantial. The group rather than the individual, identity rather than the citizen provided the TPLF the principle for conceptualising and organising its taxonomy of the population. The right to self-determination including to secession which was inscribed in the constitution (article 39, FDRE) became the principle from which the principal policies for the government of the country was built (Tibebu, 1995). A double process occurred at the same time: the ethnicisation of the political culture and the politicisation of ethnic identity as the primary vehicle for claims and entitlements to economic resources and political power. The civic basis for politics was displaced by the legalisation of ethnic ideology, the creation of ethnic based political organisations, the creation of ethnic-designated regional states and the division of the country's territory along ethnic lines. This new social arrangement is called ethnic federalism. Ethnic federalism was promulgated into a fundamental constitutional law above and beyond any customary law in 1995. Ethnic-federalism has been elevated as the centrepiece and organising principle of Ethiopian society, its economy, politics and culture.

Nine Member States of the Federal Democratic Republic of Ethiopia were created. These are: the State of Tigray; the State of Afar; the State of Amhara; the State of Oromia; the State of Benshangul/Gumuz; the State of Southern Nations, Nationalities and Peoples; the State of the Gambella Peoples; the State of the Harari Peoples; and the Somali National Regional State.

So far the ethnic federal arrangement has not produced any tangible results. Public life has been poisoned by in-group amity and out-group enmity, 'them and us' or 'the self' and 'the other'. And there has been the erosion of social capital by the prevalence and divisive and dividing logic of elite politicisation of ethnic difference (Muchie 1999).

Poverty and violence, war and famine continue to stalk Ethiopia. In 1999 the Centre for Reassert Development (CDR) in Copenhagen, reported that 8 million people were under threat of famine.

Refugeedom

In Ethiopia, a predominantly rural society, the life of peasants is rooted in the land, from which they eke out a meager existence. Through the ages, they have faced frequent natural disasters, armed conflict, and political repression, and in the process they have suffered hunger, societal disruption, and death.

A drought that began in 1969 continued as dry weather brought disaster to the Sahel and swept eastward through the Horn of Africa. By 1973 the attendant famine had threatened the lives of hundreds of thousands of Ethiopian nomads, who had to leave their home grounds and struggle into Somalia, Djibouti, Kenya, and Sudan, seeking relief from starvation. By the end of 1973, famine had claimed the lives of about 300,000 peasants of Tigray and Welo, and thousands more had sought relief in Ethiopian towns and villages.

After assuming power in 1974, the military regime embarked on a program to improve the condition of peasants, but famine and hunger continued despite this effort, which was supplemented by substantial foreign assistance. Moreover, the escalation of the military campaign against the insurgent movements in Eritrea, Tigray, and the Ogaden forced thousands of Ethiopians to flee into neighbouring countries.

The 1977-78 Ogaden War and the 1978 drought in eastern Ethiopia forced large numbers of people across the southeastern frontier into Somalia. After the defeat of Somali forces in the Ogaden, the government launched a counteroffensive against Eritrean guerrillas, and several hundred thousand Ethiopians sought refuge in Sudan. Meanwhile, in the Ogaden, international relief agencies estimated the number of refugees entering Somali refugee camps at more than 1,000 a day. Most were women

and children, and many suffered from dehydration, malnutrition, and diseases such as dysentery, malaria, and tuberculosis. There were more than 700,000 reported refugees scattered in twenty-six makeshift camps, where the absence of sanitation and inadequate medical assistance were compounding the misery created by the food shortages.

By mid-1980 most observers considered the refugee crisis in the Horn of Africa to be the world's worst. During the 1980s, the crisis intensified, as 2.5 million people in the region abandoned their homes and sought asylum in neighbouring countries. Although drought, famine, government repression, and conflict with insurgents were the principal causes of large-scale refugee migrations, other factors such as resettlement and villagisation in Ethiopia and conflicts in southern Sudan and northern Somalia also generated refugees. Sudan's war against the Sudanese People's Liberation Army (SPLA) forced many Sudanese into Ethiopia. In northern Somalia, the Somali National Movement (SNM) had been fighting Somali government forces, and in the process hundreds of thousands of Somali fled into Ethiopia.

Several factors were responsible for the refugee crisis in Ethiopia. The repressive Mengistu regime was ruthless in its treatment of both real and imagined opponents. During the so-called Red Terror of 1977-78, government security forces killed thousands of students and urban professionals. Because human rights violations characterized the government's policy toward dissidents, there was a constant exodus of young and educated people. The regime also found itself engaged in continuous civil war with one or more of the insurgent groups, which had a devastating impact on the people, the land, and the economy. The fighting not only generated hundreds of thousands of refugees but also displaced thousands of other people from their farms and villages. Forcible villagisation and resettlement also generated refugees. In Harerge alone, the forced imposition of villagisation prompted 33,000 people to flee to Somalia.

Famine also contributed to Ethiopia's refugee crises. The 1984-85 famine resulted in the death or displacement of hundreds of thousands of people within Ethiopia and

forced about 100,000 into Somalia, 10,000 into Djibouti, and more than 300,000 into Sudan.

Disagreements persist concerning the number of Ethiopian refugees in Somalia in the late 1980s. A United Nation's survey (1991) estimated the number of Ethiopian refugees in Somalia at 450,000 to 620,000.

Djibouti was home to about 45,000 Ethiopian refugees from the Ogaden by late 1978. These people had fled after Somalia's defeat in the Ogaden War. In 1983 the UNHCR began a repatriation program, which resulted in the departure of 15,000 former refugees by mid-1984. But the 1984 drought in Ethiopia brought an additional influx of 10,000 refugees into Djibouti. Slow, steady repatriation continued through 1989, by which time there were only 1,500 Ethiopian refugees in Djibouti.

A large influx of Ethiopian refugees into Sudan occurred in 1978, during the escalation of the conflict between Eritrean insurgents and the Mengistu regime. The influx continued into 1983, when the refugees numbered about 132,500. The 1984 drought and famine forced 160,000 refugees into Sudan in 1984 and more than 300,000 by April 1985.

Another important reason for the refugee exodus from Ethiopia is the failure of the Federal Government to improve its human rights practices. Serious problems remain, with some local officials and members of the security forces being responsible for human rights abuses, such as the beating of detainees and arbitrary arrests and detention. The Federal Government has difficulty in protecting constitutional rights at a local level. Local administrative, police and judicial systems remain weak in many areas. Human rights violations continue to be committed by armed opposition groups, notably in the Oromo and Somali national states.

Allegations have regularly been made that State security forces have committed human rights abuses during counter-insurgency operations, particularly in the Oromo and Somali national states. People suspected of supporting armed opposition groups have regularly been held in detention for long periods without trial.

Conclusion

The refugee exodus is associated with the recent political history of Ethiopia. The country's politics have been bedeviled by the Ethiopia's varied reading of the country's history. Those who hold the ancient view of Ethiopia's history find it difficult to even talk with Ethiopians who reduce its age to 100 years, 50 years or even as old as the tenure of the current regime can be. There is a lack of a constitutive myth or a shared understanding of the idea of Ethiopia let alone an agreement on the territorial, linguistic and other features of the country. The absence of a shared metaphysics/metanarrative embodying the concept of Ethiopia makes the country to be one of those condemned by history to ooze, leak and impel populations to migrate. With war, famine and lack of predictable transition of political power and lack of the rule of law, Ethiopia as a country has become a refugee generating country. At the heart of its continued dilemma is the problem of a shared conception of who Ethiopians are. What geographical area should they inhabit? What do they wish to become and can realistically become? It is the lack of such a shared conception of Ethiopia as an idea, entity, country, nation, people, history, name, age, flag, currency and symbolic representation- that has proved an intractable Achilles heel undoing the best laid plans, any ideology and any vision to make a difference.

Chapter 4

Health and Social Welfare Profile of the Federal Democratic Republic of Ethiopia

Introduction

Western medicine came to Ethiopia during the last quarter of the nineteenth century with the arrival of missionary doctors, nurses and midwives. But there was little progress on measures to cope with the acute and endemic diseases that debilitated the large segments of the population until the government established its Ministry of Public Health in 1948.

During the reign of Emperor Haile Selassie 1930 -1974, the number of modern medical facilities had increased relatively slowly, particularly in rural areas, where at least 80% of the population still did not have access to techniques or services that would improve their health. Forty six percent (46%) of the hospital beds were concentrated in Addis Ababa, Asmara, Dire Dawa and Harar (Library of Congress 2000). Most of the rural population was relying on traditional folk medicine and traditional healers.

In 1973/1974 there were 546 physicians in the country to serve a population of 42 million people, a ratio of roughly one physician per 77,000 people, one of the worst ratios in the world (Library of Congress 2000).

During the Derg regime of 1974 – 1991 the number of health professionals and health institutions increased significantly. Health services were expanding to the rural areas with a significant pace. In 1975, the regime embarked on the formulation of new health policy emphasising disease prevention and control, rural health services, and promotion of community involvement and self-reliance in health activities. The government health

policy emphasised implementation of primary health care and expanding services to the rural population.

During this period, the World Health Organisation (WHO), UNICEF and other non-governmental organisations (NGO) increased their assistance to improve the health services of the country by funding popular health programs such as the expanded program of immunisation for childhood diseases. Efforts were made to supply communities with potable water and adequate sanitation. The effort was short lived, because health workers were allocated to warfronts, conflict areas and army barracks to treat the army and militia and some health units were providing services to the army.

The government policy of implementing primary health care strategy to reach the bulk of the population was badly affected by the popular uprising against the regime. Towards the end of the regime, many health institutions were closed or were not providing effective health services because of the civil war, campaigns that involved many health workers, and massive resettlement schemes which drained the remaining health workers. The Derg regime saw devastating famine, epidemics of cholera, diarrhoeal diseases and measles that claimed the lives of many children and adults.

The present government which came to power in 1991, inherited a much weakened health service system, because of the damages done to the health units, such as looting and theft, during the fighting and the resultant power vacuum.

The health policy of the present regime is to strengthen the primary health care approach in order to improve the health services of the country. The country is prone to drought and famine which causes havoc to people's health and to the economy. Ethiopia is also facing a devastating HIV/AIDS epidemic. This is causing many deaths amongst the reproductive age group and leaving many children orphans.

The other challenge to the health services of the country is its inability to retain health professionals. Even though, there is a significant increase in the number of health units, staff retention and inadequate medical supplies are affecting the health services.

Ethiopia's current main health problems are communicable diseases caused by poor sanitation and malnutrition and exacerbated by the shortage of trained human resources and health facilities. The leading causes of adult morbidity are dysentery and gastrointestinal infections, malaria, parasitic worms, skin and eye diseases, rheumatism, malnutrition, fevers, upper respiratory infections, and tuberculosis. The leading causes of morbidity in children under the age of five are upper respiratory tract infections, diarrhoea, eye infections including trachoma, skin infections, malnutrition, and fevers. It is estimated that nearly 60% of childhood morbidity is preventable (USAID Ethiopia Profile, 1995).

Table 4.1: Demographic and Epidemiological Data of Ethiopia

| | 1984/5 | 1990/3 | 2000 | Source |
|--|-----------------------------|-----------------------------|-------------------------------------|--------------------|
| Population estimates | 42,000,000 (EC 1984) | 51,700,000 (LoC 2000) | 70, 340, 000 (BUC9401) | |
| Birth rate | | 45 per 1000 | | |
| Death rate | | 15 per 1000 | | |
| Infant mortality rate | 139 per 1000 live births | 116 per 1000 live births | 101.29 per 1,000 live births * | |
| Maternal mortality | | | 7-10 deaths / 1000 live births * | |
| Life expectancy (Male) | | 48 years | 44.41 years * | |
| Life expectancy (Female) | | | 45. 94 years * | |
| Life expectancy at birth (Total population) | | | 45.17 years * | |
| Total fertility rate | | | 7.07 children born / woman * | |
| Population growth rate | | 3.0% per annum * CSA | 2.8% per annum * - IDA | |
| BCG vaccination | | 46% | | WHE9403 |
| Measles vaccination | 6% | 28% | | WHE8801 WHE9403 |
| Tetanus Toxoid (TT2) Vaccination | 4% | 13% | | WHE8801 WHE9403 |
| Polio vaccination | 6% | 28% | | WHE9403 |
| ORS Access | 22% | 50% | | WHD8500 WHD9401 |
| Access to potable water (Rural) | 9% | 19% | | WHO9101 |
| Access to potable water (Urban) | 60% | 91% | | WHO9101 |
| Access to Adequate sanitation (Rural) | | 7% | | WHO9101 JMP9301 |
| Access to Adequate sanitation (Urban) | 96% | 76% | | WHO9101 JMP9301 |

Key:

* Estimated figure

EC – Ethiopian Census

LoC – Library of Congress

CSA – Central Statistical Authority

IDA – International Development Association

BUC - United Bureau of the Census

WHE - WHO Expanded Program on Immunisation

JMP - WHO/ UNICEF Joint Monitoring Program

(Water and Sanitation)

ORS – Oral Rehydration Salts

Social structures, the family and the role of women

As discussed in Chapter 3 (The Ethnohistory of Ethiopia) the current social arrangement is called ethnic federalism. This is based on the creation of ethnically designated regional states and the division of the country's territory along ethnic lines.

The Constitution of the Federal Democratic Republic of Ethiopia was finally ratified by the elected Constituent Assembly on 8th December 1994. The Constitution formed a Federal Democratic Republic of nine federal states. This was a break from the centralised form of government that existed previously in Ethiopia. Each state is said to enjoy power of governance including fiscal power.

The devolution and decentralisation of power from central government to the federal state governments goes even further as they have devolved some responsibilities to '*woredas*' that have elected councils to serve 100,000 people. Each '*woreda*' receives a budget from the regional state based on the population of the '*woreda*', the capacity of the '*woreda*' to generate income through collection of taxes, and its level of development. It is the communities who discuss and decide on development priorities through the '*kebele*' associations.

The basis of class formation and social stratification during the imperial rule was people's landholdings. Most landlords were Christians whereas most landless peasants were non-Christians. It is also significant to state that in the last 60 years, education also played an important role in the social order of the Ethiopian society. Educated people formed a small middle class group independent of land ownership. The dissolution of the imperial system and the nationalisation of urban and rural land did not result in a less stratified society. The hierarchy based on landholdings was replaced by one based on political power and influence.

Language and religion are also important factors which influence the Ethiopian societal structure and its social relations. During the imperial rule the Christian identity of

Ethiopia was nurtured although not imposed on the other religious groups. However, most high-ranking government and military positions were held by Christians. The current regime and constitution guarantees freedom of religion and all religions have equal status. In terms of language, Amharic, the official language of the imperial system, remains the official language of the current government although five other languages (Oromo, Tigrinya, Welamo, Afar, and Somali) have been approved for use in schools and radio broadcasts.

Ethiopia has a high birth rate due to early marriage and religious beliefs that generally encourage large families. Further, the absence of family planning services for most of the population, and the belief that large families have a greater financial security and are better situated to provide for their elderly members, contribute to a high birth rate. As a result of low life expectancy for both men and women remains (around 45 years), Ethiopia's population is fairly young with children under the age of fifteen making up to 50% of the population (figures for 1989, Library of Congress 2000).

The Ethiopian woman's worth, as in many other developing countries, is measured in terms of her role as a mother and wife. Over 85% of Ethiopian women live in the rural areas, where they marry very young. Apart from bearing lots of children, they work in the fields, grind the corn, cook and raise their families. They are subordinate to men, and even those women who live and work in urban areas, earn less than the men despite the proclamation of equal pay for equal work. In 1986, only 39% of women, most of whom lived in urban areas, had undertaken primary and secondary education.

The growing involvement of women in the democratisation process has been significant. Women participated fully in the struggle and, as a result, achieved greater respect and recognition in society and developed greater confidence in themselves as agents of change in the democratisation process. The democratisation process during the 1991 war also saw a transition in the attitudes of society towards women. Negative attitudes to women are being consistently challenged for the first time.

Implications for the British health care system

The number of Ethiopians seeking refuge in other countries increased dramatically during the Derg regime of 1974–1991. Under the new regime (1991 onwards) the number of Ethiopians leaving their country has not decreased. Although reliable figures do not exist, it is estimated that there are around 25,000 Ethiopian refugees living in the UK today. The majority of the refugees are young single men and women.

It is important to note that Ethiopian refugees come from a country with poor health services and unknown social services. It is also important to remember that the majority of them come from extended families, where they supported one another. Many of the Ethiopian refugees living in the UK may be isolated and would almost certainly not enjoy the benefits of the social support provided by their families and friends in their home country. It is now accepted by the UK government that such social isolation, social exclusion, poor housing conditions and poverty which most of the refugees experience, have negative effects on their physical and mental health.

Chapter 5

Cultural and Self-care Health Beliefs and Practices in Ethiopia

Introduction

The uniqueness of any culture is revealed by its norms and customs, and by the way these are interpreted and practised by those belonging to that culture. This section presents information on a range of social and self-care practices in an attempt to provide the symbolic and practical meaning and significance which Ethiopian people attach to them.

Marriage

In Ethiopia marriage is highly valued. Marriage is seen as both an achievement and a blessing in life. For a man, it is seen as a stage of reaching manhood. Marriage puts him in a special place, and he is respected for that. This is also true for women. The community thinks that marriage provides the continuation of its people. The couple will receive assets during their marriage, which would help them in their new lives.

In Ethiopia there are many types of marriages. Some marriages are arranged, some are of Western type, and some are the result of abduction. Arranged marriages are popular in Ethiopia. The family takes the responsibility to arrange the marriage of their son or daughter. The tradition of arranged marriages is even extended to unborn children something which is practiced in Begemidir and Gojam of the Northern part of the country. In some parts of Ethiopia girls as young as 7 years of age are married. In such cases, the bride ('mushirit') lives with the family of the bridegroom ('mushira') until she is considered old enough to have a sexual relationship with her husband. Unfortunately, in many cases this rule is not observed and girls end up having genitourinary and mental health problems as a result of it. Often when this

happens the girls are abandoned and become isolated with little or no support. The abduction of girls with subsequent marriage is still practiced in Ethiopia. Forced marriage is common in the Western part of the country (Wollega) locally called 'Butii' in Orommo or 'Telefa' in Amharic. This type of marriage sometimes causes violence between the relatives of the couple and the abductor, since it was without the consent of the woman and her family.

Infertility

Infertility is a stigmatizing condition that causes distress to a husband and wife. The consequences of the stigma particularly effect women. It causes low self-esteem and denies them respect and a stable marriage. Ethiopia is a traditional country where male supremacy is extensive. Infertility among couples in rural Ethiopia is believed to be a mishap caused to the women as result of a curse by God. Some people believe it is caused by witchcraft. To overcome infertility, couples usually try their best by using holy water ('tsebel'), going to a spiritual healer 'kalitcha' (Amharic) or 'qaalluu' Oromiffa. They also seek modern treatment. Infertility is almost always thought to be the woman's fault. Sadly, many men will subsequently leave their wives.

Widows

Widows are treated fairly in all communities in Ethiopia. They receive sympathy and support from their relatives and relatives of their deceased husbands'. In some communities, if the widow has children, one of her brothers in-law will marry her. This is meant to support the children and the widow. Elders decide the marriage. The marriage takes place after a minimum of one year of bereavement. This practice was particularly common in Welo (North Central Ethiopia) among Christians and Moslems. It is also practised among Christians, in the Oromo Community. However this practice is less popular nowadays.

Homosexuality

Homosexuality is another unacceptable and stigmatizing condition in Ethiopia. It is believed that only poor and marginalised people are homosexuals. In rural Ethiopia, the word 'homosexuality' exists, but homosexuals do not! Lesbianism is also extremely rare. Since homosexuals fear persecution, rejection and ridicule, they most certainly would not admit to it in public.

Protecting small children

The Ethiopian Christians shave the hair of small children completely except for a small amount of hair around the anterior fontanel. Leaving a bit of hair on the head is believed to protect the child from evil eye called 'buda'. This is a means of diverting the attention of people from looking at the child and putting the 'buda' onto them thus causing them to become ill.

Another practice is that of children, mostly boys, wearing beads of different sizes and color and a small bell with beads for protection against evil eye/buda. This is called 'bilbila' in Oromiffa. It is believed that people are attracted to the beads/'bilbila', and will see them rather than looking at the child, thus it will be less likely to 'put the evil eye/buda' on the child.

Young people in the Western part of Ethiopia, burn small patches of skin on their hands by sticking leaves and then setting them on fire in order to protect themselves from evil eye ('buda'). As a result, small scars are left on the hands called 'tatate' (Amharic) or 'ichima' (Oromiffa). Some believe that this practice would also give strength to their hands.

Food

Food can be used as a form of medicine in Ethiopia. For example meat is believed to provide strength and to maintain health. In Humera, northern part of the country, near

the Sudanese border, many people suffer from night blindness caused by vitamin A deficiency. People eat liver to treat their sight. People who have night blindness go to slaughter houses/places early in the morning to buy fresh liver. Garlic is believed to be a panacea for various illnesses. 'Teff' (Amharic) a grassy cereal grown in Ethiopia, is believed to be important for blood formation and also believed to help heal diseases as well as wounds and abscesses.

Soup made from wheat/oats is believed to help in healing common cold, sore throat and flu symptoms. Soft diets such as porridge, soup and milk are believed to help lactating mothers in producing milk. In the Wollega region women only drink milk when they give birth. According to the culture of the region milk is meant for men and children. Salt is also used for relieving toothache and healing wounds.

For the Oromo Community in Hour Gudru in the Wollega region, solid salt 'amoolee' is believed to provide strength, to prevent illnesses, to help in the production of milk for both people and animals, and to aid people's general health.

Chocho

'Chocho' is a feeding, fitness programme for men aimed at preparing them for a hard task ahead; it is organised by peers or neighbours. It was popular among Oromos of Ethiopia about 50 years ago. The aim was to be healthy and strong, thereby to be effective and more productive in day to day work. 'Chocho' was organised once a year before harvest, when farmers were less busy. The aim of the 'chocho' was to embrace harvest, the busiest and hardest part of their task with strength and fitness. It was organised in a secluded area not far from village. The men would build a local temporary house, for sleeping, keeping their belongings and for keeping food and drinks. They build their temporary house close to a river to help them fetch water easily for cooking and bathing. Each member brings food and drink according to the resolution passed by all members. The length of stay in 'chocho' away from home is decided by the members. This could take couple of weeks to one month. Members eat, drink and do physical exercises. They stay together until the end of the 'chocho'. It is forbidden to have sex until the end of 'chocho'. Mainly they eat meat and drink home made beer. At the beginning and the end of 'chocho' elders bless members to be healthy and also wish them successful harvest.

Alcohol

The consumption of small quantities of alcohol is acceptable. However, on market days in the Wollega region, people drink a lot of alcohol, which sometimes results in chaos and loss of life because of fighting. Home made gin ('arakie'), local beer ('tella') and drink made from honey and water ('tej') are mostly consumed in rural areas. Arakie is believed to relieve abdominal discomfort and distension. In the same region even small children are encouraged to drink arakie. Poisoning as a result of arakie drinking is not uncommon.

In Ethiopia, there is no law that prohibits alcohol consumption by young people, nor do they have laws that prohibit drinking and driving.

Personal hygiene and sanitation

Standards of personal hygiene vary greatly between urban and rural population. Large sections of the population suffer health problems as a result of using impure water and due to poor sanitary conditions. In the rural areas it is often very hard to find clean water, and in some areas women walk long distances to fetch it. Water collected from rivers and unprotected springs is usually contaminated. Diarrhoeal diseases, typhoid and typhus are common in the country. Ethiopians are fond of bathing and do so whenever they have the opportunity, such as in running streams.

Ethiopians value water and they consider it as a source of life. Some worship rivers and springs and do not cut trees grown near the river or a spring as a respect to the spirit of the river. Ethiopians living in the south of the country in the lowlands near the Kenyan and Somali boarder dig deep wells and use well-water for their cattle and for themselves. These nomads use up to nine people depending on the depth of the well to bring water to the surface through a relay system. These nomads are experts in locating areas where water could be found. The rural population is not clean because of their occupations and difficulty in getting water. However, there is a considerable

amount of washing twice a year: on New Year's Day and at Epiphany. Women take perineal baths twice a day and this is a strictly observed cultural practice.

In rural areas very few people have access to adequate sanitation and as there are no latrines for use, people defecate anywhere suitable. Traditional rural housing is often unhealthy. The poor have but one room, where all the family sleeps, all the household goods are stored and their domestic animals also sleep. The reason why owners live under one roof with their animals is to keep them safe against the hyenas. The other reason is that they want to keep their animals comfortable in a relatively warm room. In addition, it is easier for them to feed animals that are malnourished or for fattening certain animals by being close to them.

Traditional self-caring methods and health related customs

Common cold

In Ethiopia people use herbs such as eucalyptus leaves to relieve nasal congestion and sore throat caused by the common cold. The leaves are boiled and the steam is inhaled. 'Dama Kassie' is a small creeping plant with a pleasant smell and popular for its medicinal effects. It is used for treating sore throats and is taken with tea.

Abdominal cramps

'Tena Adam' is short bluish plant with an attractive smell. It is popular among both the rural and urban populations. It is used for treating abdominal cramps. It is crashed and taken with tea.

Skin diseases

Skin diseases such as scabies are common in rural areas where personal hygiene is poor. In some parts of Ethiopia people wash the affected areas with the urine of a cow or use herbal leaves to bathe with.

Eye infections

Eye infections are common in Ethiopia. Trachoma is the main infection that causes blindness to many Ethiopians. Eye infections are common in childhood as a result of

poor personal hygiene. People try different ways of treating the infection. In some localities in the northern part of Ethiopia, the eyebrows are scratched to let blood run in the eye in an effort to overcome eye infection during childhood.

Head lice and fungal infections

In many areas of Ethiopia women put butter on their heads all the time for various reasons. One of the reasons is to prevent head lice and other fungal infections. In some areas they add salt to remove head lice. Butter is also used for cosmetic reasons to improve the quality of the hair and also to have a pleasant odour when used with a perfume. In some localities, it is a sign of wealth and happiness. Many Ethiopians believe that it is good for their health and wellbeing to apply butter on their head. In some communities men also put butter on their heads for cosmetic reasons.

Headache

The most common treatment for headache is the application of pressure on the head by wearing a headband to contain the pain. If this does not help a minor blood letting treatment is undertaken. The back of the head (occipital area) is shaved and scratches are made to it. This is done by anyone who can suck blood from the patient by using a device called 'wagimt' made of cow's horn. This is applied to the scratched head and blood is sucked from the patient.

Pain

Applying heat on the body usually on the chest is believed to relieve chest pain. People use a lit cotton roll which they place in a glass and then onto the chest of the patient. When the cotton is completely burnt and given enough heat, it is removed. This practice is more popular in rural areas in Ethiopian.

Rheumatism

In the Oromo community (Western Ethiopia) some women wear bracelets on their wrists ('ambarrii/bitawu') to prevent rheumatism. Women who grind corn/wheat with their hands suffer from rheumatic pain and it is believed that wearing 'ambarrii' is helpful.

Injuries and wounds

Wounds are treated by washing them in a solution of salt. Human urine is also used to wash fresh wounds with. The extract of various leaves is also applied on wounds. This is usually done in rural areas where there are scarce health services. Some people wear a ring on their third/middle toe for protection against injury.

'Mitch'

This is a condition that follows exposure to sunlight after eating spicy and oily food. When someone exposes himself to sunlight after eating oily food without washing his hands and mouth, he would develop 'mitch'. As a result the person will get swelling of the gum and lips. 'Mitch' causes fever. The other cause of 'mitch' is the collision of hot and cold air. When a person exposes parts of his body, for example his feet from warm to cold, this could cause 'mitch'. In this case the person develops itchy blisters on the areas which were uncovered.

Paralysis

Paralysis, ('shibanet'), is not uncommon in Ethiopia. Many people have been paralysed as a result of the civil war in the country. There is also childhood paralysis. Some people believe that childhood paralysis is the result of stepping on a witchcraft. Some believe that it is the result of having injections. There is also a belief that sleeping on straw of a certain cereal called 'guwaya' causes paralysis.

Uvulectomy

The removal of the uvula ('intil mequret') as a result of frequent swelling of the uvula is not uncommon in rural Ethiopia. Traditional healers believe that removing the uvula would give life long cure of many illnesses. Uvulectomy is also done as a means of preventing illness. This practice was popular in rural areas before health units expanded to these areas. The practice is decreasing as a result of the expansion of modern medicine and may also be as result of bleeding and infection which many children suffer following the procedure.

Male and Female circumcision

Circumcision is a common practice in Ethiopia. The age at which circumcision takes place varies according to the cultural and religious practices as Ethiopia has many different ethnic and religious groups. Every community has its own traditional practitioners. Male practitioners circumcise boys. Similarly, female practitioners circumcise girls. Female circumcision is not practiced in a region called Gojam. Female circumcision, called by some as female genital mutilation (FGM), is now illegal in Ethiopia, in most European countries, America, Australia etc. However, despite the law, Ethiopians continue to practice FGM, as it is a tradition strongly embedded in their culture for various reasons. However, many girls and women suffer physical and mental ill health as a result of it. Infection, bleeding, pain, incontinence, and even death may occur.

'Wurdie'

This is an Amharic word meaning latent syphilis. In Ethiopia it is believed that the latent stage of syphilis could be passed on to babies. It is believed that even if people are cured from syphilis, 'wurdie' still remains in the body. It is also believed that 'wurdie' causes death to newborn babies. The baby who is born to a woman, who has 'wurdie', needs antibiotic injections soon after birth. The mother also needs to have injections.

Gonorrhea

Even though it is becoming an old belief, men say gonorrhoea is a disease of women. There is also a belief that it is caused by urinating facing the sun or the moon. And yet there are some who say that it is caused by urinating on a hot stone.

Traditional health care givers and services

Folk healers

In Ethiopia there are many types of healers, pure secular and technical experts like bonesetters ('wogesha'), midwives, tooth extractors or herbalists, spiritual healers 'kalicha' or 'qaallu'.

Bonesetters 'wogesha'

'Wogeshas' are folk healers who are expert in treating fractures and dislocations. They also know how to make splints for immobilising the affected parts. Some bonesetters have ready-made splints/moulds for immobilising. They also have special cloths for traction. Some are very popular as a result of their expertise. They also provide health education on diet, and advise the patients regarding the care needed for the affected part.

Traditional Birth Attendants 'yelimd awalaj'

These are some of the most respected and valued members of the community. This role is exclusively devoted to women. They usually provide free services but are usually given small gifts or food products. They are found in every locality.

During the Derg regime (1971- 1991) efforts were made to retrain and integrate them in primary health care activities. Some traditional birth attendants were trained from all over the country under a WHO supported scheme. The scheme was successful in some areas but also faced challenges, as trained midwives demanded incentives for their services and many localities were not willing to pay them. The reason was that many peasant associations and communities felt that the government coerced them to pay them. As a result the scheme collapsed and the conventional way is back in place.

Tooth extractors

These are dentists in the rural community. Their job is to remove decayed or milk teeth. Canine teeth are thought to cause diarrhoea in babies and small children. Consequently many Ethiopians have their canine teeth extracted during childhood. The dentists have a locally made tooth extractor, which has a curved end. This instrument could vary from place to place.

Illegal injectors

People who give injections without training and in illegal ways are called illegal injectors. If they were found giving injections, they could be prosecuted. The government feels that they are dangerous to the health of the nation as a result of many consequences such as anaphylactic shock, the development of resistant strains of bacteria, and in transmitting HIV and other infections through dirty needles. It is

not known when these people have appeared in Ethiopia. Their practice consists mainly of giving injections of various Western medicines. They have little training usually only a brief association with a health professional. They often work as cleaners, security guards and so on in various health units/clinics. It is believed that these people emerged with the growing popularity of injections in the country and survive as a result of the communities' preference for injections over oral medications. They invariably have no knowledge about the drugs that they are injecting into the patient.

Deliverance

This is a common practice in Ethiopia. However, it appears that the practice also takes place in the UK. The Pentecostal Church is one of the churches who provide 'deliverance service'. Deliverance means to cast out demons. It also means to liberate/free. If a person is a true believer and follower of Jesus Christ, there is no need for deliverance, because s/he is not possessed by the demon/Satan. People who believe in Jesus Christ and are gifted could provide deliverance services. When deliverance services are conducted in the churches 'aganent' (Satan) leaves the person.

It is believed that those who have mental illnesses and personality disorders could also be treated. People who have committed sin could be freed by means of 'deliverance'.

'Tenquay'

Deliverance of a different kind is provided by the 'tenquay' which in Amharic means magician/witch doctor. A 'tenquay' is a person who deals with people who are believed to be possessed by demons/Satan ('aganent'). The 'tenquay' diagnoses the illness from which the patient is suffering. A 'tenquay' also prays for the person affected. He instructs his patient to do various things in order to be free from 'aganent'. For example he may advise the patient to kill a chicken, spin it over his head and put it on a road or footpath; when a person walks over it, the 'aganent' will enter him/her, thus freeing the person who consulted the 'tenquay'. In the meantime he also gives other medicine which would be smelled. The 'tenquay' also gives the patient a medicine for protection against demons or 'buda'. He writes a script on a

long piece of paper with red ink. The paper is folded into a small object, then wrapped with a piece of cloth or leather and then tied on the patient's neck. This is called 'irz' or 'tsihuf' or 'kitab'.

Weqabi

Another form of spiritual healer is the 'Weqabi' who treats a number of health problems including pregnancy, fertility, and mental illness. The solutions given by the 'Weqabi' concentrate on 'mystical' remedies and actions, and church-related cures. These include treatment with holy water 't'äbäl or tsebele' and ashes from the church 'emät'. Orthodox priests as well as other healers and curers also commonly recommend this kind of treatment. The 'Weqabi' may also recommend the use of animals to appease the spirits.

Conclusion

People continue to hold their traditional beliefs even when they no longer live in their country of origin. In fact cultural beliefs and practices continue to exist within migrant communities for at least three generations albeit in modified forms. It is therefore important for health and social care practitioners to have some cultural knowledge about Ethiopian migrants. The following points should be considered:

- Immigrants and refugees try to recreate their own 'Ethiopia' abroad as, at least in the beginning, they feel more safe and comfortable being with people who share common beliefs and traditions.
- Ethiopian herbs, foodstuffs, traditional medical devices and traditional practitioners are often to be found in the host country.
- The sole application of 'Western' rules and ways of explaining health and social problems is not always appropriate. Traditional Ethiopian ways could profitably be combined with 'Western' ways.
- Although health and social care professionals are not expected to have extensive knowledge about Ethiopian health beliefs and preferred practices, they can fill their knowledge gaps by asking the patients or their Ethiopian significant other/s in a sensitive and respectful way.

- Finally, we must try not to stereotype. The information given in this chapter may not apply to every Ethiopian. This information should be used flexibly, as a background resource that should always be validated by the patient or relative when possible.

Chapter 6

Refugees and Asylum Seekers: Legal Aspects

Introduction

Population movements of a size and complexity unprecedented since the Second World War have resulted in the displacement – mostly involuntary - from many countries of the world. Toole and Waldman (1993) reported that the number of refugees and internally displaced persons in need of protection and assistance had increased from 30 million in 1990 to more than 43 million in 1993. At the beginning of the year 2001 the number of people needing protection and assistance from the United Nations High Commission for Refugees (UNHCR) was almost 22 million. Of them, 12 million were refugees, six million were internally displaced people, almost one million were asylum seekers, almost another million were returned refugees, and another two million came under various other categories. Undoubtedly this number has increased by the end of the 2001 as a result of the aftermath of the events that took place in the United States of America on the 11th September 2001. War and civil strife have been largely responsible for this epidemic of mass migration that has affected almost every region of the world, including Europe.

This chapter seeks to identify some of the international laws and conventions pertinent to refugees and asylum seekers in general. It also outlines UK laws and Bills introduced to manage immigration and refugeedom and examines how international laws and conventions have been implemented in this country.

The Human Rights Act 1998

The Human Rights Act 1998 was incorporated into UK domestic law on 2nd October 2000 whilst securing the provisions of the European Convention on Human Rights and Fundamental Freedoms. The Human Rights Act can be directly relied upon and

enforced in the UK courts and tribunals at all levels. This means that if a human right is breached, a client will now be able to take her/his complaint to a court or tribunal in the UK, rather than have to go to the European Court of Human Rights (ECHR). When all domestic remedies have been exhausted in the UK courts, or if no domestic remedy is available, it is possible to take the case to the ECHR in Strasbourg.

Below the relevant rights expressed as articles are summarised. These are based on the Universal Declaration of Human Rights (1948), which were subsequently agreed by the Council of Europe at the Convention for the Protection of Human Rights and Fundamental Freedoms in Rome (1950); some articles are derived from the 'First Protocol' (Paris Convention 1952) and the 'Sixth Protocol' (Strasbourg Convention 1983).

a) The Convention Rights and Freedoms

Article 2: Right to life

This article states that everyone has the right to life and shall be protected by law. According to this article no one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law. However, deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force, which is no more than absolutely necessary such as:

- a) in defence of any person from unlawful violence;
- b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
- c) in action lawfully taken for the purpose of quelling a riot or insurrection

Article 3: Prohibition of torture

The article states that no one shall be subjected to torture or to inhuman or degrading treatment or punishment. According to this article very serious forms of discrimination or harassment may also constitute degrading treatment.

Article 4: Prohibition of slavery and forced labour

According to this article:

- a) no one shall be held in slavery or servitude
- b) no one shall be required to perform forced or compulsory labour

Forced labour is a punishment, which is not voluntarily accepted by the individual or victim. For example, if an immigrant worker's passport or any other document were taken away so that the worker is unable to leave her/his employment, this would constitute forced labour.

Article 5: Right to liberty and security

The article provides everyone the right to liberty and security of person. This right covers a wide range of issues related to all stages of criminal process, from arrest to appeal. It also covers the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics, drug addicts and vagrants. The article also provides that those arrested shall be informed promptly, in a language which they understand, of the reasons for their arrest and of any charges made against them.

Article 6: Rights to a fair trial

The right to a fair trial includes the right to a hearing, which is:

- a) Fair
- b) Public
- c) Heard by independent and impartial court or tribunal
- d) Heard within a reasonable time

The article refers to employment disputes, property and disputes affecting family life. Immigration, asylum and taxation disputes are outside of Article 6. The article also refers to the right to silence and freedom from self-incrimination. Breaches of Article 6 may arise, for example, in the areas of housing benefit appeals, education appeals, the placing of children in care, fostering and adoption and the settling of parental access arrangement.

Article 7: Freedom from retrospective criminal laws

This article provides that no one shall be held guilty of a criminal offence for an act, which did not constitute a criminal offence at the time it was committed. Nor should

someone be given a heavier penalty than that applicable at the time the offence was committed.

Article 8: Right to respect for private and family life

As enshrined in this article everyone has the right to respect for his private and family life, his home and his correspondence. According to this article there shall be no interference by a public authority with the exercise of this right except such as in accordance with the law and is necessary in a democratic society in the interests of national security, public safety, the economic well-being of the country, the well-being of national security the protection of health or morals, or for the protection of the rights and freedom of others.

Act 9: Freedom of thought, conscience and religion

The article provides everyone with freedom of thought, conscience and religion. This right includes freedom to change her/his religion or belief and freedom, either alone or in community with others and in public or private, to manifest her/his religion or belief, in worship, teaching, practice and observance.

Article 10: Freedom of expression

The article provides everyone with the right to freedom of expression. This article includes freedom to hold opinion and to receive and impart information and ideas. The article covers freedom of artistic expression and teaching materials and censorship. Journalistic and media expression, political expression and commercial advertising are also covered in this Article. In addition, it is relevant in the field of employment, for example, the right to have an opinion and not to be dismissed for it. The right not to conform to a dress code and the ability to speak about concerns at work are also enshrined in the article.

Article 11: Freedom of assembly and association

The article provides everyone the right to freedom of peaceful assembly and to freedom of association with others, including the right to form and to join trade unions for the protection of her/his interests. However, it does not prevent the imposition of restrictions on the exercise of these rights by members of the police, the armed forces and the civil services.

Article 12: Right to marry

This article guarantees men and women of marriageable age the right to marry and to found a family according to the national laws governing the exercise of this right. However the state can prevent marriage between transsexuals and same sex couples.

Article 14: Prohibition of discrimination

The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth of other status.

b) The First Protocol Rights and Freedoms

Article 1: Protection of property

The article provides every natural or legal person the entitlement to the peaceful enjoyment of his possessions. The article emphasises that no one would be deprived of his possession except in the public interest and subject to the conditions provided for by law and by the general principles of international law.

Article 2: Right to education

This right provides that no person should be denied the right to education and that the state should respect the right of parents to ensure that teaching is in accordance with their religious or philosophical beliefs. However, the UK Government has stated that it is only bound to by this right in so far as it is compatible with the provision of instruction and training without undue public expense.

Article 3: Right to free elections

This right provides that free elections be held by secret ballot under conditions which ensure the free expression of the opinion of the people in the choice of the legislature.

c) The Sixth Protocol Rights and Freedoms

Article 1: Abolition of the death penalty

No one shall be condemned to such penalty or executed.

Article 2: Death penalty in time of war

The State may make such provision in its law.

Absolute, qualified and limited rights

The Human Rights Act 1998 distinguishes between absolute rights which cannot be restricted in any way, qualified rights which have to strike a balance between individual rights and the general public interest and national security, and limited rights which means that they can be restricted in circumstances specified in the Act for example, during the national emergencies.

The Absolute Rights are:

- a) Convention Article 2: Right to life
- b) Convention Article 3: Prohibition of torture and inhuman and degrading treatment
- c) Convention Article 4: Prohibition of slavery and forced labour
- d) Convention Article 7: Freedom from retrospective criminal laws
- e) Convention Article 12: The right to marry

The Qualified Rights are:

- a) Convention Article 8: The right to respect for private and family life
- b) Convention Article 9: Freedom of thought, conscience and religion
- c) Convention Article 10: Freedom of expression
- d) Convention Article 11: Freedom of assembly and association
- e) Protocol 1, Article 1: The right to peaceful enjoyment of property
- f) Protocol 1, Article 2: The right to education

The Limited Rights are:

- a) Convention Article 5: The right to liberty and security
- b) Convention Article 6: The right to fair trial
- c) Protocol 6, Article 1: The abolition of the death penalty

Asylum in the UK

The Immigration and Asylum Act 1999 removed the rights of asylum seekers to access main stream welfare benefits, public housing and some forms of local authority assistance such as services to meet a need that 'arises solely out of destitution or the effects of destitution'. The new Act commits the Government to deliver a fairer, faster and firmer immigration asylum system. As from April 2001 the Government aims to deliver most initial asylum decisions within two months and most appeals within a further four months.

The main features of the asylum system are:

- a) All claims receive a fair hearing
- b) Fast track process mean that some claims (and subsequent appeals) are dealt with in about four weeks. Claimants may be detained for all or part of that time;
- c) All claimants have a responsibility to co-operate with the authorities considering their claim. They must,
 - Tell the truth about their circumstances;
 - Obey the law. It is a criminal offence to submit a claim involving deception, the maximum penalty for which is two years imprisonment;
 - Keep in regular contact with the authorities considering their claim;
 - Leave the country if their claim is ultimately rejected.
- d) Support is provided to those asylum seekers who are destitute. Accommodation is provided on a "no choice" basis in parts of the UK where there is less pressure on accommodation than in London and other parts of the South East. Asylum seekers are given vouchers for food and other goods, and £10 cash per week. The dispersal system and provision of vouchers is organised by National Asylum Support Service (NASS).
- e) Some claimants are removed to another EU Member States in order to pursue their claim there, if that member state is responsible for the claim under the terms of the Dublin Convention. Some other claimants are removed in order to pursue their claim in a safe country outside the European Union.

- f) Asylum seekers can appeal against refusal of their application or against the granting of exceptional leave to remain rather than refugee status. There is now a single “one stop” right for appeal.
- g) The Government is also introducing a scheme to regulate immigration advisers to prevent asylum seekers being exploited by unscrupulous or incompetent advisers.
- h) Those who are unsuccessful on appeal will be required to leave the UK. If necessary they will be removed.
- i) Those who are recognised as refugees will be granted immediate settlement in the UK and will be helped to build a new life.

Who is an asylum seeker?

An asylum seeker is a person who has applied to the Immigration and Nationality Directorate to be recognised as a refugee but who has not yet received a decision, or is in the process of appealing against an initial rejection of her/his claim for asylum.

Who is a refugee?

A refugee is someone who has fled, or who is unable to return, to her/his country because of her/his fear of persecution. The UK has a responsibility to refugees because it has signed the 1951 United Nations Convention and the 1967 Protocol on refugees. The Convention says a refugee is someone who, *‘owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is unable, or, owing to such fear, is unwilling to return to the country of her/his nationality or former habitual residence’*.

Claiming asylum

To be accepted as a refugee in the UK one must first apply for asylum. The Home Office will make a decision on the asylum application. While a person is waiting for a decision s/he is called an asylum seeker.

There are two ways to apply for asylum:

- a) To the immigration officer on arriving at the port of entry (the airport, seaport or at Waterloo train station if coming through the Channel Tunnel).
- b) Applying to the Home Office after entering country as a student, illegal entrant or visitor.

People that applied for asylum at the port of entry are called 'port applicants'. Those who apply for asylum to the Home Office after entering the country are called 'in-country applicants'.

The asylum interview

When one applies for asylum s/he will normally be interviewed about the details of the claims. During the interview the person is expected to provide all the information that could be relevant to her/his claim.

The Home Office must provide an interpreter if there is a need for one. Those under 18 years and alone in the UK should not be interviewed without an adult representative present.

Port application

This is where someone applies for asylum as soon as s/he arrives at the airport (including airports and Waterloo station). A short interview will be given to establish the identity and the way the person travelled to the UK. The person may be allowed to enter the country on temporary admission, or may be detained. If the person was allowed to enter the country on temporary admission he will then have another interview or be given a Statement of Evidence Form (SEF) to complete and this will be used to make a decision about her/his application. The application of the person will then be forwarded to the Asylum Group in the Home Office. S/he will be given a standard acknowledgement letter (SAL1 for port applicants) which is proof that s/he has applied for asylum and a proof of her/his identity.

In-country application

Any other asylum applications are made either in person or in writing to the Immigration and Nationality Directorate at the Home Office.

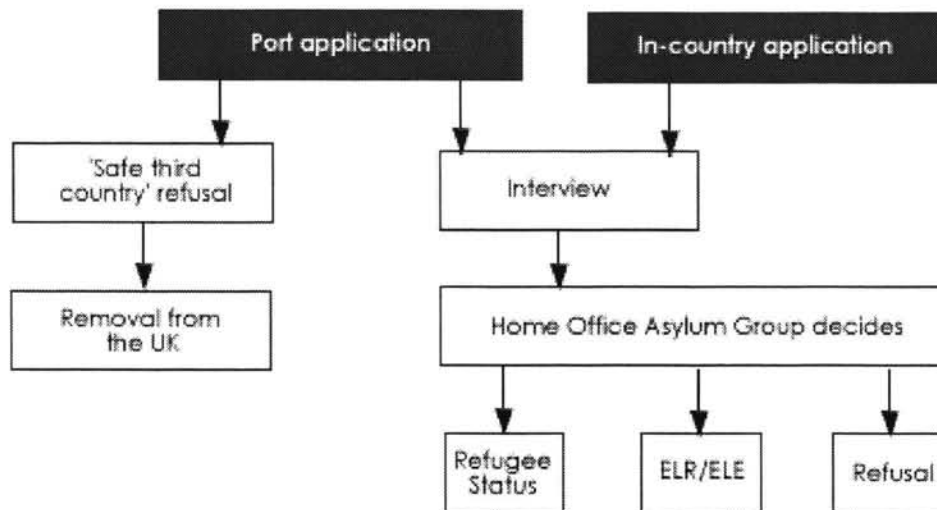
Legal advice

The asylum process is very complicated. It is important that someone explains the rules for asylum applications to the asylum seekers. The asylum seeker should also ask a legal representative or a solicitor to help her/him to fill the SEF.

Detention

Asylum seekers may be held in immigration detention centres or even prisons while their claims considered by the Home Office. Home Office policy states that they do not detain people under 18 years old but if this happens, the person needs to prove her/his age.

Fig. 6.1: The asylum application process



Decision on an asylum application

When the Home Office makes a decision about an application it may:

- a) Grant a refugee status;
- b) Refuse refugee status but grant exceptional leave to remain (ELR) or exceptional leave to enter (ELE);
- c) Refuse application completely

Asylum seekers, who are granted refugee status, are also granted indefinite leave to remain (ILR) (settlement) at the same time. This means that there is no time limit on stay in the UK. People who are granted refugee status can look for work and can apply for benefits if they need to; and they have a right to family reunion and a UN Convention travel document.

Exceptional leave to remain (ELR)

The Home Office grants ELR or exceptional leave to enter (ELE) if it thinks that, although someone is not a refugee, it is not safe for her/him to return home. People granted ELR/ELE are usually allowed stay of four years, at the end of which they can apply for indefinite leave to remain (ILR). With ELR/ELE someone can look for work and also can apply for benefits.

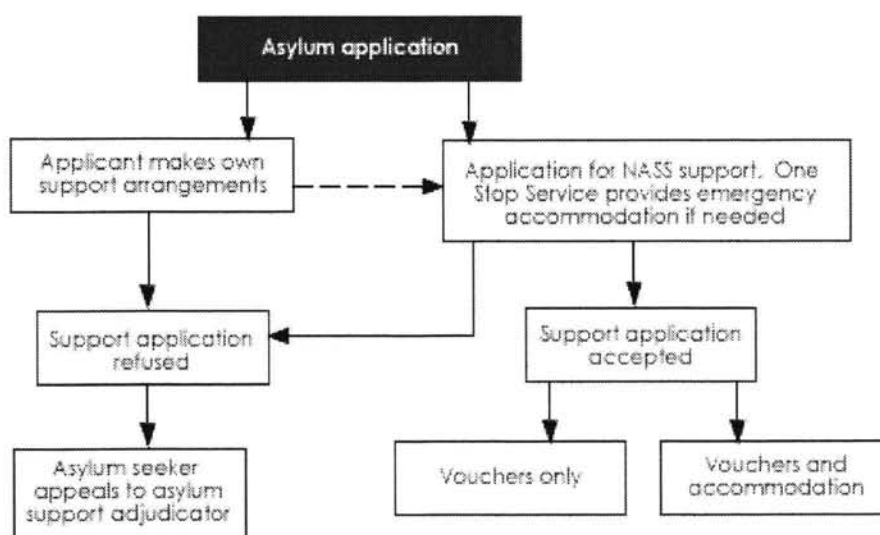
Appeals

It is possible to appeal against the decision of the Home Office if some one is not satisfied with the decision. It is important that the person who is seeking appeal gets a legal consultation.

Getting support/National Asylum Support Service (NASS)

An asylum seeker can apply for NASS if they are destitute, for accommodation and/or means to buy food.

Fig. 6.2: NASS support arrangements



The support package

If an asylum seeker qualifies for accommodation and vouchers s/he should be given details of where s/he is likely to live within seven days. The asylum seeker could be

given accommodation anywhere in the UK and cannot appeal against the location of his/ her accommodation.

Services for people with disabilities

An asylum seeker who has a disability or looks after someone with disability, is entitled to an assessment of need from the local authority under community care legislation.

Payment for clothes

If the asylum claim takes longer than six months to decide, a person is entitled to a £50 payment for clothes and other items that need replacing. In this case the asylum seeker needs to apply to NASS.

Travel to asylum and appeal interviews

An asylum seeker may have to travel to London for the asylum interview with the Home Office. If s/he is getting help from social services, his/her travel expenses will be paid by them. Asylum seekers who are supported by NASS will have their travel expenses covered by NASS.

Unaccompanied children

Unaccompanied children (under 18s) are the responsibility of their local social services departments under the Children Act 1989 or the Children (Scotland) Act 1995.

'One Stop' services

The One Stop service will tell asylum seekers about services in the area s/he lives, such as health and education and will help him/her to use them if necessary.

Healthcare

Asylum seekers are entitled to free treatment under the National Health Service (NHS) and can register with local GPs and also could access hospital and accident and emergency services. An asylum seeker will be able to receive medicines and other services free but only with an HC2 exemption certificate. With the exemption certificate s/he will be able to get:

- a) Free NHS prescription;
- b) Free NHS dental treatment;
- c) Free eye tests and vouchers for NHS glasses;
- d) Fares to hospital for NHS treatment.

Education for children

Children of asylum seekers must be treated the same as any other children. They cannot be discriminated against on the grounds of ethnic or national origin. If a child has to wait for more than six weeks to find school place, this could be discriminatory.

Types of schools

In the UK, children are admitted to a particular class in school according to their age. It is forbidden for a child to be in a class with children who are at a different age, even if a child has previously missed a lot of school.

Education for 16 - 19 year olds

At 16 years, education is no more compulsory. Different colleges have different policies about fees for asylum seeking young people. Some sixth form colleges and further education colleges allow 16 – 19 asylum seekers to study free, although they may have to pay a very small fee to register.

Adult Education

There are many courses available to asylum seekers who want to learn English or a new skill, or get further and higher qualification. There are many different types of English courses for refugees. The most suitable introductory English courses for refugees are called ESOL classes (English for Speakers of Other Languages) which are usually free of charge.

Higher Education (HE)

Universities and other higher education institutions offer courses leading to degrees, diplomas and other advanced qualifications and could be full-time and part-time. Further Education (FE) and HE courses have two rates: 'home student fees' and the higher 'overseas student fees'. Home fees would only be available at the discretion of the college or university. An asylum seeker will not be able to receive loans and

grants from the student support system to pay for part-time or full-time higher education course.

Permission to work

An asylum seeker is not allowed to work unless granted ELR or ILR.

Travelling abroad

It is unlikely that the Home Office will issue an asylum seeker, waiting for the decision on his/her asylum application and who wishes to travel, with a travel document, other than a one-way document to allow him/her to leave the country.

The implications of Immigration and Asylum Bill

The Immigration and Asylum Bill of 1999 has been criticised by a number of organisations dealing with asylum seekers as well as by many statutory service providers. The Refugee Council in its response to the new Bill provided a comprehensive analysis of the implications of the new Bill and made a number of recommendations. Notwithstanding its support to the more simplified and faster decision making system, and the proposed regulation of the provision of immigration advice, it expresses its grave concerns about the government's massive experiment in social engineering with its huge new bureaucracy needed to move asylum seekers around the country and to provide for their needs. The Refugee Council stated that it remained convinced that allowing asylum seekers access to welfare benefits is the most humanitarian, efficient and cheapest way of providing support to them. They opposed the introduction of vouchers, and the dispersal of asylum seekers to areas where there is no community support, legal representation or existing ethnic minority population. They are particularly concerned about the Bill's measures which are targeted at families with children and the disabled. In their view these will damage children's welfare and development and consequently will breach the UN Convention on the rights of the child. The Refugee Council (2000) expressed its concern about the new power for immigration officers, the changes to immigration control, and the detention of asylum seekers, and concluded that this legislation will further marginalise an already dispossessed population, punishing all asylum seekers by restricting their access to services in an attempt to deter economic migrants.

One of the Health Authorities, which made its opposition to the Bill public, was the Enfield and Haringey Health Authority (2000) (now Barnet, Enfield and Haringey HA). In a report on the health implications of the new Bill, it stated that there are between 25,000 to 30,000 refugees and asylum seekers living in Enfield and Haringey. Despite the fact that they are all entitled to NHS treatment and care, the report refers to anecdotal evidence that their needs are not adequately met in Enfield and Haringey. In particular, accessing primary health care is often a major hurdle for asylum seekers. Adequate language support to use health services effectively is another problem. There are also concerns about cultural awareness of health care staff, about delays in referrals to secondary services, and about the lack of culturally appropriate counselling services. The report also states that refugees and asylum seekers are among the most disadvantaged members of UK society. The report concludes with the following predictions, which were arrived at following their analysis of the new Bill:

- a) Increased number of asylum seekers/refugees who are destitute, and receiving minimal support;
- b) Reduced morale of asylum seekers through making them dependent on support in kind, e.g. vouchers to obtain food, which would 'mark' them out in the local community and increase the risk of encountering prejudice;
- c) Separation of asylum seekers from established communities resulting in social isolation and lack of cultural support;
- d) Separation of asylum seekers from statutory organisations with expertise in dealing with the health and other problems that they face;
- e) Separation of asylum seekers from healthcare workers with at least some cultural awareness and language support structures.

The Terrence Higgins Trust and the National Aids Trust in their submission to the Special Standing Committee (March 1999) explained that within London there are HIV services for most specific affected country and regional groupings, and also a wide range of culturally-appropriate services such as counselling, advocacy, health education, self and family support and treatment information and interpreting services with experience of HIV information and terminology. They also spelled out

that none of these services exist outside London, with the exception of a handful of general health promotion groups in three to four other major areas. Therefore the dispersal policy of the new Bill will create enormous problems both to HIV/AIDS affected refugees and asylum seekers, and to health service providers both in the statutory and voluntary sectors.

Conclusion

In its attempt to discourage bogus claimants, the proposals in this bill put the physical health, mental health, and sometimes lives of genuine refugees in jeopardy. The policy of support in kind dehumanises an already persecuted and traumatised group. The policy of dispersal is a solution to a number of problems, but fails to solve the humanitarian problem which refugees pose to this country. The health consequences of the proposals in this new Bill are potentially profound for this vulnerable and disadvantaged group.

In October 2001 the government responded to criticisms about the humiliating nature of the food voucher system and announced that this will be phased out by the autumn of 2002. Other changes include the establishment of new reception centres around the country where food will be provided, and the provision of pocket money.

Chapter 7

Representation of Ethiopian Refugees and Asylum Seekers in the Media

Introduction: Refugees and the Media

There is no doubt that the media play a significant role in informing the public about events, trends, governmental policy, news and so on. There is also a consensus regarding the impact that media plays on influencing and forming the public's attitudes. Chomsky (1993) stated those who control the media can present to the public a picture that has only the remotest relation to reality. The truth of the matter is buried under edifice after edifice of lies. Chomsky (1993) went on to say that many governments have a public relations industry, which is committed to controlling the public mind in favour of them through the media. Propaganda is to democratic governments what the bludgeon is to totalitarian states.

However, it is fair to say that the media can and does also promote positive attitudes, and can and does play a role in improving the lives of the community or country. Despite Chomsky's pronouncements which enjoy extensive support, in the UK, at least in theory, the media is independent of direct government control. Some papers carry many unfounded stories and are very xenophobic. In 1999 the UK Audit Commission conducted a survey of 161 local newspaper articles collated by the Refugee Council and found only 6 per cent of the stories had cited any positive contribution made by refugees and asylum-seekers. On the other hand 28 per cent of the stories focused on housing or employment difficulties of asylum-seekers and 15 per cent concerned crimes and offences committed by asylum-seekers (cited by Fekete, 2001).

The Campaign Against Racism and Fascism (CARF, April/May 2000) stated that people of the host country would naturally feel concerned when new people arrive in their country. However, although it is unwise to expect a warm welcome from the indigenous people, it is unacceptable to accept the barrage of xenophobic and racist hatred promoted by some of the media in the UK. CARF explained that over the previous two years, tabloid attacks on asylum-seekers had grown in frequency and ferocity, spreading from the open hatred of local newspapers such as those in Dover, to national press 'exposes' of spurious refugee crime waves. With nobody to oppose the frequent stream of tabloid scare mongering, least of all the government, a new strain of xenophobia has become part of an everyday 'common sense' way of thinking about new arrivals. This xenophobia easily spills over and mixes with the racism already faced by longer established immigrant communities.

CARF (February/March 1999) stated that the 1980s was the decade of the 'Sun' newspaper which more than any other newspapers articulated Thatcherism into the working class identity; a crucial part of this was their championing attacks on the anti-racist movement and the 'loony lefties'. The 1990s saw the sales of the 'Daily Mail', the archetypal tabloid of middle England steadily increased, whilst its relationship with Blairism has mirrored that of the 'Sun' and Thatcherism. However, even though the 'Daily Mail' tried to make anti-racism palatable to middle England by including stories on Steven Lawrence and Michael Menson, nevertheless it continued to promote the view that the majority of asylum-seekers are only interested in getting their hands on state benefits. Therefore, even though it has been condemning racist violence it has also been contributing to a series of misleading reports and headlines such as '*And still they flood in*', '*Brutal crimes of the asylum-seekers*' and so on, adding to the atmosphere of hostility towards asylum-seekers and fanning the flames of racist violence.

The recent Home Office research into migration (Glover et al 2001) found that there is little evidence that migration damages the employment prospect of the existing resident workers. On the contrary the report suggested that managed migration could help to fill labour market shortages, improve public finances and contribute to the development of

new industries and jobs. This was more recently echoed by Robinson (2001) who proposed that Britain will have to encourage more immigration in the 21st century to help pay for the pensions and healthcare of the aging population. Despite the fact that black and Asian people have been settling in the UK for more than 300 years they have yet to overcome the stigma of being labeled as 'outsiders' or 'others', and they continue to be labeled as 'problems' by many British people. Yet, both the Home Office and Robinson reports state that migrants have made significant cultural, social and economic contributions to the UK society.

Ethiopian refugees and the media

Ethiopian refugees started arriving in the UK in large number since 1974. In the mid 1970s many Ethiopian officials who worked under the Emperor Haile Selassie, and other political activists opposed to the military junta fled to Europe, the USA and neighbouring countries in order to avoid persecution and to seek asylum. Currently, there are about 25,000 – 30,000 Ethiopian refugees living in the UK. They are dispersed all over London although most live in Haringey, Hackney, Lambeth and Southwark.

For the purposes of this study, we explored media representation of Ethiopian and other refugees by examining the way that the 'Sun' and 'The Guardian' newspapers reported on refugee related issues during the months of February 2000 and February 2001. We believe that these two newspapers represent the two opposing poles of the continuum of views. We have summarised all the articles featured in the 'Sun' which related to refugee issues. However, due to the volume of articles carried by the 'Guardian' we concentrated on those which featured UK based stories. Since one of the main issues which relates to refugees is racism, articles which dealt with its implications or the attempts to eliminate it have also been included. Our search for media representations about Ethiopian refugees has yielded nothing specific. However, the general climate created by newspapers, which carry stories on other ethnic groups of refugees and asylum-seekers, has a direct impact on Ethiopian refugees.

Search findings

a) Articles carried by the Sun, February 2000

The Sun, Tuesday,

February 1, 2000 page 30

On this day the Sun reported about the Afghan aircraft siege at Stansted and demanded that the government should 'Jail Hijackers' and send 'Asylum Seekers' home.

The Sun, Friday,

February 11, 2000 page 38

Paul Evetts

Under the heading: 'Jail Hijackers and send Asylum Seekers Home' the Sun reported that more than 70 hostages had claimed asylum since the Afghan jet siege finally ended. The report went on to say that immigration officials believed the entire drama was nothing than an elaborate asylum-seeking scam. Paul Evetts went on to report some of the readers' views:

- If the government lets the asylum seekers from Stansted stay in the country, we will start an avalanche of hijackers with willing "hostages" on board, seeking asylum.
- The hijackers should be jailed for at least 20 years and the passengers returned to their country. It has clearly cost a fortune and we should not have to pay any more of the cost, human rights or not. We have to show the world we are not a soft touch.

The Sun, Tuesday,

February 14, 2000 page 30

Jack Straw, the current secretary of the Home Office was criticised for letting in thousands of refugees, some of whom were called 'murderers' and 'rapists'. The Labour government was branded 'lunatic'.

An article entitled 'Stop Refugee Crisis Before it Cripples us' reported the following:

Last week I was walking past a department store when I felt a dragging sensation on my leg. There was a refugee hanging off my ankle, begging for money. Shaken by the intrusion, I pushed him off and he remained on his knees rolling backwards in a praying gesture. Behind him, a young girl of about 10 was repeating the exercise with another shopper while her mother extended her hand for money. This has to stop. Every time I write about asylum seekers, I am inundated with letters from people who are sick to the back teeth with the problem. Not only because it is costing the taxpayer millions, but because the escalating number of them on our streets will undoubtedly lead to yet another rise in crime against the person.

Yet the Government just doesn't seem to be getting a grip on this problem, quite the opposite in fact. Yesterday, it was announced an extra £41 million of our cash is to be allocated to local Councils to help pay for the growing number of under 18s seeking asylum in Britain. Well, what a fantastic incentive that is to stop them coming here. Yes, it is awful that any youngster feels desperate enough to leave his/her home county. But in this matter sentiment leads to detriment for British-born children whose already over-burdened, schools will undoubtedly be lumbered with educating the refugees. In the West London Borough of Hillingdon alone, the number of refugees under 18 it cares for has risen from 175 to 426 in less than a year.... "We look after refugees from 46 different countries and obviously there are issues such as language barriers, gender, religion and diet to be dealt with, all generating enormous costs" said one official. What about the "issues" of people who live in the county and have paid into the system all their lives? If you imagine this country as one bank account, the escalating trend of handing cash to those who never make deposits will ultimately result in total collapse. A country the size of Britain simply cannot be the solution to the problems of 46 other

countries. The Government's refusal to recognize and act on this is slowly crippling us.

The Sun, Thursday,

February 24, 2000 page 11

A report entitled 'Woman, 46 Sues Straw after Rape by Refugee' stated that a woman raped by a bogus asylum seeker is suing the Home Office for failing to deport him. Officials were ordered to send pot smoking psychopath Rashid Musa back to Kenya after he has served a jail term for vicious offences. But although the papers were signed by Home Office Secretary Jack Straw, immigration officials let 22 year old Musa go, saying they had insufficient resources to deal with him. Four months later the maniac raped the 46 year old woman at knifepoint in a London Hospital, then raped a teenager schoolboy on a train. Now his female victim wants substantial damages in a landmark case.

The Sun, Saturday,

February 26, 2000 page 17

Neil Syson

The paper reported that a man claimed asylum because he is gay. According to the paper, Anderson Nicholas may get special treatment he does not deserve, for reasons of political correctness. He says that if he is sent back to Trinidad, where homosexuality is illegal, he will be persecuted. He makes the Caribbean Island sound like Nazi Germany. It is not. It is a happy-go-lucky holiday paradise that Prince Charles has just visited. If Nicholas wants to go somewhere he will feel at home, he should try San Fransisco.

b) Articles carried by the Guardian, February 2000

The Guardian, Thursday

February 3, 2000 page 7

Julia Hartley-Brewer

- 1) The paper reported that the Metropolitan police is to pay £55,000 in damages to 11 Kurdish refugees after armed officers stormed their rehearsal of a Harold Pinter play believing the amateur actors were armed with real guns. The out-of-court settlement was agreed yesterday as a district judge at central London county court criticised the

“extraordinary state of affairs” which led to the arrest and five-hour detention of the theatre group, which included a boy aged 12. The group was rehearsing *Mountain Language*; a play inspired by the plight of the Kurds which includes violent scenes of torture. The men, who all have home office status as refugees, after fleeing torture and oppression in Turkey, brought a civil action against the police for assault, trespass and false imprisonment. In what the men's solicitor called “a horror story of life imitating art”, dozens of armed police smashed down the doors of the Kurdistan Workers' Association community centre, in Finsbury Park, North London, on the evening of June 19, 1996, after a member of the public reported seeing men in combat gear pointing guns at people on the floor. The group was arrested at gunpoint, handcuffed and held in the back of a police van for more than five hours without explanation. The actors were forbidden to speak in their native language - in scenes similar to the play they had been rehearsing. Ahmet Yuksel, then 12, was held elsewhere, uncertain of his friends' whereabouts, while police searched the building and discovered that the weapons were props on loan from the Royal National Theatre - a fact made known to local police weeks earlier.

The New Life Theatre Group had been due to perform *Mountain Language* in front of Pinter, who wrote the play after witnessing Kurdish persecution in Turkey. The title is a reference to the Turkish-imposed ban on the Kurdish language, which is derided as the “mountain language”.

- 2) On the same day **Peter Hetherington**, Regional Affairs Correspondent reported that ministers have promised town halls a big cash boost to take thousands of asylum seekers away from the south-east to housing estates and hostels in the north. Amid fears that authorities would be unable to cope with the refugee dispersal programme, they said the extra funds were for housing costs. The Local Government Association (LGA) said the money, an extra 20 pounds weekly to compensate councils for each family, was in addition to reimbursement rates of 150 pounds for a single person and 220 pounds for a couple. Out of this, refugees get 30 pounds weekly in food vouchers. The extra cash has been won after heated discussions between the LGA

and the Home Office. Councils in England say they face a 90 million pounds shortfall in meeting the cost of housing asylum seekers, and local taxpayers might be forced to pick up the tab. The overall cost to the Home Office in the current financial year is put at 210 million pounds. In a letter to Councils yesterday the LGA chairman, Sir Jeremy Beecham, said that 1,200 people had been dispersed voluntarily from London and Kent in the past few weeks. But housing for at least 5,000 more would have to be found before the 31st March when tougher dispersal measures come into force.

The Guardian, Wednesday

February 9, 2000 page 1

Will Woodward and Colin Blackstock

The paper reported that four men escaped from the cockpit of the hijacked Boeing 727 at Stansted airport in a dramatic development to the hostage crisis late last night. They ran towards police waiting on the tarmac from where they were taken to a medical area to receive checks. They were examined and found not to have been seriously injured during the escape. It was not certain early today whether the men were crew or passengers, but police virtually ruled out the possibility of them being members of the hijack gang itself. However speculation grew in that the hijackers may be seeking political asylum.

The Guardian, Friday

February 11, 2000 page 4

Alan Travis

The paper reported that Jack Straw sounded tough when he declared that he personally would decide on asylum claims by those on board the hijacked Afghan aircraft but Home Office sources confirmed last night that it was likely to be at least two months before final decisions were made. Immigration lawyers said last night that decisions on asylum claims from Afghans on the plane might not be as straightforward as supposed. It had to be borne in mind that Britain officially regarded Afghanistan as such a dangerous place that nearly all Afghan asylum seekers over the past three years had been given exceptional permission to stay here on compassionate grounds.

The latest figures for 1998 show that only 65 out of 1,600 Afghans who sought refugee status were refused permission to stay.

Nick Hardwick, the Chief Executive of the Refugee Council, said last night that there had been three groups on the plane. There was no doubt the first group, the hijackers, should face criminal charges. But he said the second group, made up of their families, could face death in Afghanistan. The third group identified by Mr Hardwick, was the rest of the passengers, who, because they could afford the fare for the internal flight showed themselves to be members of the middle class elite who had suffered the brunt of persecution by the Taliban regime.

The Guardian, Friday

February 11, 2000, page 25

The paper reported that there were two immediate tasks facing the Home Secretary when he addressed the Commons yesterday on the peaceful conclusion of the hijack at Stansted: a) to signal to would-be international hijackers that the UK was not a soft and cosy haven to head for; and b) to reassert our legal obligations under international law to treat all asylum applications seriously. His task was made more complicated because the hijacked plane contained four different groups: hijackers; relatives of hijackers seeking asylum; non-relatives seeking asylum; and passengers keen to return to Afghanistan.

According to the paper, where firmness was needed, Jack Straw provided it. No concessions or undertakings had been granted to the hijackers. The surrender from the plane was 'unconditional'. Some 21 people were under arrest. Some 60 people with 14 dependants had applied for asylum. The rest of the passengers would be returned to Afghanistan, or nearby Pakistan if they wished, beginning today. The idea that the UK is a 'soft touch' is absurd. We have some of the most rigorous rules in Europe. Similarly, the UK is not a hijackers' haven: of the 18 hijackings involving European states in the past decade, only two have involved the UK. Hijacking can never be an asylum option. Mr Straw's tough talk may have appeased the right, but it rode roughshod over civil rights. He should have resisted temptation.

The Guardian, Friday

February 11 2000 page 24

Nick Hardwick, Chief Executive of the Refugee Council

Nick Hardwick is appalled with how we deal with the tiny number of refugees who get here. We rant about scroungers. This has been a truly awful week for not only many of those on the hijacked aeroplane but also for all those in this country who want a credible asylum system. Whatever these individuals are (on the hijacked plane), they are not 'economic migrants' involved in some frivolous action to gain the dubious joys of a dodgy bed and breakfast hotel in one of Britain's inner cities and a long wait on vouchers.

Hijacking this aircraft was a desperate act by desperate men who would appear to have had good reason to fear for the safety of themselves and their families. This does not excuse the hijacking - but it does put the media hysteria into context, where the hijackers are simultaneously portrayed as Islamic fundamentalists, international terrorists and dole scroungers. The simple truth is that asylum seekers in the UK live on more reduced levels of support than ordinary citizens and are entitled to only the most basic accommodation. But, to those who want a credible asylum system which produces fair decisions quickly, this whole affair and its media coverage is a body blow and could not have come at a more critical time. We are only weeks away from the implementation of the government's new system, which will support asylum seekers as they await a decision on their asylum application.

A key plank of the new system is to disperse asylum seekers away from London and the south-east. Support will mainly be provided through a voucher system which will humiliate and stigmatise the recipients. Asylum seekers are likely to be isolated from the support of their communities and in consequence many will drift back to London.

The Refugee Council has been vigorous in its criticisms of the Home Office. However, it does also need to be said that those responsible for establishing the new support system have been genuinely open and responsive. If anyone can make the system work, they can - but they cannot do it on their own. We need to do all we can to ensure the new support system does not fail.

We need to take the crisis out of the asylum system. It beggars belief that one of the richest countries in the world cannot deal with the tiny proportion of refugees who come to us, without becoming hysterical. We all have a responsibility to restore some sanity to the situation.

The Guardian, Monday

February 14, 2000, page 1

Ewen MacAskill, Lucy Ward and Paul Kelso

Seventy-two former hostages from the Stansted hijack were this morning on their way back to Afghanistan, while the British government began negotiations with Pakistan over the price to be paid for providing a home for the remaining passengers seeking asylum. As they prepared for departure, a foreign office spokesman said talks had been held about the future of the 73 other passengers, all of whom are expected to apply formally for asylum today. Nineteen men are expected to appear before magistrates at Southend today charged with offences under the prevention of terrorism act and international hijack law. Yesterday three men arrested at the end of the hijack last Thursday were released without charge.

The Home Secretary, Jack Straw, made it clear yesterday that he is to press for international reform of the rules under which the Afghan hostages have claimed refuge in Britain. He will urge ministers from other countries to redefine the 1951 convention, arguing that the law was never designed to cope with the various types of refugee seeking shelter in Britain and Europe.

The Guardian, Friday

February 16, 2000 page 18

The view from Wall Street

The paper reported that Britain is one of the world's more civilised countries. So it came as no surprise that it allowed a hijacked Afghan airliner to land at Stansted last week. But reaction to the news that more than 70 of these accidental tourists now want to stay has

cast the country in an uglier light. Britain's tabloid press has played on popular fears that immigrants want to take people's jobs or dole money.

"We'll wager that most 'victims' of the Stansted hijack are still enjoying life on benefits in Britain, five years hence," said the Daily Mail. Even British Home Secretary, Jack Straw, has said he wants the remaining passengers to leave the country as soon as is practicably possible. His reaction is far from what one might expect from the chief legal officer of such a rich and historically tolerant nation. With Afghanistan's fundamentalist Taliban regime recognised by only three other countries (Britain is not among them), it would seem that the case for asylum might have merit. The fact that the Taliban have already said that the hijackers themselves could face the death penalty, a seemingly disproportionate punishment, suggests that they too should be dealt with under British law. It is a pity that Mr Straw seems bent on passing up this high-profile opportunity to lead by example. Britain should show the likes of Austria's Jorg Haider how civilised countries treat the dispossessed, not present him with an opportunity for accusations, however unwarranted, of hypocrisy.

The Guardian, Saturday

February 17, 2000 page 21

Alan Travis

The paper reported that Britain faces a skill shortage. A Home Office report finds most successful asylum-seekers are highly skilled but racism stops them working. Surprisingly, perhaps, in the light of Jack Straw's promise to expel all those aboard the hijacked Afghan plane, it is official government policy that Britain has long benefited from the rich culture, energy and diversity that refugees have brought to this country. Mr Straw recognised that, 18 months ago when he abolished the need for recognised refugees to wait four years before it was decided whether they could stay in Britain indefinitely.

Under the Labour government the proportion of those given refugee status or exceptional leave to remain has risen from under 20% of all asylum applicants to over 30%. Yet the debate continues to be dominated by claims that Britain's asylum system is being

'swamped' by poor economic migrants whose only interest is to milk the social security system.

However, most refugees go home when the political situation in their country makes that possible. For example, some 1,570 Kosovans who came to the UK last summer have already gone back under a voluntary return programme. The most recent figures show that in the 10 years between 1988 and 1998 a total of only 58,350 people were given the right to settle in Britain, including children and dependants. All were officially recognised as having come to Britain because they had been living in fear or had suffered persecution and even torture.

Home Office research published in 1995* exploded the myth that these people have few skills to offer Britain. Two-thirds had been in jobs in their countries, but only a quarter had employment at the time of the interview. Only 14% had been regularly earning for most of their time in this country. Their unemployment rate was far above that even for ethnic minorities in the inner city.

Many of those who were employed considered themselves to be in jobs well below the level for which they were qualified. A high proportion was found to be highly qualified people, many with university degrees. One-third of all those accepted as genuine refugees had a university degree, post-graduate or professional qualification. Only 18% had no educational qualifications. The one in seven who had found work were either working for themselves or in the 'ethnic job sector' such as fast food ethnic restaurants.

Many had been in good jobs in their own countries when they fled. There were academics, senior civil servants, doctors, accountants, teachers, lawyers, engineers, businesspeople, managers, members of the armed forces, office workers, nurses, technicians, mechanics, drivers, electricians, shop assistants, factory workers, security guards and waiters. The unskilled only accounted for 5% of recognised refugees.

Disturbingly, the same research found that half had encountered racism since they had been in Britain, with almost a third having suffered verbal abuse and threats. Some 18% had been attacked. But five years on from the 1995 report, the same problems are still being reported**. The new national system of dispersal of asylum seekers throughout Britain that comes into effect in April has meant that in the 'cluster areas' a special effort is being made to develop new networks to support refugees in this situation. A lot of this work is done in London and the south-east by voluntary organisations or community associations but the dispersal decision means that the government is having to start from scratch in these 'cluster' areas. The deep hostility, bordering on racism, towards asylum seekers seen in much of the media in the past week does not bode well for the political will that is needed in these new parts of the country for the future reception and settlement of refugees.

** The Settlement of Refugees in Britain, Home Office, Research Study 141, 1995.*

*** Consultation Paper on the Integration of Recognised Refugees in the UK, Home Office, October 1999.*

**The Guardian, Monday
February 26, 2000 page13
Alan Travis**

Southern councils which are exporting asylum seekers hundreds of miles to private landlords in the north have been officially warned to abandon their freelance dispersal arrangements. The attempt by some councils, such as Westminster and Slough, to solve their asylum problems by bussing refugees across the country has sparked protests from the receiving authorities. The northern authorities, including Newcastle and Hull, are faced with providing essential services to the asylum seekers without any warning.

The official caution was sent out as the latest Home Office figures showed that the number of new asylum applications had fallen from 7,180 in December to 6,110 in January. The number of decisions leapt from 2,320 in December to 4,040 in January, but despite this improvement the backlog of cases continued to grow, reaching a new record of 104,890.

The extent to which the Conservative Party intends to use the issue of asylum in this May's local government elections became clear yesterday. Two Conservative-led local authorities, Kent county council and the London borough of Hillingdon, said that their voters would face council tax increases in order to pay for the costs of supporting increased numbers of asylum seekers waiting for decisions.

London councils believe there is a £10m shortfall between the cost of providing services to the 55,000 asylum seekers living in the capital and the funds being made available by Whitehall.

c) Articles carried by the Sun, February 2001

The Sun, Tuesday,

February 1, 2001 page 30

Under the title 'Lunatics have Lost Control of Asylum' the paper reports that the number of foreigners seeking asylum has soared to more than 100,000 under Labour – rising 50% in the last year alone. Readers reckon we should stem the refugees. Here are their views.

a) It is strange that Jack Straw lets thousands of refugees stay in the UK whatever the merits of the case. It is not that British people are unsympathetic to 3rd World Countries, but some refugees bring with them an attitude that it is OK to take advantage in order to survive. How on earth do we know who we are letting in anyway? We could be welcoming murderers and rapists. All we ask of refugees is that they behave and respect us.

b) Whatever Government is in power seems to have no power to the mass immigration of people into this country. Far from fleeing tyranny, most come here for a better life. Yet when they get here we never hear the end of Fascism complaints. If they are so hard done by here perhaps they should consider returning to their own countries.

c) First the Government spends £50 million on the Millennium Dome. Now from April all asylum seekers will be housed and fed. Most working class people cannot afford to visit the Dome. Patients are dying due to long NHS waiting list and the homeless don't know when they will get their next meal. New Labour? Or Monster Raving Loony Party in disguise?

The Sun, Monday,

February 12, 2001 page 6

David Wooding

The paper reports that taxpayers are forking out a record £835 million a year on asylum seekers which amounts to £34 for every household in Britain. Ann Widdecombe, the Shadow Home Secretary, said that this was the most damning indictment of Labour's record in government. She went on to say that all this money could be spent on thousands extra police, teachers, school buildings and new hospitals.

The Sun, Wednesday,

February 14, 2001 page 1

1) The front main story of the paper entitled 'Lunatic Asylum' by **George Pascoe-Waton**, reports that 3,200 new illegal immigrants set up home in Britain every month but only just 12 asylum seekers a month are booted out. It is reported that of those who set up home illegally in Britain, only a handful are ever caught. Martin Slade, Chief of the Immigration Service Union is quoted in saying that the Home Office is stretching the truth and that people on the streets know exactly what is going on and can see it day by day. According to him, the majority of those who leave do so voluntarily as the NHS is not delivering the service they came here for. He also claimed that the illegal immigrants have false identities and most police forces are not bothering.

The article concludes that Tory chief William Hague has vowed to build camps where ALL immigrants would stay until their cases were heard.

- 2) In the same issue the paper praises Home Secretary Jack Straw for doing his honest best but even he is not getting far yet. The paper suggests that he should do what the Americans do: every few years, we open the doors to anyone who is prepared to sign away any entitlement to immediate welfare benefits and who promises to learn English. That way, the spongers get the message that if you aren't prepared to work, you starve.
- 3) The main story of the **Sunwoman** in the same issue, is about a 16 year old girl who married an unemployed Kosovan refugee who was smuggled into Britain on the back of a lorry. Although the girl reports that she and her husband are very much in love, the paper suggests that probably the Kosovan's motivation behind the marriage was a permission to stay in this country.

The Sun, Thursday,

February 15, 2001 page 2

- 1) **George Pascoe-Watson** reports that William Hague accused the Prime Minister of making Britain the "asylum capital of Europe". The Tory leader piled into Mr Blair just 24 hours after it was revealed that immigration chiefs boot out only 12 bogus asylum seekers a month.
- 2) On the '**Dear Sun**' page 15 of the same issue under the heading "Labour must get tough over bogus refugees" nine readers' letters are printed all complaining about the number of refugees and what they cost this country. One reader from Coventry writes that thousands of refugees arrived in his/her hometown a few months ago. They are given vouchers to buy food but they buy mobile phones and the latest trainers. S/he suggests that these refugees who beg in the streets are laughing at Mr Blair, and asks, 'with free handouts and homes why would they ever want to leave?'

The Sun, Thursday,

February 23, 2001 page 1

- 1) The front page features a picture of a Kurdish refugee with his two wives and six of his nine children living in a French refugee camp. The headline reads 'Kurds on the

Way'. **Tom Worden** asks will Jack Straw send them back? The paper reports that hundreds of huge Kurdish families like the one on the photograph are heading to Britain from the French refugee camp. It quotes the Kurdish man saying 'we know how easy it is to get papers in Britain'. The paper reports that a furious Jack Straw insisted that Britain will not be a dumping ground for France's refugee. He warned that any Kurd crossing the Channel will be sent straight back.

- 2) '**Littlejon**' on page 11 of the same issue, reports that when he heard that a boatload of Kurds had run aground on the French Riviera, he told his friend that 'they'll be over here by Friday', and that he was only out by a few days. In his view Jack Straw will not turn them away even though he says he will because that is what he said about the Afghans who landed at Stansted a year ago and most of them are still here. He goes on to talk about the benefits which refugees receive and that Britain is a soft option for them. He asks: 'If it's not the state hand-outs and pushover appeals system which attract the vast majority of illegal immigrants to Britain...then can someone give me another reason why those Kurds would rather settle in beautiful downtown Dalston instead of on the French Riviera?'

The Sun, Thursday,

February 24, 2001 page 4

Tom Worden

The paper reports that 700 of the 911 Kurdish refugees who arrived in France had not applied for asylum there. The paper believes that most of them plan to head for Britain.

The Sun, Thursday,

February 27, 2001 page 11

On '**Littlejon**'s page a big cartoon is featured showing a ship called 'DSS Handout' arriving in Britain with signs of 'Welcome to soft-touch Britain' and 'This way to the gravy-train station'. The story beneath the cartoon goes like this:

There is a grim inevitability about the daily reports of the Kurds closing on Britain. It is a bit like looking at the opening titles of dad's Army with

all those arrows pointing towards Dover. Somewhere in the bowels of the Home Office there is only an operations room plotting their progress across France with little Subbuteo figures, Dinky toy lorries and Hornby trains being pushed across a giant ordinance survey map by women called Bunty. We might as well give in now and make a day of it. There is no point Jack Straw pretending they won't get through. Of course they will. So let's welcome the Kurds in style. Throw a party like the one, which greeted the task force back from the Falklands. They should sail into Dover harbor surrounded by a flotilla of small ships, decked out in bunting, brass bands playing, topless lovelies waving from the white cliffs. They could be met off the boat by Carol Vorderman and Carol Smillie bearing a giant cardboard blown-up of their very first Giro. And even if the Home Secretary does summon up the courage to serve them with deportation papers, you can be certain of one thing. We'll meet again.

d) Articles carried by the Guardian, February 2001

The Guardian Thursday

February 1, 2001

The paper reported that the Audit Commission warned Councils last night, of landlords fraudulently claiming for non-existent asylum seekers. Housing benefit accounted for 92% of detected fraud cases for councils.

Guardian, Monday

February 5, 2001

Alan Travis

A joint Anglo-Italian initiative to stem the flow from the Balkans of tens of thousands of illegal entrants into Europe through the "Sarajevo route" will be followed this week by further measures to strengthen the "fortress Europe" approach to migration. Britain was leading the way in the crackdown on human trafficking, the immigration minister, Barbara Roche, said yesterday. "The Prime Minister has taken a very, very close personal interest in this," she added.

Mr Blair's decision to put his weight behind measures to tackle illegal migration reflects the recognition in Downing Street of the politically explosive potential of the issue in the run-up to the general election. He also backed calls to open up opportunities for legal migration into Europe. "Every day we hear of the horrors illegal immigrants endure at the hands of the people-traffickers," said Mr Blair, in a joint article in the Observer with Giuliano Amato, the Prime Minister of Italy. "The catalogue of death in recent times speaks for itself - 58 Chinese at Dover last year, hundreds drowned yearly crossing the Mediterranean to Spain, Italy and Greece. There is evidence that traffickers have thrown women and children, many of whom cannot swim, into the Adriatic in the middle of the night simply to avoid detection by police patrol boats."

Guardian, Tuesday

February 6, 2001

Alan Travis

The plan by the Home Secretary Jack Straw to revise the way the West treats the world's asylum seekers has come a long way since he first floated the idea in Lisbon last June. He hopes to end the criminal trade which forces asylum seekers to travel halfway across the world - often in the back of a lorry or in a dangerously overcrowded ship - to Europe to claim refugee status. He wants to do this by ensuring that asylum claims are decided not in the final destination country of the migrant, but in the nearest safe haven to the country from which they are fleeing. The plan replicates the United Nations' emergency humanitarian evacuation programme from Kosovo two years ago.

Guardian, Tuesday

February 6, 2001

Nicholas Watt

Thousands of asylum seekers could be forced back across the channel to France under a radical scheme with Paris to curb the flow of illegal immigrants to Britain. In a sign of pre-election jitters over asylum, Tony Blair will discuss the idea of summary deportations with the French President Jacques Chirac at an Anglo-French summit on Friday. The initiative follows an Anglo-Italian scheme, launched over the weekend by

the Prime Minister and his Italian counterpart, to crack down on up to 50,000 illegal immigrants through Bosnia and the western Balkans into Europe.

Guardian, Wednesday

February 7, 2001

Polly Toynbee

Sometimes there is no right answer, there is only better and worse. Nothing currently said or done about asylum seekers is good, though it could be worse (some European countries are far tougher on refugees). Very little honesty is spoken about it: Labour's pollsters warn them it is a wicked issue with voters, Tory politicians use it wickedly. "Bogus" and "abusive" is what politicians call migrants, but bogus and abusive better describes the way most politicians talk. The Straw plan envisages camps set up in neighbouring third countries. Afghans fleeing the Taliban, for example, would stay in Pakistan. Pakistan would be paid by the EU or UN to run camps that would process them: those accepted as genuine refugees would then be assigned to western nations according to quota, as happened in Kosovo. The advantage for Europe is that anyone arriving by any other route could be turned round at port and sent right back to these camps. Few would risk their savings on a terrifying illegal journey only to be sent straight back to the region on arrival. At last, says Straw somewhat disingenuously, this would be a system that makes sense, since not even genuine asylum seekers can currently arrive here legally.

Seventy-five thousand people claimed asylum last year - up from 35,000 in 1997. The backlog of old cases stands at 66,000. The government tosses figures around cavalierly - Straw was at it again in yesterday's speech - but they rarely are what they seem. For example, he said 80% of asylum seekers are refused. (The rest are the "abusive" poor). First of all, "refused" is a term of art. The system requires applicants dumped on God-forsaken sink estates to fill out a 20-page form in English, without a lawyer, within 14 days. If they fail to do it correctly they are deemed "non-compliant" and automatically refused asylum. There are seven days to appeal on another form, in English; most fail - or not. The Home Office triumphantly declares to the press that most are refused. But that's all a technicality, they are not actually sent back. That is not the end of the story. This

arbitrary cruelty is all for show. Last year only some 8,000 people were actually deported.

The fact is that almost all people who make it to these shores end up staying. It is practically impossible to send most of them back because there is no "back". Most of the world's refugees are already camped on the borders of their own countries - the poorest nations forced to cope with the great exoduses caused by war-driven famine. According to Professor Guy Gordon-Gill, Oxford professor of international refugee law, only 0.3% of global refugees ever get anywhere near the EU. Only the relatively rich or remarkably resourceful make it, so we need not fear a vast expansion of numbers. Keeping more of them in camps will do nothing to stop the criminal gangs bringing in illegally from China or Eastern Europe. Nor will it become any easier to return them. Many will come, many will stay.

A recent UN population study predicts that in the next generation Italy will lose 28% of its population, Estonia 33% and Germany 25%. Already Europe is heavily dependent on unknown battalions of illegals who cook, clean and heave rubbish in the cities, pick and dig East Anglian fields. Illegals who disappear into the fabric of countries are no problem. The worst problems are caused by trying to contain them: for six months on vouchers they are kept in expensive, festering hell-holes, prevented from working though willing to do the worst jobs for the least pay. After that, they will make their own way and assimilate. So why bother? Both Jack Straw and Anne Widdecombe talk through their hat when they each propose new systems that will prevent/deter/end migration. Most asylum seekers come from the poorest most war-torn places - Somalia, Iraq, Iran and Sri Lanka. In the long run, the gradual spread of democracy and peace, solving problems at source - as in Sierra Leone - will be the only solution.

Guardian, Wednesday

February 07, 2001

a) The Home Office faces a compensation bill that could reach millions of pounds for wrongly jailing asylum seekers for travelling on false passports.

b) The paper also reports that the Home Secretary's initiative to stem the flow of illegal migrants into Europe by creating a common asylum system has taken off as a serious project in the European Union.

Guardian, Thursday

February 08, 2001

The run up to an election is the worst possible time for reforming asylum procedures. Conservative Party officials have hailed the way immigration in earlier elections "played well" in the tabloids, and Labour leaks have shown Tony Blair worrying about the government looking soft. Even so, Jack Straw, who visits Stockholm today for talks with EU interior ministers, is right to be pushing two issues: speeding up the UK's current application process; and seeking a common European approach to asylum seekers.

Guardian, Friday

February 09, 2001

EU interior ministers agreed yesterday to speed up co-ordination of asylum policies to cut the number of illegal immigrants, but pledged not to spurn refugees fleeing persecution. Meeting in Stockholm, ministers broadly backed calls by Jack Straw, the British Home Secretary, for closer collaboration in an area of increasing concern across the EU.

Guardian, Thursday

February 15, 2001

The Home Office has scrapped a £77m computer system that was intended to help clear the backlog of asylum seekers, it was reported today.

Guardian, Thursday

February 15, 2001

MPs overburdened with high numbers of asylum seekers in their constituencies may be given more money to pay for an extra member of staff to help cope with their ever-increasing caseloads.

Guardian, Tuesday

February 20, 2001

The 900 refugees whose ship was beached on the French Riviera at the weekend are the visible tip of a much larger exodus fleeing harassment by Saddam Hussein, Kurdish sources said yesterday.

Guardian, Wednesday

February 21, 2001

The paper reports that the United Nations is investigating allegations that some of its employees were members of an organised crime network in Africa which took bribes to resettle refugees in the West.

Guardian, Friday

February 23, 2001

The paper reports that a Tory government would slash Labour's spending plans on housing within three years of coming to power, the shadow Environment Secretary, Archie Norman, has promised.

Guardian, Tuesday

February 27, 2001

Councils that rely on government funding to meet the costs of supporting destitute asylum seekers were told by the high court today that thousands of refugees are not covered by the scheme.

Conclusion

The themes which were revealed in our Sun/Guardian search for the month of February 2000 and 2001 appear to be very similar to those which the Refugee Council identified during the year 2000 in a number of national and local newspapers papers. The fact sheet which the Refugee Council produced in response to these themes is reproduced here as a useful summary of factual information.

| The Claims | The Facts |
|--|--|
| <p>“asylum strains”</p> <p><i>from Southend Yellow Advertiser, 23/2/00</i></p> | <ul style="list-style-type: none"> • The least developed countries in the world host the overwhelming majority of the world’s 21 Million refugees. Britain hosts less than 1 per cent. Is that too much to ask of one of the richest countries in the world? • From fish and chips to the designer of the mini, the UK economy has been greatly enriched by the contribution of refugees. And as research has shown, since refugees are mainly young people, they tend to be net contributors to the public purse. |
| <p>“Britain is seen as the softest of touches”</p> <p><i>from the Daily Mail, 26/2/00</i></p> | <ul style="list-style-type: none"> • Figure from the United Nations High Commissioner for refugees (UNHCR) show that the UK only ranks 9th in Europe in terms of asylum applications per 1000 inhabitants. • Belgium, Ireland and Norway are just some of European countries that offer more generous support to their asylum seekers than the UK |
| <p>“the figures for asylum seekers, almost all of them bogus, are totally appalling”</p> <p><i>from The Sunday People, 13/2/00</i></p> | <ul style="list-style-type: none"> • The fact shows that over half (54%) of asylum seekers in 1999 resulted in protection being granted for the applicant. The real figure, once successful appeals are taken into account, will be even higher. • Few can doubt that the main countries producing asylum seekers are countries in turmoil and where persecutions occur. The main countries in 1999 were the former Yugoslavia, Somalia, Sri Lanka and Afghanistan. |
| <p>“some supposed asylum seekers repay our generosity by cheating the benefit system...begging and thieving in town and city centers; and even setting up violent criminal networks”</p> <p><i>from the Daily Mail, 7/3/00</i></p> | <ul style="list-style-type: none"> • There is simply no evidence to suggest that the level of criminal behavior of asylum seekers is above average. • In fact, it is noticeable that when asylum seekers themselves are the victims of physical or verbal abuse, as in Dover last year, it is rarely reported in the press. Supt. Chris Eyre of Kent Constabulary estimates that racist assaults in Dover have cost his force £28,000 in overtime alone so far. (<i>Police review, 28/1/00</i>) |
| <p>“New curse of the awayday beggars”</p> <p><i>from The Daily Mail, 10/3/00</i></p> | <ul style="list-style-type: none"> • It is outrageous to suggest that the behavior of a tiny minority is typical of all Roma (some of whom are recognized as in need of protection) or asylum seekers in general. • The Refugee Council believes that the welfare of children should be everyone’s primary concern. Although there are a very small number of individuals involved, it is clearly unacceptable to use children for begging. |

| | |
|--|--|
| <p>“pensioners in particular are outraged that they have to scrape by while a few refugees receive huge benefits”</p> <p><i>from the Daily Mirror, 15/3/00</i></p> | <ul style="list-style-type: none"> • Everyone in the UK is eligible to Income Support to help meet basic living and welfare needs. But under the new system, asylum seekers will only be entitled to the equivalent of 70% of Income Support, e.g. from this April, the minimum a single pensioner will be allowed to live on is £78 a week. While this is by no means adequate, it is significant more than the maximum of £36.54 a week a single asylum seeker will be able to receive. • Yet even this meager provision will be largely in the form of humiliating and inflexible vouchers from which change will not be given. |
| <p>“Asylum problem grows day by day”</p> <p><i>from Eastern Daily Press, 19/11/00</i></p> | <ul style="list-style-type: none"> • Few rights are more fundamental than the right to be free from persecution. This is why the right to asylum is incorporated in the 1984 Universal Declaration of human Rights. • The number of asylum applications in 1999 was higher than the previous year but so were the instances of human rights abuse, political persecution, internal conflict and turmoil raging around the world. This period also included the war in Kosovo, described as ‘the greatest humanitarian disaster since the end of World War Two’, by NATO spokesperson Jamie Shea. • The number of asylum applications is expected to fall this year. |

Source: *Refugee Council Briefing, April 2000*

The findings from our newspaper searches illustrate the difference in the way the two newspapers reported the various stories about refugees and asylum seekers. The Sun adopts a populist, short, sensationalistic approach for its readers who are mainly working class people. The Guardian on the other hand, provides a more in-depth and balanced analysis and carries more stories both from the national and international perspective, for its middle class readers. Both papers are very influential in terms of public attitude formation and also in terms of reporting the alleged views of their readers. In this way, they both aim at influencing the government by either supporting or criticising its policies. Our findings paint a generally negative picture about the refugees and asylum seekers. The Sun is openly hostile to them, whilst the Guardian, even though it provides more facts and is generally sympathetic, most of the stories deal with the problems which refugees face or the problems they create. Nothing positive about that.

Thus the Ethiopian refugees not only have to overcome deep seated prejudices and institutional racism, they are faced by a generally negative press, which adds to their burdens and makes their attempts to settle down in this country, to integrate and make a useful contribution, very hard indeed.

A recent Home Office Research into migration (Glover et al 2001) reported that managed migration can help to fill the labour market shortages, improve public finance and contribute to the development of new industries and jobs complementing other labour market policies, according to research published today by the Home office.

Its key findings include:

- Migrant experience mixed success in the labour market, but on average earn more than the existing population, contributing to economic growth.
- There is little evidence that migration damages the employment prospects of existing resident workers, although more research is needed in this area. The research suggests that migrants fill labour market gaps reducing inflationary pressures and improving productivity.
- Migrants make significant cultural and social contributions to UK society, including a widening of consumer choice and the contributions of many notable figures in the arts, academia, science and sport.
- Reduced transport and transaction costs and increased economic integration, as a result of globalization, have led to increased flows of people around the world in recent years, both to and from the UK.
- There is a need for more research in this area – indeed it is striking how little research on migration there has been in the UK.

Related 'Guardian' articles

Full text of Straw's speech

http://www.guardian.co.uk/Refugees_in_Britain/Story/0,2763,434341,00.html

How to claim asylum

<http://www.guardian.co.uk/theissues/article/0,6512,184656,00.html>

An A-Z of asylum seekers

http://www.guardian.co.uk/Refugees_in_Britain/Story/0,2763,212675,00.html

The main parties' positions on asylum seekers

http://www.guardian.co.uk/Refugees_in_Britain/Story/0,2763,211609,00.html

06.02.2001: Straw wants to toughen asylum rules

http://www.guardian.co.uk/Refugees_in_Britain/Story/0,2763,434185,00.html

04.02.2001: Tony Blair and Italian counterpart Guiliano Amato write for the Observer

http://www.guardian.co.uk/Refugees_in_Britain/Story/0,2763,434184,00.html

06.02.2001: Asylum seekers to be 'sent back'

http://www.guardian.co.uk/Refugees_in_Britain/Story/0,2763,434169,00.html

05.02.2001: Grim war on human traffickers

http://www.guardian.co.uk/Refugees_in_Britain/Story/0,2763,433627,00.html

28.01.2001: Bosnia's corrupt elite grow fat on human cargo smuggled to West

http://www.guardian.co.uk/Refugees_in_Britain/Story/0,2763,430019,00.html

28.01.2001: People trade makes Bosnia rich

http://www.guardian.co.uk/Refugees_in_Britain/Story/0,2763,430044,00.html

Interactive guide

Seeking asylum: who, where and why?

<http://www.guardian.co.uk/flash/0,5860,334788,00.html>

Chapter 8

Reasons for Leaving Ethiopia and Modes of Escape

Introduction

This chapter is divided in two parts. The first part discusses the reasons why the study participants left Ethiopia, whilst the second part describes the modes of escape. The reasons that were given were varied, however many described fear as the underlying motivating factor. Their fear was often described as being related to the ‘oppressive’ and ‘undemocratic’ political regime, or related to conflict and war in Ethiopia around the time they left. About ten per cent (10%) were either reluctant to elaborate why they had left Ethiopia, did not know why, or gave a non-specific reason.

Each individual’s reasons for leaving could be viewed using the following framework: The socio-political circumstances of the country at the time (context); the beliefs and behaviours of the individual and their ethnic origin; and the consequences resulting from the tension in the relationship between the individual and their society. Although the refugees who were interviewed fled the country at different times and from different political regimes, they shared many experiences in an Ethiopia that was described using the following terms:

- Oppressive
- Undemocratic
- Corrupt
- Poor human rights / little freedom of expression
- Divided on ethnic lines
- Chaotic
- No peace

Part a) Reasons for leaving

The participants primarily described their reasons for leaving Ethiopia in terms of protecting themselves or their family against the consequences of their problematic relationship with their country, or simply from the impact of war. The reasons for leaving Ethiopia listed below are not mutually exclusive; participants frequently gave more than one reason:

- To avoid imprisonment
- To avoid death and injury
- To have freedom of expression and will
- To improve life opportunities
- To seek a safer, better life for their children

To avoid (further) imprisonment

Of the ninety-eight (n=98) participants who were asked to recount their reasons for leaving Ethiopia, nineteen (n=19) reported that they had left predominantly because of fear of, or following imprisonment of themselves or family members for political reasons. Some were journalists or had worked for newspapers in other capacities. An ex-newspaper editor recounted how his activities resulted in imprisonment:

'The reason why I left my country is because of oppression by the present Ethiopian regime called Hiwat. I was in prison for about two years. The reason why I was imprisoned was not because I had committed crime. I was editor- in -chief of a newspaper.... In the newspaper, I criticised the Ethiopian and Eritrean alliance due to their oppression on the Ethiopian people.... I was critical to Government mistakes and their alliance with Eritrea. As a result of the critique I was in jail for two years' (017m: 492).

A middle-aged male participant had a similar story to tell:

'The reason why I left my country was that I wrote papers critical to the Government. As it was part of my career, I used to write papers. As a result of my writing in the papers, I was denied freedom of speech and writing. Above all I was kept behind bars and beaten up. All those sufferings had left a scar in my life.... I did not want to work under the regime, which I did not support. I preferred to flee the country and seek refuge where I could live peacefully. My papers were critical to the regime. I could not praise nor say something good about the regime. As a result, I was detained and beaten up. This had caused depression and low morale to me and ultimately forced me to seek refuge' (026m: 580).

Some of those who had been political prisoners reported that they had been detained in dark, overcrowded and 'suffocating' conditions. Others (n=7) said that either they had been 'beaten up' and / or tortured. *'We were beaten up while we were in detention. I was ill because of the beating and hardship in detention'* (040m: 451). Fear of becoming a political prisoner was therefore a strong motivating force for seeking asylum in another country.

Some of the participants whose close family had known or suspected allegiances with opposing political groups reported being afraid of being assumed to have the same allegiances, as described by a female participant:

'The reason why I left my country was because of the Ethiopian regime that was oppressing my people the Oromo people as well as my family. My brother was alleged as a supporter of the Oromo Liberation Front. He was arrested, beaten up and paralysed as a result of torture. He was behind bars for 12 years. My father was also alleged as a supporter of Oromo Liberation Front and was arrested.... He was also behind the bars. They had an intention to arrest me as well. I was also alleged as a supporter of Oromo Liberation Front and narrow nationalist.... So, I had to leave the region before I was arrested' (025f: 525).

To avoid death and injury

Some participants fled following the death of family members as a direct or indirect result of the politics of the country, or war. A middle-aged Amhara man recounted how he fled following the death of two of his brothers and his own imprisonment and torture:

'I left Ethiopia because of political reasons. I lost two immediate older brothers. One was accused of being involved in anti-government political movement and was taken to prison. After two weeks he was taken out and killed and his body was thrown into the forest and we were not allowed to bury his body.... My other older brother, who then was a military was also sent to the war front though he was a high official and was purposely put in a position to get killed because, according to them, he allowed his younger brother to be involved in anti-government politics. The government focused on the family, mainly myself and youngest brother. They took me to a prison several times and tortured me...(065m: 248).

Some participants expressed how they felt it would only be a matter of time before they met the same fate:

'I left my country because of persecution. ...My tribe [Wolaita] is being oppressed by the present Ethiopian regime. ...I hated the oppression and the suffering of the people and I did not want to see all these. People were being jailed, beaten and killed. I did not want to wait until it happens to me...' (015m: 235).

One young woman illustrated the impact that the threat of being removed by the political regime had on her when she said, *'I was frightened with the situation. Many people, whom I knew, had disappeared. I thought, I should leave before my turn comes and I left the country'* (053f: 320).

Several reported that they or their family had left as a direct result of the war between Ethiopia and Eritrea, or because of civil war that was based on internal conflicts between different political parties. One of the participants explained how he felt that incessant conflicts over generations had created a long-term situation of exodus:

'There is war in every generation. Every new generation is a victim of war. Therefore every Ethiopian thinks of getting out of the country to save their lives. Everyone wants to run away from the civil war. Every family wants their children to get out of the country and live the rest of their life outside of the country. (44m: 367).

Another reported that leaving the country was the only way to survive:

'Basically, I left Ethiopia because at that time there was a war. People were basically dying in one way or another. People were scared. For you to survive, you need to leave the country. So, no one knew what would happen tomorrow. Therefore, I did not come for any other thing...' (076f: 269).

None of the participants said that famine or starvation was one of the reasons for them leaving Ethiopia. This may be because the participants in our study were from more wealthy families. Those most likely to be affected by famine would have been poor and unable to afford to flee to the West.

To avoid conscription

Five male participants left the country to avoid conscription into the army or were sent away in childhood for this reason. Conscription was perceived as being likely to cause injury or death. At least two participants spontaneously reported that they had witnessed friends returning from fighting with injuries or not coming back at all. They said their friends had been sent to the front line within a very short time of being conscripted. Avoiding conscription was said to be very difficult. For example, a twenty-six year old man of Ethiopian and Eritrean parentage came to the UK with his

mother in 1985 at the age of eleven. He describes below how his parents sent him away to protect him from being conscripted:

'From what I remember, they [the government] used to do forced conscription. They used to pick up a bunch of students, put them on a truck and send them to training camps. Two weeks later they would be sent to the front. None of them came back and the thing is, the age limit was still dropping and my parents didn't want me to wait until my time comes. They took me out of the country while it was legal to do so. But after the age of twelve basically, you needed a lot of things to legitimise for a child leaving the country. At eleven it appeared too early and the authorities were told that I was going to visit my grandmother. So it was okay' (010m: 159).

To have freedom of expression and will

Fear of imprisonment, actual imprisonment or death of family members were some of the more extreme reasons for people fleeing Ethiopia. Others (n=18) reported that they had left for 'political' reasons; to escape what was described as an 'oppressive' and 'undemocratic' political regime. A middle-aged Oromo man summarises this quite succinctly when he said:

'I left my country because of the Woyane or Tigray regime. I did not want to see or live in the country where the minority, three percent of the population rules the other ninety-seven percent. The present regime has been perpetuating division on the basis of tribalism / ethnicity. I was opposed to their policies of ethnicity and I was forced to leave my country' (011m: 131).

The oppression was described as impacting on everyday activities to such an extent as to deny people any sense of freedom, as described below by an Amharic man:

'At that time it was a terror time and freedom of movement from one area to the other was very restricted, and it was not easy to get together with friends for a party because it is assumed that you are conspiring against the government. I remember once I went to my home town and we were in groups sitting in one of my friend's house having a cup of tea and chatting, and a person whom we know closely and works in a Government office came to us and told us to disperse immediately as they are searching the area looking for people gathering or having a meeting. So it was very hard even to visit friends, and it was like prison even though you are not actually in prison' (065m: 263).

Such lack of freedom of expression in Ethiopia was frequently recounted as being a reason for leaving, as was harassment by the authorities such as the police. In some instances the harassment went further and resulted in being held in custody. For example, a young journalist (42f: 581) said she had been repeatedly arrested and held without being questioned or charged, although she asserted that she had been reporting without political bias. Another reported that in Ethiopia he was being 'studied and monitored' to ascertain 'who was who' with the aim of '*weakening and removing opponents*' (012m: 277). Another participant said that the politics of the country were 'misleading' and that most people held different opinions from the Government. This he said, led to a '*lot of killings*' (044m: 362). Another stated:

'The reason why I left my country was because I hate the present Woyane [the present Ethiopian regime as called especially by opposition forces] regime who is waging a coercive policy against the Oromo people. I had to leave the country because I could not express my feeling peacefully. The reason was that if I tried to express my feeling they would either put me in jail or kill me. I have also experienced mistreatment by the regime. Since the regime causes trouble, I could not live peacefully in my country and therefore, I had to leave' (039m: 370).

One young man, a self-declared socialist who came to study in the UK, illustrated how important the freedom of speech was, and how adherence to this principle created a fear of returning to Ethiopia:

'The other thing is I love my freedom very much. I want to express my opinion at any time and place. The existing government denies such a right. Because of this and also from my experience, I lived with them...then I didn't dare to go back...' (059m: 287).

Those who rebelled against the political regime reported that they faced repression through detention, beatings and killings, as has already been described. However, coercion was also reported, and seems to be the most insidious of these repressive practices. At least two of our participants described being coerced into joining allegiance with the ruling political group. One Amharic man for example, who was imprisoned in Ethiopia, reported that his release had been conditional upon his advocacy of the ruling group. Another had a similar story,

'...finally I was asked that if I am willing to work for the government as a political advocator then I will be released. Then I had no chance and have to accept the offer and planned a way out' (065m: 248).

Another said she was refused a job as a journalist unless she became a member of the ruling party:

'When I applied for a job in the public sector, I was told to be a member of the ruling party to get a job.... I turned down the offer. In principle a journalist should not be a member of a political organisation. A journalist should be neutral or he should stand on zero' (042f: 560).

To improve life opportunities

Six (n=6) participants had won scholarships to study in the UK and others came here to be educated, paid for by their parents, themselves or by 'Ethiopia'. Two young men described how during their time here in education, the political situation in Ethiopia had worsened and they were afraid to return. They subsequently sought asylum:

'... My main reason to leave Ethiopia was to get educated and better myself. But then, as you know, the politics changes as the governments are changed. I did not support the new politics. Then I decided not to return back to my country. I lived here for nine years now' (050m: 343).

Another stated,

'I left Ethiopia for a scholarship. Not only for scholarship, I was also worried for my safety because of the situation in the country at that time. There was cloud of fear in the country. The cloud was a civil war feared by many people. Even though I left my country for scholarship, in the meantime I was also escaping from the civil war' (031m: 446).

Six participants (n=6) reported that they had left Ethiopia for economic reasons, because there were few occupational opportunities in Ethiopia. They felt the need to leave in order to find good jobs to support themselves, their families and sometimes their country rather than directly because of war or conflicts. Two female participants recounted their reasons thus:

'[In the UK] it was possible to support your family. You can live as others do. You can work and improve yourself. However, there is a difference between Ethiopia and this country. Back home there are no jobs as such. You cannot get good education in Ethiopia.... If you go abroad you can support yourself, your family and your country at large. You will be obliged to leave your country because of these things' (034f: 419).

'The reason why I left my country was to look for a job abroad. I wanted to work and support myself. I also wanted to support my family. This was the reason why I left my country. It was not because of war or conflicts that I left' (032f: 309).

To seek a safer, better life for children

Some came to the UK as children because their parents wanted to protect them from death and disease and to have better healthcare and life chances. Some came with parents, others were sent to the UK alone or with siblings. One young woman said she did not know the full story as to why she and her sister had been sent to the UK. However, she understood it to be due to her parents' wish not only to provide safety from the wars, but also to increase their children's educational and life opportunities:

'I do not exactly know the full story [as to why we left Ethiopia], but I heard that there was wars in the country and it was safer for us to come here. It is not actual peace but more safer and plus education-wise for me and for my sister would be educated and lead better life than I would in Ethiopia. So, it is more of an opportunity' (091f: 220).

Some of minors described themselves as 'economic refugees':

'I think I would see myself as an economic refugee really. ...I guess we came here because my mum wanted a better life for us, like in terms of education and that kind of stuff, that is why we came here really' (092f: 273).

There is some suggestion that the young people's understanding of the reasons for leaving Ethiopia may be attributable to their youth at the time (the young woman cited above was only five years old when she came to the UK). Another explanation may be that their parents may have wanted to protect them from full knowledge of the reasons. Also the children may have been discouraged from openly discussing the real reasons for them leaving Ethiopia. This is a likely explanation for the young woman cited above who went on to describe what may have been the underlying reason for the family leaving Ethiopia:

'... my mum was accused of being a - I think, what do you call them 'Yehapa' or something like that and she was briefly in prison. She was

accused of like, killing people who don't agree with that political party's beliefs and ideas' (092f: 304).

Part b) Modes of escape

The interviewees were asked how they left Ethiopia and arrived in England. In some instances this question was not recorded as being asked. The responses related to the following aspects of coming to the UK:

- The means of obtaining visas and travel documentation
- Who had helped
- Transit to the UK and arrival

The means of obtaining visas and travel documentation

Gaining entry to the UK by legal means for non-European Union citizens is not easy, neither is it easy to get permission to leave Ethiopia for Europe. This is especially so if the applicant is under government scrutiny. Therefore, if life is endangered and a quick exit is necessary, the only option open to people may be through illicit means. These illicit means include crossing borders undetected by stowing away on lorries, ships and other means of transport; obtaining false travel and visa documentation; or through staying beyond the duration permitted by a visa.

Four (n=4) participants said that they had obtained entry visas to come to the UK for short periods or to study in UK Universities, and subsequently had sought asylum. Others managed to get visas from British Embassies in other countries, as explained by one of the participants:

'It was through the application of a visa to the English Embassy in Bulgaria that most of us were able to come here. Therefore it was my own effort to get the visa. No body helped me' (006m: 174).

Others described obtaining travel documents through illegal means and at great cost. A Gura man who came via Kenya stated that,

'The visa was not legal. It was through business people. A lot was paid. I think it was about 10,000 dollars. ...When we arrived in London the Immigration officer took us from the plane. ... When they checked our passport [on the computer], no visa. They said we will be sent back. They were bullies and treated us badly to return us to Kenya.... God has helped us eventually and they released us...' (103: 833).

The high cost of seeking refuge in the UK was summed up by one participant who asserted that; *'You need money to get in here. ...You have to pay for the businessmen who are going to arrange all the process for you. Otherwise it is not possible to come here if you do not have money'* (007m: 292).

Others altered existing documentation, such as a middle-aged Amhara man who, in desperation to save his life, changed the details on his papers;

'When I come back to England first of all my visa had expired. ...As a matter of life and death situation I made a little bit dodgy thing. I changed the year '92 to' 93.... I passed with no problem both the Ethiopian immigration and Ethiopian airlines. They didn't suspect me.... So, I came by plane to London Heathrow.... They arrested me on arrival. They checked everything on the computer and put me in a detention centre' (102MH: 238).

Intense anxiety about the risks involved in the process and its uncertain outcome was another cost described by an Amhara/Tigrayan man:

'You worry a lot while passing through all the processes because of the illegality of the whole thing and also you do not know what is happening next. You have to just follow and do what the person is telling you to do. It involves the risk of losing every thing. Therefore it was not easy to come here. However the best thing was to be able to free myself from all

those problems that I have been through. Even though living here is not easy at all' (007m: 295).

Bribing officials was spelled out as being a major means of passing through the process of seeking refuge, as another of our participants said:

'At that time one had to spend much money for a bribe to process his passport. Many things were needed at that time. My parents were able to help me leave Ethiopia, after paying a large amount of money for bribe and other things' (014m: 263).

Another gave a little more detail of how the process worked, and how it constituted an underground economy:

'The reason why they helped me to get a passport was not to save my life. They wanted the money. ...the officials did not know who I was. There was a middleman. I gave the money to him.... It was through bribe that I got the passport' (15m: 255).

Only one participant reported that they were enabled to stay in the UK through marriage.

Some asylum seekers get help from others whom they do not know and who expect payment in kind. These asylum seekers are particularly vulnerable to exploitation in the receiving country due to having no legal immigration status, being dependent, feeling beholden, or by being physically forced to remain in the situation against their will. One of the female participants described how she was imprisoned in the home of those who brought her to the UK:

'People brought me to Sudan under the guise of a housemaid. And from there I came here. However, the man who brought me here caused me a lot of difficulties. The man who brought me here lived in the countryside outside of London. There I was locked in his house for eight months. It was after that I found some people I knew before and came to London' (009f: 16).

Who helped

Getting to the UK was invariably expensive, and several participants said that they had received financial support to get to the UK. Others had financed it using their own assets, as described by one of the male participants:

'There is an Amharic proverb, which says; 'if there is money there is a way in the sky'. I had a little amount of money and asset and used it for my journey. I used the money to process my passport and visa. So, I did not ask anybody to help me. ...It was like any commodity in the market. I was in the market and I bought it' (012m: 329).

Some participants described having received financial support from several sources. Others were funded by one individual, often at great personal loss. For example, a young man stated that his mother had sold all her jewellery and used her savings to send him abroad.

Family and friends mainly provided financial support. Other people were needed to help with arranging the process. Some government officials had the means to assist with the process, as an Eritrean participant recalled:

'...there was this guy who was working for the government. He was on friendly terms with my parents.... He sort of smoothed things up. In the old days you needed to have what they call 'Wase' [a guarantor that somebody will come back, if not the guarantor will go to jail]. He sort of waived this requirement' (010m: 185).

The church was reported to have helped in two cases either by giving financial or practical help without charge. Others described how their situation at the time had made it easier to leave Ethiopia. For example, one young man stated how it was easier for him to come to the UK as he was employed at home and therefore he was trusted to return. However, he did not. An Amhara /Tigrayan man explained that he had bought a return ticket to the UK, got a six-month entry visa and then stayed

beyond this term; he was then granted indefinite leave to remain. Others came as quasi employees of those who had rights to UK residency.

In several cases, the interviewers did not ask the participants how they had come to the UK. In other cases the participants were reluctant to answer, or they gave only brief non-specific replies. The participants were not pushed into answering or answering more fully because of the sensitivity of the topic and the anxiety this may have aroused. The data on this subject for these participants is therefore incomplete.

Transit to the UK and arrival

Fifteen (n=15) participants reported that they had come to the UK via another country, most commonly via Bulgaria (n=4). Other countries in which they had spent time prior to coming to the UK include India, Russia, Kenya, Nigeria, Sudan, Saudi Arabia, France, and Austria. Most of these participants said they were engaged in work or education in these other countries. Many reported that when it was time to leave the country, they had sought asylum in the UK because of the political situation in Ethiopia.

One of our participants said she had gained entry into the UK with a family via Sudan in the guise of a housemaid. Others were actually working in the UK legitimately when the political situation in Ethiopia changed and it became dangerous for them to return.

A Gurage man described his eventual arrival in the UK following several months in Kenya where he was assisted with his accommodation and food with funds given by a Catholic Sister. He was on his way to seek refuge in another North European country travelling via London where he was intercepted. He went on to describe what happened following his release by UK immigration officials:

'For the three days we were with the Refugee Arrival Project. The Project was helping refugees with accommodation. The Refugee Arrival Project called the Eritrean Community to help finding us accommodation. The

worker at Refugee Arrival took us to the community office.... After that they took us at Seven Sisters for three days. ... the Eritrean community person telephoned the Ethiopian Community office and told them to take care of me. The Ethiopian Community took me to Highbury Islington hotel accommodation' (103MH: 850).

Another described how the person who brought him into the UK unexpectedly abandoned him on arrival and was left to find his own way out of the airport. He eventually found support from an Ethiopian community organisation.

Discussion

Most of the participants described their reasons for leaving Ethiopia as being due to the political situation in the country at the time, and because of war and conflict. They reported enduring persecution, harassment, torture, political imprisonment, death or disappearance of family members, threats to their own safety, lack of freedom of expression and will, coercion to support the ruling political regime, and other infringements of their human rights. Few reported being simply 'economic refugees'.

Parents who sent their sons to the UK in early adolescence to prevent conscription may have been unaware of the difficulties their sons may later face here. However, for such a difficult decision to be made, they must have been reasonably convinced that their actions would prove beneficial in that they believed conscription would almost certainly have led to injury or death.

Getting into the UK to live and work by legal means was difficult. In order to gain entry the participants had often to resort to illegal means such as false travel documents or being smuggled across national borders. These types of activities are likely to have caused a considerable degree of guilt and distress in the participants who were mainly religious and professional people. The guilt may have explained their reluctance to discuss their mode of entry, something which they were not pressed to disclose. They may also have been reluctant to relate the whole story for fear of exposing effective methods of gaining entry and ruining them for future

asylum seekers, fear of exposing collaborators, or fear of deportation. As interviewers were careful not to inflict undue psychological distress when asking participants to recount their reasons for leaving and their method of gaining entry, the accounts given here may not reflect the full picture. Nevertheless, it is clear that the decision to leave was often difficult, the reasons were strong, and the cost both financially and in human terms was high.

Chapter 9

Adapting to Life in the UK

Introduction

A model of acculturation that has become influential is that of Berry and Kim (1988). This postulates that on coming to a new culture, people decide how much of their own culture they wish to retain, and how much of the host culture they wish to acquire. The degree of retention of the old culture and acquisition of the new one results either in separation, marginalisation, assimilation, or integration. The type of acculturation depends not only on what the individual desires, but also on how easy the host society makes it for the immigrant to integrate. The individual may desire integration but could still be marginalised whereby they are not accepted or supported by either culture.

This study looked at participants' responses to their exposure to British culture and society and looked for variations in the process of acculturation for different sub-groups. It describes:

- The experience of being 'a foreigner' or 'a refugee'
- The importance of religion to coping in a foreign culture
- Variations in adaptation by age, gender and ethnicity

The experience of being 'a foreigner' or 'a refugee'

One of the major transitions for the participants on arrival in the UK was losing their status as citizens and becoming a foreigner and an 'asylum seeker' or a 'refugee'. Some of the participants described feeling demeaned by this new identity:

'Living in exile in a foreign country has repercussions. There is what is called "status". Status means to be a refugee and to be called "a refugee". This has a

big psychological impact on refugees. When I was in Ethiopia whether I was working or not, to be an Ethiopian was enough for me (017m: 439).

The stigma of being a refugee was reportedly compounded by the food voucher system, the visibility of which brought shame to some asylum seekers. One of the participants said that one of his older compatriots found the voucher system particularly difficult, *'Because he was a well-respected person back home and here he feels so undermined at his age to be identified as a "beggar" when he uses the voucher'* (048m: 29).

Some of the participants pointed out that Ethiopia is not a homogenous culture but that it is a 'mosaic' of cultures. Another said that Ethiopian refugees 'only have refugeedom in common'. A unifying identity therefore was found in being a refugee but this was described negatively:

'Being a refugee is like being a disabled person living with other healthy people. When we come here, we are trying to compete with people who speak the language, who live with their families, and live with their culture' (097E: 183).

Feeling like a 'foreigner' and having a sense of not belonging in the UK was experienced by some of the participants. This is distinguishable from the negative psychological impact of being labelled as a 'refugee', as one of the participants explained:

'[Ethiopia] is your own place and neighbourhood and every one knows you and you know them as well. You feel you belong to the society. But here you do not feel that you belong. Here you always feel as an outsider. ...I have been here for nine years but still it is very hard for me to feel that I am part of the society. Still I am a foreigner, a stranger or a guest. ...I think it is generally because of the cultural differences and the language. ...It is mainly a psychological fulfilment than a material one' (065m: 170).

The sense of alienation from the host culture was compared to various other negative situations. For example, one of the participants said that prison was preferable to a life in exile because, *'[In Ethiopia] when I was working as a journalist, I had a good life. Of course I had a rough ride too. I was in jail. However, at times I prefer prison to life in exile'*

(017m: 473). Living in exile was also equated with living 'like a wild animal' by another participant (018f: 374) because of the lack of social life and the subsequent loneliness.

One of the expert participants described how he aimed to integrate with British society. He wanted to retain aspects of Ethiopian culture that he felt were positive and that were not attributes of British culture:

'For example, using your language, talking to your children in your own mother tongue, attending your anniversaries, participating in social gatherings, making contact with your own people, visiting friends, knowing the bereavement process and bereavement procedures, the way of comforting and the norm regarding bereavement. This type of thing is not some thing that you would get in the British way of life. That is the positive thing that we have to keep' (095E: 341).

Some participants described how they actively tried to increase their adaptation to the UK, such as a young man who had been in the UK for more than five years:

'I want to know the culture of this country. I want know something everyday about this society how to deal with them, how to interact with them, what I need to refrain from. I also want to know how the society lives. I want to know the health system, educational, legal and social system. I want to know what people in this country like and what they do not like. I discuss with people' (081m: 289).

Difficulties adapting to the British culture was said to be a cause of stress, depression and poor health. One of the participants described the difficulties thus:

'... foreigners like that of Ethiopian refugees living in the area where there are not many Ethiopians; it could be a painful experience to live in a community with a different experience. It is difficult to integrate with the community. You cannot simply go and mix with the community. The community would not accept us either. It is always difficult to adapt and integrate quickly. Therefore, these sorts of things could have an impact on our mental wellbeing' (052m: 163).

The importance of religion to coping in a foreign culture

Participants were asked in the survey how important their religion was to them and why, they were also asked to state their religion. Of the sixty-three (59%) who stated their religion, most of the participants reported that they were Orthodox Christian (55%); the remainder were Christian (25%), Protestant (10%), Muslim (8%), and Jehovah's Witness' (2%). Only ten participants did not respond or did not enter a positive comment about their religion. Of those who did comment, the vast majority said their religion was important or very important to them. The comments they made about why it was important included the following:

Box 9.1 The importance of religion

- My religion is my culture /reflects my culture
- My religion is my identity
- My religion is my life
- It gives: hope, energy, peace of mind, strength, support, confidence, happiness, comfort, courage
- Gives opportunities to meet with friends
- It gives me guide in life
- It helps me refrain from doing bad things
- It protects me from bad things
- Cures me from disease

Several participants said religion was a central part of their cultural identity. For some it was an important aspect of life that they did not want to lose: one of the participants said, *'It is my culture and I want to stick with my religion / culture'* (087m). Religion provided them with guidance when they were troubled and when there was nobody to get support from. It gave them strength and many other positive feelings that helped them cope with life's problems:

'My Orthodox Christianity had helped me survive in the time of stress and depression. It has given me some hope, hope for the better, hope for tomorrow and for a better esteem in the time of difficulties' (098m).

It was also seen as a link with their past and attending church reminded some of them of being in Ethiopia. Religion also provided a degree of continuity and familiarity in an unfamiliar and rapidly changing society. However, it was reported by some Christian

Orthodox participants that appropriate places for worship were limited, something which was a source of stress for at least one of them.

Variations in adaptation by age, gender and ethnicity

Adapting to life in the UK was reported to vary according to age on arrival, and gender. Women were said to adapt better than men. It was reported that living in the UK had given many Ethiopian women the opportunity to be liberated from a position of subjugation and to become active in public life:

'...A woman [in Ethiopia] has no freedom. Her voice is not heard. She has no voice. People look down on women. There is no democracy. It is not like this country where women have equal rights with men' (051f: 307).

Whereas the men were reported as being likely to experience negative effects from being in the British culture, as one of the expert participants described:

'Men are considered as the head of the household and the breadwinner and are more outspoken in public in Ethiopia. Whereas women are more domesticated and play a very significant role. But...in the UK, surprisingly the roles are reversed and women are more flexible and go out and earn their living. Men I think could lose their self- esteem.... Due to this factor there is a breakdown in relationships. Marriages are affected. There is also a tendency among the Ethiopian women not to associate with Ethiopian men' (96E: 99).

Ethiopian women therefore stand to gain more from their new-found freedom and equality and to benefit more from UK society than men by adapting and integrating into UK culture. Whereas it was believed that men were denied the respect they were accorded in Ethiopia, particularly when they had to do 'women's work' in the UK, and when acculturation might mean being expected to play a more equal role in the household.

That Ethiopian women may choose to assume too much of the UK culture was seen to be negative by one of the male participants, if it put traditional values at risk.

'...We have to also keep our culture intact. When I say intact, I mean with inverted commas. Equality should be assured there is no question about that. There is no compromise on that. But, on the other hand there is dependency from the women, they take everything from the white culture. This is not acceptable. ...We have to keep our values. That is part of our identity. That is part of what we are. This is a contradiction here. Basically, there are basic human rights for all, be it for a man or a woman. I think we need to respect this. We can learn quite a lot of things from the host culture. But in the mean time we need to respect/keep our culture intact as much as possible' (082m: 192).

The reported ease of adaptation and acculturation for Ethiopian women appears therefore to be associated with their former subjugated position in a strongly patriarchal social system: Ethiopian women potentially have more to gain than Ethiopian men by living in the UK.

Variation among different age groups was also evident. Young people were believed to adapt more quickly and reportedly picked up the language and accent better than older people. Young people (but not minors) described specific disadvantages on coming to the UK. They had often not been independent of parental support before. Therefore they needed to learn to budget, cook, clean and make decisions for themselves. Many of the older males reported suffering the humiliation of financial dependency, diminished social status, and loss of identity as a worker and breadwinner. Minors appear to adapt most quickly, as one of the young participants described:

'When I was in Ethiopia I was very young and I did not see much of it and it is not going to be easy for me to see the difference. I was just a little girl going to school and helping my mum at home with the housing chores. That was why, I think, I adopted the European culture faster, and alarmingly faster' (029f: 109).

A young woman aged under twenty-five described how she now feels at home in the UK and how Ethiopians now seemed strange to her:

'...I do not feel Ethiopia as my home but western country my home because although I felt alien when I first came here, I feel stranger when I go back home

and I want to come back because I find the people very strange, including my family. There are a lot of things that I do not understand about them' (030f: 308).

Differences in adapting to the British culture and social system may also vary according to ethnic origin, as one of the expert participants explained:

'If you are an Oromo you will have a different set of ideas, if you are an Amhara, a different set of ideas. ...It is not that every refugee is similar. In many ways they are different, because they come from different backgrounds. Ethiopia does not have one culture. It is a mosaic of different cultures, a mosaic of different religions and languages...' (101E: 111).

Discussion

The accounts of our participants showed a wide variation of acculturation experiences and strategies ranging from separation to integration. Some participants did not feel a sense of belonging despite many years in the UK, whereas others adapted quickly and completely to the point of finding Ethiopian culture strange.

Berry (cited in MacLachlan, 1997, p41) suggested that acculturation strategies could be ordered in a hierarchy based on the level of stress associated with it. Integration being associated with the lowest levels of stress, then assimilation, separation, and then marginalisation which was associated with the highest level of stress. As stress is linked with poor mental and physical health, those who are less integrated are likely to have higher health care needs. They are also least likely to be able to access health services because of, for example, poor command of the English language, little understanding of the British health care system, and a preference for traditional health care (see Chapter 12).

The participants described their sense of belonging to the UK culture and their degree of acculturation as being dependent on many variables. These included personal desire for integration, and what there is to gain from it; the host culture's hospitality; their personal socio-economic circumstances; and the types and frequency of social and other opportunities

that prevailed. Negative impacts on acculturation included the stigma of being a refugee (compounded by the food voucher system), poverty, social isolation, poor command of the English language, demoralisation, and the major cultural differences between Ethiopia and the UK.

That Ethiopian women adapt better than men to the UK culture, as was suggested by our participants, was also found in a study by McSpadden & Moussa (1993). They posited that it was due to the increased sense of freedom and opportunities for independence the women had in the UK compared to Ethiopia. The males on the other hand were said to be more likely to have experienced diminished social status through losing their position of authority in the family and consequently their pride and respect. They were often unable to fulfil their responsibility of protecting their female family members or to get jobs of the same status as they had in Ethiopia.

The reported difference in adaptation between Ethiopian men and women was felt to be a cause of rifts in heterosexual partnerships. Although most participants were single and therefore not many marriages were being put under strain, the findings suggest that future marriages between Ethiopians in the UK could be threatened.

Religion was felt to be an important aspect of the participants' personal cultural identity. It gave support to help them deal with their losses and also provided a sense of continuity, community and strength. It appears to have played a positive role in easing them through the process of adaptation to life in the UK.

Chapter 10

Settling in the United Kingdom

Introduction

Asylum seekers and refugees in the UK are presented with a set of problems that are shared by many other marginalised groups in British society. These problems include high levels of unemployment, poor housing, poverty, inequality of opportunity, and discrimination. However, they also suffer the additional stress of claiming asylum, uncertainty about their future because of their immigration status, separation from their own culture, family and friends, and the need to adapt to a new culture and climate. Although all asylum seekers and new refugees are likely to experience these circumstances to some extent, there are differences among different cultural groups in how they respond to these circumstances. This chapter describes the experiences of Ethiopian asylum seekers and refugees in relation to the following aspects of settling in the UK:

- Experiences with the UK immigration department
- Experiences with employment
- Educational attainment and experiences in Ethiopia and the UK
- Experiences with housing
- Material security
- Experiences with statutory and community welfare agencies

The themes that arose were derived from interviewees' responses to questions that asked how they were settling in the UK, and how life in the UK differs from life in Ethiopia.

Experiences with the UK immigration department

Two sub-themes were identified from the theme data:

- ▶ Difficulties Claiming Asylum
- ▶ The Stress of Waiting for the Home Office Decision

Difficulties Claiming Asylum

One-quarter (25%) of those who responded to the question of whether or not they'd had problems with the immigration department reported that they had. Table 10.1 illustrates that those who had lived in the UK less than five years were much more likely to say they had problems than those who had lived here more than five years (50% versus 11%, $p = < .001$).

Table 10.1: Problems with immigration by length of stay in the UK

| Do you have problems with immigration? | How long lived in the UK | | | | |
|--|--------------------------|-------------|-----------|--------------|------------------------|
| | <5years | | 5+years | | Total |
| Yes | 17 | 50% | 7 | 11.1% | 24 24.7% |
| No | 17 | 50% | 56 | 88.9% | 73 75.3% |
| Total | 34 | 100% | 63 | 100% | 97 100% |

Convincing the immigration department that an application for asylum was genuine was reported to be extremely difficult. Producing evidence of severe danger when in the midst of it can be particularly problematic, as described by one of the participants:

'Proving that you are a person genuinely fleeing the country within the procedures and guidelines in this country is very difficult, for the very fact that one cannot search for proof when his or her life is endangered. It is not possible to get documentary evidence to do that. Even those who are prominent political activists are not able to do that' (095E: 266).

The difficulties in producing evidence of the need for asylum appear to be compounded by the psychological consequences of political persecution in Ethiopia. For example, one of the participants pointed out that Ethiopian asylum seekers and

refugees *'will feel less secure and will be scared of authorities'* (010E: 79). Such fear of authority may hamper an individual's ability to assert their needs to the Immigration Officers and potentially compromise their success in claiming asylum. In the very least, it is likely to create a stressful situation for the asylum seeker.

Compounding the fear of authority is the reported Ethiopian tendency to be shy and unassertive. This was thought to be more of a characteristic of women and children because of their particularly subjugated status in Ethiopia. One of the expert participants explained this disadvantage thus:

'...As far as women and children are especially concerned, Ethiopian culture is very suppressive. [They] are not allowed to speak out what they think. ... So fewer children and fewer women will be explaining their problems. They feel ashamed in front of others to speak in front of others. This is a big hindrance. ...They are not practising or exercising their rights properly...' (101E: 42)

The lack of assertion was reported to be so extreme in some cases as to be a threat to their life as they risk being deported back to a dangerous situation, as one of the participants explained:

'Because of politics and the government we were made not to say what we want and when we come here that is our problem: many Ethiopians don't say what they want. Maybe they will start telling you the basic parts but not all the details, even if it is life threatening because they are shy...' (03m: 280).

The shyness was reported to manifest itself in body language whereby eye contact is avoided as a sign of respect. Another participant explained how this body language could have potentially serious consequences:

'...let's say somebody goes to the Home Office or to the police station, and the policeman is questioning an Ethiopian, then, because in respect Ethiopians always look down, they don't look a person in the eye...and if

they are being questioned, they may well be ...misconstrued as lying...'
(022f: 597).

The Stress of Waiting for the Home Office Decision

In 1999, the average length of time applications for asylum took to process by the Home Office was eighteen months (Aldous, 1999). Some of the participants in our sample had been in the UK for over five years and were still awaiting a decision. Not knowing what the decision would be was reported to be a significant source of stress:

'The second and most important thing that stresses me is my immigration case. I sometimes have nightmares about it. I wonder if they are going to reject me. This I think would be any refugee's cause of stress' (0450f: 437).

The fear of deportation could persist for several years if for example, they did not have a clear-cut case, such as someone who has only been granted exceptional leave to remain, or who has immigration problems:

'I know about more than 10 of my friends with immigration problems. They always think about the Home Office paper. They don't sleep. Whenever they receive brown enveloped letter from the Home Office they think about deportation, court hearing and the like. They cannot settle. They are here five or six years. They are still in fear of deportation. I know people who have nothing, not even a radio. Because they are uncertain about their stay here, about their future. You can imagine what a life of fear for six or five years would feel like!' (104MH: 328).

The loss of freedom of mobility was also reported as being problematic for asylum seekers. It was described by one of the participants, who came to the UK in 1992, as depriving him of fundamental freedoms and the ability to fulfil some of his basic human needs:

'It is like a prisoner without the immigration paper. If your family back home is sick or passed away or have a wedding or other important things,

you cannot travel anywhere without this paper. You cannot visit your relatives living in other countries. Due to this, you can consider yourself in a big prison.... No matter how we work very hard to make money and help ourselves... we cannot go for a holiday. It has a big effect' (104MH: 275).

Discussion

Ethiopians may be vulnerable to a negative outcome from the Home Office because of their tendency to be unassertive and to feel threatened by authority. In addition, their body language may be misconstrued as indicating that they are lying. They may therefore need encouragement to give the details of their reasons for seeking asylum. Ethiopian advocates or translators can do much to help in this regard.

Being out of contact with relatives and friends in Ethiopia had a deleterious effect on the emotional wellbeing particularly of those who were asylum seekers or who had exceptional leave to remain. These groups do not have rights to leave the country and return or for relatives to visit them. Further stress is caused to asylum seekers by the frequent long wait for the Home Office to decide on their application for asylum. The Immigration and Nationality Department (IND) aims to ensure that 'by 2004, 75% of substantive asylum applications are decided within two months' (Glover et al, 2001, p17).

Experiences with employment in the UK

Ethiopian refugees have the same rights to employment as British citizens, apart from not being able to work for the civil service. People granted exceptional leave to remain are also permitted to work. However, asylum seekers cannot work for the first six months following their application for refugee status, they may then apply for permission to work.

Employment has positive impacts on refugee and asylum seekers' material and emotional well being. However, there are barriers to refugees finding suitable work and consequently many suffer the effects of unemployment, underemployment or

unsuitable employment, in addition to the stress of adjusting to a new culture and society.

The following sub-themes were identified from the theme data:

- ▶ Employment status in Ethiopia
- ▶ Employment status in the UK
- ▶ Barriers to employment and self sufficiency
- ▶ Illegal Working

Employment Status in Ethiopia

All one hundred and six (106) participants were asked what their occupation was in their home country. Seventy-seven (n=77) described their occupation, twenty-one (n=21) respondents did not answer, and for eight (n=8) the question was not applicable. Non-response to this question could mean that they did not have an occupation, did not wish to disclose it, or other reason. Just over one-third (n=37) of respondents recorded that they were students back home. Of the forty (n=40) who described their occupation in Ethiopia, many had been professionals such as nurses, teachers, lawyers, engineers, accountants and managers. We do not have explicit data on unemployment in Ethiopia for our sample to compare with the UK.

Employment in the UK

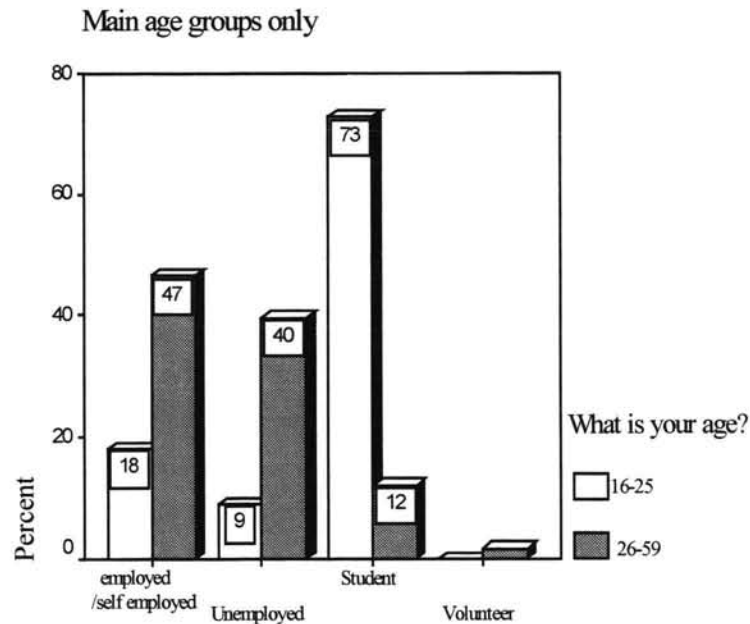
Respondents were asked what their employment status was currently in the UK. One-third (33%) reported that they were employed, just over a quarter (26%) were unemployed and two-fifths (38%) reported that they were students (Table 10.2). Some recorded being unemployed and a volunteer, or a student and a volunteer, these were counted in the 'unemployed' and 'student' categories respectively. Two (n=2) said they were volunteers only.

Table 10.2: Employment Status in the UK

| Employment Status | Number | % |
|------------------------|------------|--------------|
| Student | 40 | 37.7 |
| Employed/self employed | 35 | 33.0 |
| Unemployed | 28 | 26.4 |
| Volunteer only | 2 | 1.9 |
| New arrival | 1 | 0.9 |
| Total | 106 | 100.0 |

Figure 10.1 illustrates the variation in employment status in the UK between the two main age groups (aged between 16-25 and 26-59). Those in the younger group were more likely to be students (73%), whereas those in the older age group were more likely to be either in work (47%) or unemployed (40%); $p < .001$.

Fig. 10.1: Employment Status by Age Group

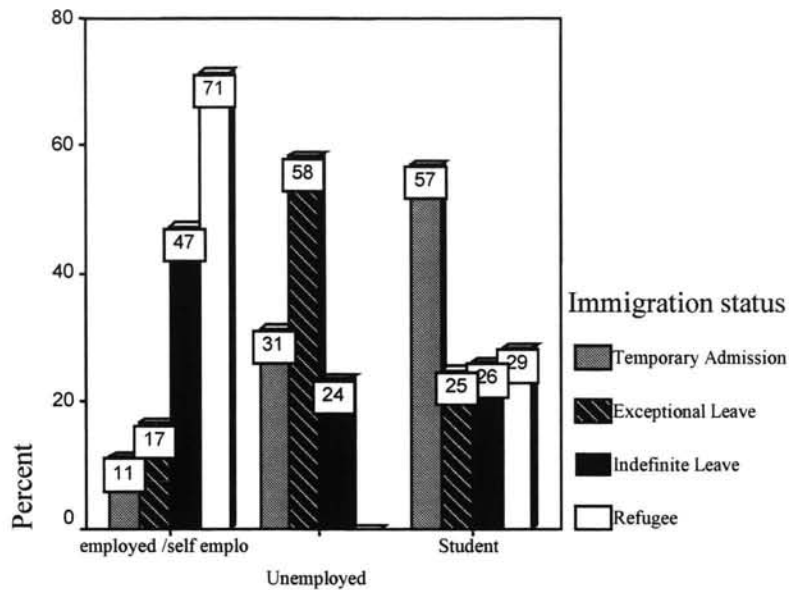


As there were few participants under the age of sixteen or over the age of sixty, these were excluded from the analysis of employment status by age.

Variation in employment status was also found to vary according to the immigration status of the respondents (Fig. 10.2). Of the participants who had temporary admission, over half were students (20/35), one-third were unemployed (11/35), and around one-tenth (4/35) were in employment. Of those with exceptional leave, over

half (7/12) were unemployed, a quarter (3/12) were students and the rest (2/12) were unemployed. Half (18/37) of those with indefinite leave were employed and the rest were either unemployed (9/37) or students (10/37). None of those with refugee status (n=7) were unemployed; they were either working (n=5) or students (n=2); $p < .001^*$.

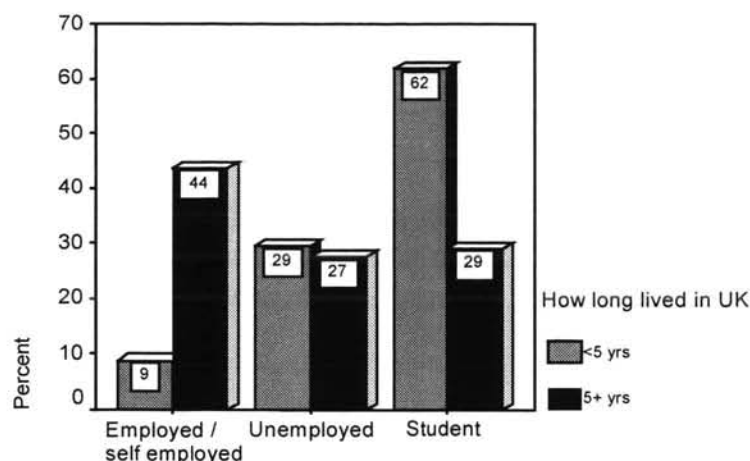
Fig. 10.2: Employment Status by Immigration status



The graph above excludes four participants whose immigration status was classified as 'other', missing data and those who described doing only voluntary work. There were ninety-one cases included in this analysis.

*More than 20% of cells in the cross-tabulation table had an expected frequency < 5 , therefore a larger sample size could reveal different patterns in the association between immigration status and employment status.

Variation in employment status by length of stay in the UK was also explored (length of stay being re-categorised into those who had stayed less than five years and those who had stayed five or more years). As would be expected, the participants' length of stay in the UK did effect their employment status (Fig. 10.3). Although almost equal proportions were unemployed, there was a marked variation in their status as workers or students: those who had been in the UK under five years were twice as likely to be students and were least likely to have a job (9% versus 44%; $p < .05$).

Fig 10.3: Employment Status by Length of Time in UK

The data were further explored to determine how length of stay in the UK impacted on employment status for those in each age group (Table 10.3). None of those aged under twenty-six who had been in the UK less than five years had a job; all but one (21/22) were students. This contrasts with the under twenty-six year olds who had lived in the UK five or more years who were more likely to be employed (21%), some (16%) were unemployed and fewer (63%) were students.

Of the twelve (n=12) participants who were aged twenty-six and over and who had been in the UK less than five years, most (75%) were unemployed, none were students, and only a quarter (25%) were employed. This again was in contrast to others in their age group who had lived in the UK more than five years (n=43). Of these, more were in work (54%), fewer (33%) were unemployed and more (14%) were students. Some of the older age group who have been in the UK several years may have taken up courses to improve their opportunities of finding work, or as an alternative to employment, as unemployment was still relatively high for this group.

Table 10.3: Employment status by age group and length of stay in the UK

| Employment Status | Age <26 In UK <5 yrs | | Aged <26 In UK >=5 yrs | | Aged 26+ In UK <5 yrs | | Aged 26+ In UK >=5 yrs | |
|-------------------|-------------------------|--------------|---------------------------|--------------|--------------------------|--------------|---------------------------|--------------|
| | N | (%) | N | (%) | N | (%) | N | (%) |
| Employed | 0 | (0) | 4 | (21) | 3 | (25) | 23 | (54) |
| Unemployed | 1 | (5) | 3 | (16) | 9 | (75) | 14 | (33) |
| Student | 21 | (96) | 12 | (63) | 0 | (0) | 6 | (14) |
| Totals | 22 | (100) | 19 | (100) | 12 | (100) | 43 | (100) |

The associations for Table 10.3 were statistically significant ($p < .001$) but the number of cells with an expected frequency of less than five (50%) render these findings unreliable in terms of generalising the findings to the population from which the sample was drawn.

There was no statistically significant association between gender and employment status.

Ethiopians were described as being hard working people by one of the expert participants and being out of work was described as being an additional and major source of stress. Stress was believed by a third of respondents to be a cause of illness, and two-thirds reported work to be linked to being a healthy person.

'There are a lot of refugee people who can contribute to this country if given the chance. Lack of this opportunity makes people feel some sort of incompleteness. This is a good cause of stress. As a refugee, I cannot begin and end the reasons for stress. Being a refugee by itself is a source of stress' (105MH: 93).

Some (n=6) took up voluntary work so that they could contribute to their community and they stated that it gave them a lot of satisfaction; *'Most of the time I am doing voluntary work...because I enjoy doing it. I get mental satisfaction.... I am in touch with my community. I am contributing to the welfare of the community'* (031m: 474).

Some participants had difficulties finding work that was comparable to the work they had done prior to coming to the UK. For example, a researcher in Ethiopia became a residential social worker in the UK, an accountant became a waitress, and a teacher became a mini-cab driver. Some others, such as one of the nurses and another

accountant were fortunate in securing the same role in the UK. Coming to the UK as an asylum seeker caused significant downward social mobility for many of the participants. Some of these described their sense of self-worth and sense of future being replaced by feelings of desolation. For example, a female participant said:

'I was a journalist back home. I used to work for a private firm as a reporter. We had a professional union. ...We used to discuss about our plans for future activities. After I arrived in this country, I had no plan and I have nothing to plan for' (042f: 508).

Another participant described how he also became demoralised and lost his self-respect and self-worth when he could not find suitable employment in the UK:

'Back home I was a university lecturer. Being a university lecturer itself puts people in a special position in the society. I used to meet my ex-students working for different organisations. ...They would wish me health and peace with respect. In this country (UK) however, I am nothing. I am nothing at all. They would say a black man is walking in the street. I know what they would say, and I also know my place in the society' (058m: 378).

Gaining employment was reported to help refugees settle in the UK and to gain a sense of belonging and citizenship. An Amharic participant, who had been in the country more than five years, described the impact of working on adaptation succinctly when he said:

'I am settling well now in terms of finance and health. I am working at this moment. ...I am supporting myself. I am not taking Income Support. I cope with the system now. ...England is as my home now. I am accepting here after long years that this is my life. This is my country. Everything that happens in this country, bad or good is as it happens on me. I accept it like people who are living in England or who are born in England' (102MH: 468).

Barriers to Employment and Self Sufficiency

Finding suitable employment was described as being fraught with difficulties and these are listed in Table 10.4. Several participants said they had to take jobs that were well below their capacity because they lacked qualifications, lacked work experience in the UK, or did not have a good command of English. Some had qualifications that were not valid in the UK. Many others could not find (suitable) work for other reasons.

Table 10.4 Biggest problems in getting work

| Biggest Problems in Getting Work | % |
|---|----------|
| Little or no work experience in the UK | 40 |
| Need more qualifications | 38 |
| Immigration status | 29 |
| Poor English | 27 |
| Discrimination | 27 |
| Qualifications not valid in UK | 27 |
| Other problems (specified) | 17 |

More than one reason could be selected.

Other reasons given for finding it difficult to get work included the lack of money to travel to look for work, health problems, having young children and no child care support, and not understanding how the employment system works. Women are particularly likely to be unable to work if they cannot find or afford child care, and as refugees they are unlikely to have an extended family member who can take on the child care responsibilities whilst they work. Another barrier to finding employment, according to the Audit Commission (2000) is employers' confusion about refugee and asylum seekers' entitlement to work and their status.

Although asylum seekers can apply for permission to work after six months, in practice they may have problems getting work because the process is bureaucratic and long. They may also have difficulties opening a bank account into which a salary can be paid because of lack of adequate or valid documentation or references, this may put off a potential employer.

Those who reported that poor English was being a barrier to them getting employment were indeed more likely to be unemployed than those who had no reported problem (50% versus 21%; $p < .05$).

Many of the participants were, or had been working towards removing the barriers to (suitable) employment through taking up educational opportunities since arriving in the UK, such as English language and vocational courses. However, some felt very disappointed that even with extra qualifications they could not find appropriate work, such as a female participant who said:

'...I arrived in this country to work and improve my qualification. It is my ambition to improve my qualification. To achieve this I need to have determination. Therefore, I started studying. I studied. I completed my study. I want to work in line with my qualification. Now, I am trying my best to get job according to my qualification. I have been searching for a job since my graduation. I could not succeed to get a job up to now. ...Therefore, I am very much concerned about getting a job. I could go mad if I fail to get a job' (071f: 175).

The tendency to get frustrated when work appropriate to their level of education could not be found was reiterated by one of the expert participants:

'Some researchers have identified that amongst refugee communities, the Ethiopians are the best educated, and they are highly educated and possess a wealth of professional work experience. And yet they find it difficult to get employed that is to the standard of their qualification and experience, and [they] become frustrated. They greatly value their education and experience and loath to do what they see as menial' (94E: 177).

On the other hand, there were others that were willing to gain work experience and self-sufficiency by taking any opportunity for employment, such as agency work, shift work, or part-time work. One of the female participants who had been an

academic in Ethiopia recalled her struggle to achieve a permanent job (she eventually became a residential social worker):

'At the beginning I was relying on government support, but eventually I took some training and registered with an employment agency. After a couple of year's experience I managed to get a permanent job. In the beginning it was a struggle and was not easy at all (064f: 252).

Getting a permanent position for this participant was an improvement on having temporary work, even though it was of a lower status than the work she had in Ethiopia.

Some reported feeling angry that they had invested so much time and energy into their education and careers only to find their qualifications were not recognised in the UK. This was particularly so for those who felt that their age now mitigated against starting studying again. Other participants seemed to accept having to start all over again, such as a middle-aged man who had been a teacher in Ethiopia who said:

'Thank God. I have been in part-time employment for more than three years. Currently, I am studying a course to help me get a full-time job. Even though my income has been very small, I am self-sufficient. So, I am very happy because I am free from government handout. Currently, I am working hard to develop my career and be in full-time employment' (011m: 198).

These participants are at least partial success stories, and they illustrate how determination and a willingness to lower expectations, at least initially, can pay off. However, there were barriers to finding suitable work that participants did not have the power to change. These were their immigration status, and racial discrimination. More than a quarter of the participants felt they had experienced discrimination and racism when seeking employment. One of the female participants described how she believed employers discriminated:

'It is mainly your language and also your name. If two people with names Tsehaye and Steven applied for a job, they give priority to Steven while they are having the same qualification. Therefore, if you are a foreigner it is very hard to get a job. You assume that there is an equal opportunity but practically there is none. How can I explain it to you? This is usually done indirectly and hardly noticed. The reasons that you usually get [for not getting the job] are not convincing' (05f: 270).

She also felt that speaking on the telephone to potential employers with a non-English accent evoked unfavourable discriminatory responses.

Refugees are also disadvantaged in finding suitable work because they do not have the network of contacts or mentorship that many people who are settled in the UK have.

'When we come here, it is different. We are seen as second class citizens. We cannot achieve what we want to. For example, to be a doctor here needs more than studying. ...Contact, friendship and nepotism are also needed. Effort is needed. Confidence and self-esteem is also necessary' (014m: 197).

One of the expert participants suggested that the Ethiopian tendency to be modest could lead them into failure to be competitive enough in the employment market:

'I believe those Ethiopian values and beliefs affect Ethiopians. There are also some negative aspects as Ethiopians come from a background of a religious society, where modesty is considered to be one of the good qualities. So, in a competitive society you find it very difficult to compete with the rest of the society and achieve. Sometimes it frustrates and leads to mental health problems' (096E: 46).

Others said that adapting to a new culture and language also made it harder to succeed academically or with employment as it diverts time and energy:

'Many Ethiopians spend much of their time in settling down and adapting to the British way of life. ...Their productive years could have been used for studying or where they could progress in life. [Instead] many Ethiopians spend their time studying English, sorting out their lives and learning the culture. These are the main problems' (014m: 222).

One young man described being completely exhausted by his struggle to live in the UK to such an extent that he felt unable to work:

'I cannot say I am absolutely psychologically healthy because of life in this country. The reason is the problems I faced and the hardships I experienced had an impact on my confidence and have influenced my life. This means that in my prime time, when I am supposed to work and have a family, I am emotionally drained. I have been struggling with myself and I have lost my energy. ...I think I have burnt out. This is why I am not working here, as I wanted to work' (014m: 292).

Illegal Working

For some, the inability to work legitimately and their desperation, both financially and psychologically, made them open to exploitation as illegal workers. They accepted very low pay for doing work that many other people would be unwilling to do, or to do for the wage. One described the type of illegal work he did as the worst he had ever done. It involved cleaning toilets and kitchens. One of the male participants explained the illegal worker's plight thus:

'There is a real, real shortage of money, there is an amount of money the government gives depending on age for food, but that is not enough. However, for it to be enough and to have a little extra money there is undercover work. Even though the money is not much, it gets you some change into your pocket. That is the kind of jobs many Ethiopians do in this country, it means they do part time jobs, they do 16, 18, 20 hours a week...' (093m: 413).

Another suggested that the inability of asylum seekers to work as a means of improving their financial circumstances might lead some into other criminal activities. He stated, *'In the UK if you are genuine, you could not earn anything unless you fiddle, steal or do these sorts of things. The reason is that the capitalist mode of production or system encourages fraud'* (011m: 184).

Discussion

The Ethiopians in our sample were generally ambitious and keen to progress. Self-sufficiency and not having to worry about one's livelihood was seen by many of the participants as necessary for good health and wellbeing. None of the participants talked about becoming rich or being materially successful for its own sake. They described how working had given them financial security, independence, improved wellbeing, and a greater sense of belonging in the UK. It helped them to integrate by facilitating an improvement in English language and a better understanding of the UK culture. This is supported by at least one other study (Carey-Wood et al, 1995). Voluntary work also provided a satisfying and very positive experience.

Despite eagerness to work, high levels of unemployment were found among the sample, particularly in those in the twenty-six and over age group who had been here less than five years. Those with exceptional leave to remain (ELR) had a higher level of unemployment than other immigration categories. This may be due to their indeterminate length of stay in the UK, whereby potential employers may be less willing to take them on and invest in them. The potential employee with ELR may also have difficulties committing to activities that will improve their chances of employment, such as educational activities. They are in effect in a state of 'limbo'.

The participants confronted many other barriers to employment, such as lack of qualifications (or invalid qualifications), lack of work experience in the UK, language barriers, and racial discrimination. Those with qualifications that were invalid in the UK and who felt they were too old to start again felt particularly frustrated and despondent, as did those who could not get work with equal status to the work they had in Ethiopia.

The accounts of the participants showed wide variations in response to disadvantage in the employment market. Some showed resilience and readjusted their work expectations. These participants seemed to appreciate improvements in socio-economic status in a relative way rather than an absolute way. This was indicated by the comparisons they frequently made in the interviews between their initial circumstance in the UK and now, or comparisons between themselves and other refugees. For example, one of the female participants said, *'When I say that I have a nice life, I mean that I have a job. I mean I have my own house to live in. My life is better than that of some of my fellow refugees'* (54f: 292). Comparing themselves positively in this way seemed to offer consolation when reflecting on their (often) diminished social status and may have been a useful coping strategy.

The variation in employment status in the two main age groups suggests that age is a significant factor in the types of social experiences the participants are likely to be exposed to in the UK, and that this may impact on acculturation. Those who were over twenty-five and in the UK less than five years being perhaps more likely to feel excluded from mainstream society due to a higher likelihood of being unemployed. Whereas the younger age group, who were mostly students would have been exposed to a social environment in which pressures to adapt and opportunities to learn the culture were greater.

Women with dependent children may also be disadvantaged in the labour market and in education, as the jobs they can get may not pay enough to afford childcare. They are also unlikely to have the informal childcare support of an extended family. Unemployed migrants are more likely to suffer mental and physical ill health thus putting a burden on health services.

The study also highlighted the need for advice on education and employment that is given in Amharic as well as English to help them make appropriate choices that are more likely to lead to positive outcomes. There was also a suggestion that Ethiopian asylum seekers should be informed early on about British culture and society, and the sorts of difficulties and experiences they as new migrants are likely to face. This was

thought to be helpful in reducing the stress and disappointment experienced by many refugees as they struggle to achieve their goals and expectations.

Educational attainment and experience in Ethiopia and UK

- ▶ Educational Attainment in Ethiopia
- ▶ Educational Experiences in the UK

Educational Attainment in Ethiopia

The participants were asked what qualifications they had when they arrived in the UK. Of the eighty-four (n=84) who responded, fifteen percent (15%) reported that they had none, whereas nineteen percent (19%) said they had a Bachelor degree or higher degree. Others had diplomas (10%) or professional or vocational qualifications such as nursing and accountancy (6%). However, when those with qualifications were asked which qualifications were recognised in the UK, two-fifths (42%) of those who answered the question said that none of their qualifications were recognised. This sudden invalidity of qualifications on arrival in the UK, and the realisation that one had to study again was reported to be another source of stress:

'Looking for a job is hard and also when people come here thinking that they have finished their studies they are told that their qualification is not accepted. This means that they will have to go back to school and that could make them stressed and worried' (047m: 175).

Educational Experiences in the UK

Over half (57%) of the participants reported that they were currently studying in the UK, twenty seven percent (27%) of these reported that were engaged in university courses (14% of total sample). Several others were studying information technology and computing. However, many did not specify what they were studying. Others were engaged in vocational training.

Learning or improving their English language was reported as being a very important avenue to progression in the UK. Two percent (2%) had English as their first

language, eighty one percent (81%) Amharic, ten percent (10%) Oromo and the rest had other African languages. When asked what their biggest problems were when seeking employment, twenty seven percent (27%) said that their lack of proficiency in English was. As one participant said, *'Language is paramount. I personally think that if your English is good you can find a job. It is something that you use to understand and communicate with people'* (034f: 529). Fourteen percent (14%) were currently studying English as a second or other language.

The participants were generally pleased with their educational opportunities in the UK and they were grateful for them. As one of the participants said, *'When I came to this country, I do my job peacefully; go to training to improve my knowledge.... The country is also encouraging and I will have to thank them for this'* (044m: 469). However, although opportunities were there, they could not always be taken. Adult asylum seekers can take any course they want provided they fulfil the entrance criteria and can pay for their fees (as overseas students) and maintenance. For asylum seekers, an application for asylum has to have been made at least three years before they become eligible for home fees. (Refugee Council, 2000). Because of financial hardship therefore, some of the participants were unable to afford to study in higher or further education. Consequently many only took short courses, at least initially and looked forward to the time when they could do a degree:

'...I couldn't go far concerning my studies. I keep on studying short courses like HNC, six-month courses. That is what I can do. If I get money for sure, I will continue my course doing a first degree or whatever I like to study' (106MH: 147).

Having to wait to study in higher or further education caused a lot of frustration to some of the participants who were ambitious and keen to progress.

'I got a training opportunity, but could not start the course because of financial constraints. Currently, I am not entitled to Government grants. When my asylum application is resolved, I would be entitled to grants to start the course' (039m: 434).

Not only are educational opportunities reduced for asylum seekers, but their educational achievement may also be negatively effected by their immigration status. Two participants spontaneously described difficulties concentrating on their studies because of worries about their immigration application. Others had concerns about the family they had left behind in Ethiopia, as described by one of the participants when asked if he had had educational or training opportunities:

'Yes. I had the opportunity. I was not settled at the beginning. I was thinking about my family. Therefore, I could not concentrate on my education. I could not follow lessons taught in the class at that time. It took me a long time to recover and get good concentration. Currently, I am ready to continue my education. The Government has also given me the right to live in this country. Therefore, I am a bit more comfortable than before. My problems are sorted out' (069m: 437).

Unaccompanied minors living with foster parents were reported to be potentially disadvantaged in terms of educational attainment because of the stress of being away from their family and having to adapt to the UK culture. They may also be reluctant to ask their foster parents for support and assistance with their studies such as getting access to the Internet.

Having to move home frequently was cited as a further barrier to taking up or completing educational opportunities. Living in hostels or other half-board accommodation also posed a barrier to taking up educational opportunities when meal times coincided with the time of courses.

Another barrier to self-improvement reported by some participants was a lack of appropriate advice about what courses they should take to fit their needs. The advice given was often in English and was not always fully understood by those whose command of English was poor. This could lead to inappropriate educational choices leading to inability to get the work they wanted, as one of the participants recalled:

'...For some years I could not study the subject I needed to study. When I arrived I was 19, I was not speaking English. I did not know which

subjects I had to study. ...I started studying general language, then later on I started studying electrical installation....Then I started thinking about other things and it was total confusion. If it were back home, you could consult someone. There were people who could say do this and that...' (023m: 408).

Discussion

Education and fluency in English language are primary predictors of success in the labour market and in hourly pay (Glover et al, 2001, p 31/33). This relationship seems to be well recognised by Ethiopian migrants. Many took up opportunities to improve their English, such as mixing with English speaking people and studying English. Early advice (in their mother tongue if necessary) about how to gain employment in the UK, what courses are available, and what would be most appropriate for their needs is important in assisting them find suitable employment.

Professionals whose qualifications are not valid in the UK feel particularly frustrated and may need specific help. More novel schemes are needed to help refugees who are professionals into practice in the UK such as that devised to help qualified medical practitioners who were war refugees (Elliot, 1998). Ethiopian refugees are a rich source of talent and skill often in short supply in the UK, investing in them would be of benefit to the refugees and the country.

Experiences with housing

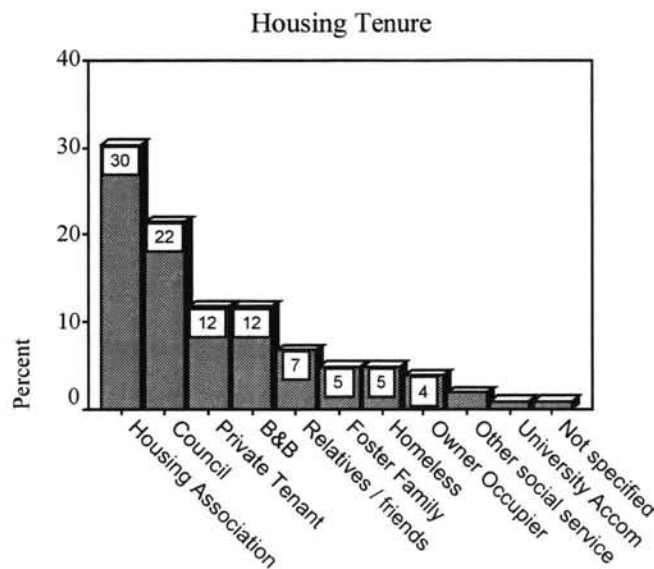
- ▶ Housing Tenure
- ▶ Satisfaction with housing
- ▶ Problems with accommodation
- ▶ Housing and mobility

Housing Tenure

Participants were asked which borough they lived in. Of the seventy-eight participants who responded, Haringey was most frequently reported (n=14), then Islington (n=8) and Westminster (n=8). Most of the remainder were living in other London boroughs including Kensington and Chelsea, Barnet, Merton, and Newham. Only four (n=4) were living outside Greater London in Liverpool (2), Leeds (1), and Croydon (1). The participants were also asked how long they had lived in that borough. Just over one quarter (28%) said they had lived there less than a year, fifteen percent one to three years, fifteen percent three to five years and forty two percent (42%) lived in their current borough over five years.

Respondents were asked to state what their current housing status was, ninety-seven (n=97) responded.

Figure 10.4: Housing tenure of respondents



A third (30%) of those who responded (102/106) reported that they were housing association tenants, and one-fifth (22%) council tenants. All the council tenants had been in the country for five or more years. Participants were also asked to record the number of rooms they had, excluding bathroom and kitchen. Just over a third (36%) said they lived in one room and almost half (46%) reported that they had two or three rooms.

Just over half (52%) said they lived alone (76% were single, widowed or separated). Of the forty-four (n=44) who lived with others (other than strangers in hostels, bed and breakfast etc) and who reported the relationship of those they lived with, twenty (n=20) reported that they were living with a spouse or spouse and children. Twenty-one percent of the ninety-six who responded (21%) reported living with two or more people. Five participants (n=5) were minors living with foster families. About a quarter (28%) said they had dependants, mainly children, and only twelve percent (12%) said they had two or more dependants.

Satisfaction with Housing

Participants were asked if they were satisfied with their current accommodation. Of the one- hundred (n=100) who answered, just over half (52%) said they were satisfied. This varied according to housing type, as illustrated in table 10.5.

Table 10.5: Satisfaction with housing by housing type.

| Owner-Occupier | Housing Assoc. | Council | Private Tenant | B&B | Relatives/ friends | Foster Family | Home-less |
|-----------------------|-----------------------|----------------|-----------------------|----------------|---------------------------|----------------------|------------------|
| 3/3 | 17/29 | 15/21 | 3/12 | 4/12 | 1/6 | 4/5 | 0/5 |
| 100% | 58.6% | 71% | 25% | 33% | 17% | 80% | 0% |

Owner-occupiers, council tenants and those living with foster families were most likely to be satisfied with their current housing. Least satisfied were those who were homeless, those living in bed and breakfast, and those who lived with family or friends. The expected numbers in some of these categories however, were low and therefore the results may not be generalisable.

Problems with Accommodation

Participants were asked why they were not satisfied with their accommodation. They reported the following reasons:

Box 1: Reasons for dissatisfaction with housing

- Lack of space and privacy (and not being able to have guests)
- Lack of personal safety and security
- Damp, dirty, cold or unsafe housing conditions
- Noisy or hostile neighbours
- Having to share a home with incompatible people
- Insecure tenancy
- 'Bad' neighbourhood or inconvenient location
- Not having an Ethiopian community nearby

The difficulties experienced were most acute prior to gaining refugee status, as described by one participant:

'Basically if you have no status you don't get a place, and once you come to this country it would take you 2-3 years to have status, which means you will be suffering for those 2 or 3 years. If it is a homeless shelter you go to a homeless shelter, if it is a hostel you go to a hostel and some of these hostels are very bad, but some might be good. It all depends on your luck' (003m: 316).

One of the young female participants gave the following harrowing account of her experiences as a seventeen year old having to share her accommodation with several adult males, and how it was only by chance that she was moved:

'We used to share with other 6 people and never had any kind of communication. They were all men and from different countries. I used to be scared so much. The flat was burgled once and was reported to the police. The police left a letter for me to contact them.... I contacted them and the police reported to Social Services as to why they put a seventeen year old girl with adult men. Because of this I was moved to other accommodation' (62f: 306).

A lack of space was the most frequently reported housing problem (twenty-one (n=21) participants said this). Having to share the kitchen and bathroom with others (strangers) was the second most frequent reason for being dissatisfied.

Housing and Mobility

Participants were asked how many times they had moved home since they came to the UK. The average number was two times and the maximum six times. As might be expected, those who had lived in the UK five or more years reported moving three or more times more frequently than those who had lived here less than five years (40% versus 9%; $p < .01$).

Discussion

Problems with housing were common and almost half were dissatisfied with their housing, mainly because of overcrowding. There were also accounts of housing conditions that were culturally and gender insensitive. Officers responsible for housing Ethiopian refugees and asylum seekers need to be aware of ethnic, religious and gender issues to avoid unnecessary distress.

Those living in hostels should have the option of taking a packed lunch to avoid them missing educational or work opportunities. Choices of meals in hostels and bed and breakfast accommodation should also be available so that religious and cultural practices can be observed.

That many reported moving home frequently is of concern as it can have consequences that will further disadvantage this already vulnerable group. For example, friends may become less accessible (friends are their main source of support), educational courses may have to be discontinued, children may have to change school, and unnecessary stress and barriers to integration may result.

Material security

- ▶ From Self-sufficiency to Dependency
- ▶ The Impact of Poverty
- ▶ Expectation & Disappointment

From Self-sufficiency to Dependency

A large majority of the participants had been in employment in Ethiopia and many reported that they had been relatively financially comfortable. These asylum seekers had sacrificed their material security for their physical safety in seeking asylum in the UK. Most participants, at least initially and reluctantly, had to rely on government aid, as an Amharic woman described:

'There are different reasons why people leave their country. It is not only to seek a better life that we are coming here. In most cases we leave our better life because of politics and war.... It is not economic as most people think. Most people who left their country are those who have been working and living at least an average life. However coming here they just have to rely on hand- outs... there is not enough opportunity for them to go out and work as there used to be' (67f: 176).

The financial support that the participants were entitled to in the UK depended on their immigration status and personal circumstances. When asked what benefits they get one hundred and one (n=101) participants responded. One-third (n=35) reported that they were not in receipt of any benefits at all at the time, or the question was not applicable. A further third (n=35) were in receipt of income support - usually accompanied by housing benefit; eight (n=8) said they received unemployment benefit, and seven (n=7) said they received food vouchers. Other benefits included child benefit, sickness benefit, and family credit. Sixteen participants (n=16) reported that they had experienced some difficulties when trying to claim benefits. These included, not being entitled, delays in processing claims, and protracted and complicated procedures for claiming, such as having to 'renew the home office paper every time'.

Ethiopians were described by one of the expert participants as 'proud people' who liked to be not only self-reliant but also able to support others. However, in Ethiopia when support is needed there is a self-help system for saving and borrowing money ('*Ekub*'). Being unable to work and being reliant on government support was a common complaint of the participants:

'To a proud person, a proud society and a proud nation being exiled is a dilemma: Am I a right person? ...Or am I a failed person...who is asking for support...[who] two, three years ago was providing not only to myself, but also to a large and extended family? So, claiming asylum by itself affects many refugees. They are not proud of it. Many Ethiopians are ashamed of it. This is the last thing they would have wanted to do' (095E: 240).

Participants who described their own experiences of taking government support recounted feeling ashamed or embarrassed: *'It is hard living on the support of people and the government. It is so embarrassing and hard' (002f: 329)*. A young asylum seeker expressed how it was anathema to him to receive money as an able-bodied person. Benefits, he said are given for *'disabled persons, for someone who can't work, not for healthy people who can work. For me, with my age - I am only twenty-eight, it is a shame. It is unfair to see other people's hand for their donation'* (060M: 245).

These sentiments were echoed by other participants, one of whom added that rather than giving income support, *'It is much better if the government finds job for these people (045f: 639)*.

The Impact of Poverty

During the interviews thirty-five (n=35) participants out of ninety-eight (n=98) reported that they were struggling financially or just 'surviving'. Only twenty (n=20) said they were at least reasonably well off and did not have any major money worries. These were generally people who had found work, although they often also reported financial difficulties and found London an expensive place to live.

Many participants described how their relative poverty severely restricted their lives. For example, some recounted how it was difficult or impossible to afford to carry on normal activities such as travelling to find work or to attend courses. This created a barrier to their progress when qualifications and employment were their only route out of poverty. A young Amharic woman described how she struggled to attend a

course whilst receiving only twenty-seven pounds per week and it could cost her twenty-one pounds to travel to her course, leaving only six pounds for food:

'...I go to Central London to attend class and if I use the underground then I will pay £21 a week, but I use the bus most of the time so I will get a bit of discount. ...I am living in Bed & Breakfast so I get at least breakfast. I don't eat lunch at home because I am at school. I save some food for my dinner' (62f: 324).

When asked what makes them feel ill, nearly half (48%) said having little money did. Only 'stress or worry' was stated more frequently as a cause of feeling ill (61%).

Lack of money also resulted in social isolation as it was difficult for the participants to conduct a social life due to the high cost of travelling and telephone calls. Social life to Ethiopians was reported to be extremely important and did not cost much in their homeland. In Ethiopia it was described as easy to get together with friends, family and neighbours for coffee as everyone lived nearby:

[In Addis Ababa] 'You would have a lot more time, you know to socialise with friends... Also everything is just not that far ...the whole of Addis Ababa you can do in 20 minutes, it is not that big of an effort for you to go to your friend's house that is 5 minutes away.... When you are here you have to think about using public transport if you haven't got a car...it is also expensive. ...You can't afford to socialise with friends every week or every day, but you can do that in Addis Ababa' (092f: 240).

Financial constraints were described as impinging on social life in less obvious ways, as illustrated by one of the female participants:

'What has changed is that, in our country we provide food to the visitor and people aggregate around a visitor. Here the situation does not allow this because of time and financial constraints' (056f: 420).

Having a low income also impacted on the diet of the participants, preventing them from getting enough nutritious food. Fifteen percent (15%) reported that their diet made them ill, many more may have been suffering from less obvious effects of poor nutrition. The participants were very aware of the importance of a balanced diet to good health. Some felt that British food was not healthy as it was often processed or frozen and they avoided eating it where possible. Those living in hostels or bed and breakfast were disadvantaged because they had to eat at set times which restricted their freedom of movement, as described by a male participant:

'In my country I used to eat three times a day. But two times in this country. Here I cannot choose the food I eat. At times I miss all meals. If I was tired and want to sleep, until 11am, I may not get breakfast and I have to wait for dinner. There is no lunch and I have to wait for dinner. I could not go anywhere because of meal schedules' (012m: 347).

Lack of money was the main reason for the participants not having adequate dietary choices, such as being able to buy culturally appropriate food, or to be able to afford accommodation with adequate cooking facilities. Lack of choice about the food they ate was particularly acute for those who were in receipt of food vouchers exchangeable at the local supermarket, as they did not always sell the food they wanted.

Those living in hostels, hotels or bed and breakfast not only had little choice as to when they ate, but also what food they ate. This lack of choice posed great difficulties for those that followed the Ethiopian Christian Orthodox or Muslim faiths that disallow the eating of pork. One of the male participants who lived in a hotel with six hundred residents described the dilemma it created for him:

'They served me pork without my choice. Because of my illness I could not eat the food I was served. If I would not eat what I got I would starve and this could lead me to death, therefore I am not happy'.

He went on to say,

'...In this country pork is one of the main foods. It is against my religion, my culture and my upbringing to eat pork. I was pressurised to eat pork in the hotel where I am currently living' (026m: 615).

Food was also seen as a means of preventing illness and of helping the healing process, as described by one of the male participants, *'If I get ill back home, I would eat good food to get better or overcome my illness. If my illness does not improve with food, I would go to the health unit' (069m: 217).*

Food is also an important aspect of the Ethiopian culture that many wanted to retain, as was the language, Ethiopian traditional dress and religion. When asked to comment on the cultural traditions and customs they practice here in the UK, twenty-one (n=21) said they eat 'traditional' or Ethiopian food. Only five (n=5) participants said they ate only British food. Ethiopian foods were said to be available in London but not outside, however it was often not affordable, as one of the participants said, *'I do not eat British food as such. ...Ethiopian food and ingredients are available here. All foodstuffs are available here. The problem is with the money, it is not enough' (070m: 416).*

Participants that were living in the same building, in close proximity to neighbours, perhaps sharing kitchens in accommodation that was not self-contained, may be more likely to suffer a loss of freedom of choice with food because of their lack of privacy. One of the female participants explained how this effected her when she said:

'I do not get on with food from this country. I am used to Ethiopian food and it is difficult for me to eat British food. I am scared of cooking Ethiopian food, because people may not like the smell. I do not wish to offend them. For the sake of my neighbours, I wouldn't cook Ethiopian food' (053f: 379).

Expectation and Disappointment

Disappointment with life in the UK was reported by several participants and it seemed to be dependent on the expectations they held to some extent. An Amharic man who had recently arrived in London explained it this way:

'Many of us had high expectations about living a better life by travelling abroad, having a good job, and earning and having money, and sending money home. When things do not add up and when it becomes a problem to earn money for daily bread, it causes a big shock. I think this is our main problem. High expectations usually lead to problems' (17m: 276).

Several participants believed that success was possible in the UK if they worked hard. Whereas they felt that opportunities for study and economic progress were fewer in Ethiopia:

'Back home unemployment is a problem. Here, there isn't that much problem. Back home there are political problems. ...There are financial problems and poverty in our country. If someone wants to study, there are no educational opportunities as such. If there are some, they are expensive...' (054f: 226).

Some reported that the energy needed to succeed in the UK could be diverted by a number of factors such as anxiety about their application for asylum, learning about the British culture, and dealing with racism and discrimination. A young female participant recognised these disadvantages to asylum seekers and refugees when she said:

'...Here it is your determination that enables you to get what you want. Back home even if you try very hard the opportunities are limited due to the country's economic situation. I think many people can fulfil their dream here if they work hard, although there are problems of cultural differences and to some extent racism' (061f: 189).

However, despite the difficulties faced in living in the UK as asylum seekers and refugees, some participants retained a positive outlook. For example, an Amharic woman who worked as a secretary explained that she was happy despite financial and housing problems. She had life choices she said, she was working towards a goal and she had hope:

'In general, I am happy with things in my own way because of my expectation from life. These accommodation and employment problems are real problems. ...I went through a path of life I chose and I like. I am still on the journey and there is a clear way for the journey. So, I am happy. I know I am not financially stable or have secured accommodation, but I am doing the things I am choosing to do' (105MH: 280).

Eight participants (n=8) spontaneously gave praise to the UK government for the support it was giving, or had given them, as one of the participants said:

'Well at least if I haven't got a job, would I be shelterless? If I am unemployed I can get treatment. For me these do satisfy my belief, so I am very happy. Not just for me, also I am happy for others for having such kind of security' (059M: 307).

Many others gave positive comments about the health and education system, and human rights in the UK.

Discussion

Many of the participants had been financially comfortable and independent in Ethiopia and had difficulties adjusting to a low income and being dependent on state benefits or vouchers. Many reported struggling financially and that lack of money impacted on their mental and physical health and increased their social isolation. The latter being particularly stressful for people from a culture based on close family and community networks.

The food voucher system was found to be humiliating and created difficulties for asylum seekers in procuring culturally appropriate foods and in reinforcing their sense of marginalisation. A decision was taken by the Government in October 2001 to phase out the food voucher system by issuing the last vouchers in autumn

2002. Planned amendments to the support of new asylum seekers will also include setting up reception centres around the country where food will be provided. Pocket money will also be given.

Experiences with social and community welfare services

- ▶ Statutory social and housing services
 - ⇒ Service use and satisfaction
 - ⇒ Experiences with welfare services

- ▶ Ethiopian community organisations
 - ⇒ Amount of contact and reasons for contacting
 - ⇒ Comments about the organisations
 - ⇒ Suggestions for improvement

- ▶ Informal support networks

Statutory Social & Housing Services

Service Use & Satisfaction

When asked whether they have any contact with a social worker, eighteen percent (18%) reported that they were in contact, in one instance this was professional contact and not as a client. This compares with around a quarter (25%) that said during the interview that they had had contact with an Ethiopian community organisation. Participants were also asked whether they had used housing services (Table 10.6).

Table 10.6: Housing services used

| Service Used | % (N=98) |
|-----------------------------|----------|
| Homeless Persons Unit | 24 |
| Private sector Housing Unit | 11 |
| Re-housing Unit | 7 |
| Neighbourhood Office | 6 |

Many had used more than one service

More participants reported contact with housing services than social services, although this could be an artefact of the different wording of the questions (Appendix 2). The Homeless Persons' Unit was the most commonly used service, used by a quarter of the participants.

Participants were asked what they thought about the housing services. Half (50%) of those who had used these services gave negative comments about them. The comments included the services being 'not helpful'; being 'daunting'; 'unhelpful staff'; having a 'poor service'; and 'long waiting lists'. Others simply stated that they were 'not satisfied'. The remainder gave positive comments such as 'satisfied' and 'very good'.

Participants were also asked whether they use any day services. As Table 10.7 shows, day services were very infrequently utilised by the participants.

Table 10.7: Day services used

| Day Services Used | % (N=102) |
|---|-----------|
| Day Nurseries | 4 |
| Day Centres | 3 |
| Community Organisations | 2 |
| Day Centres & Community Psychiatric Nurse | 1 |

One of the reasons for their relatively low use of formal supporting agencies was reported to be their reluctance to seek help from 'strangers'. If they did seek help, they may not feel able to fully express their needs, as an expert participant explained:

'I think they might not be assertive enough of their needs and they might be very reluctant. They might be very reserved in terms of letting people know what their needs are, because they might be thinking that they might be seen as a weakness' (100E: 56).

The lack of assertiveness and ability to speak out for oneself and one's needs was described as being particularly acute for women and children, as explained by another participant; *'[Ethiopian] women are not allowed to speak out what they think.*

Children are also not allowed to speak out what they think. ...So fewer children and fewer women will be explaining their problems (101E: 44).

Another participant described Ethiopians as ‘very secretive people’ who did not discuss their problems with strangers. This he saw as a factor that could lead to stress and subsequent mental health problems. Issues of accessing services will be expanded on in chapters relating to health (chapters 12 and 13).

Experiences with Welfare Services

Minors are particularly vulnerable and are most in need of support. However, social services in the UK were not always felt to be sensitive to their plight. Ethiopian community organisations often played a crucial role in assisting young people through acting as their advocate to help them access statutory services. For example, an Ethiopian boy aged less than fifteen years, who had been in the country less than a year, recounted how a community organisation had helped him get his housing needs met through Social Services:

‘I went straight to my community at first, I was then referred [by them] to Social Services... [They] placed me with Kosovan asylum seekers where I was bullied and was asked to give them money. I was very scared and had to run away.... I was sitting outside the Kosovan accommodation and was crying until an Ethiopian woman... came to talk to me and took me in her house. It was Friday and I stayed with her until Monday and I went straight to Social Services to get help. I stayed there for the whole day without eating anything. I wasn’t getting any help from social workers and had to leave the office when they closed. I therefore spent the night by the bus stop and had to go back to them again the next morning without eating again. I was given a letter explaining that they will no longer help me and I again went straight to my community. After a long argument with my community organisation, at last, the Social Services agreed and I was placed with a foster carer’ (087m:192).

Unfortunately this boy’s foster care situation broke down and was told by a social worker that he was to be transferred to Kent. He said he was not given any time to

prepare to leave London or given any explanation of where Kent was, or what it would be like for him there. His response reflects the importance of not only having basic needs met but psychological needs also:

'...I told her that I am not going to Kent because I get support from my community and don't want to go there. While explaining to her I was trying to make her understand but she wasn't a type of person who can understand my problem. ...After I left the office, [I phoned] my community organisation's Manager... at about 11:00pm in the evening and told her that I was freezing cold. She then phoned the voluntary worker in her office and asked him if I can stay with him.... He agreed and collected me and I am with him up to now' (087m: 192).

A young female Amharic asylum seeker gave another account of how at times social services did not understand her, and how a community organisation advocated successfully on her behalf;

'I was living with a foster carer. The woman was from Eritrea and I wasn't comfortable because of the political situation back home. I went to the social services to tell them that I want to change my foster carer and he refused. Therefore [an Ethiopian refugee organisation] helped me change my accommodation' (063f: 424).

The differences in how some of the participants felt about UK statutory social services and the Ethiopian community organisations were quite marked. As one of the interviewers noted about an unaccompanied seventeen year old female asylum seeker:

'She doesn't want to go to Social Services most of the time because she felt very isolated and depressed because of the attitude of the workers there. All she wants is to study and get a proper job and never go to social services if possible. She is very close to [an Ethiopian refugee organisation] as she sees them as family' (62f: 37).

Difficulties with social services were also described by some of the adult participants such as a male participant who stated that he had had a lot of problems with social workers, '*...I have been harassed by them and even been refused my entitlement. This has caused a lot of problems that have left me with bad feelings...*' (087m: 133).

Not all participants who spoke about their experiences with social services gave negative accounts. For example, one of the participants said about his social worker, '*Yes, he is good. He does what I want him to do and he is like family*' (063f: 363). Having a close personal relationship rather than a distant and impersonal one appears therefore, to be preferred.

Ethiopian Community Organisations

Amount of Contact and Reasons for Contacting

Participants were asked during the interview whether they had had any contact with Ethiopian community organisations in the UK; two-fifths of participants (41%) said they had. Most of these said they had been in contact with the Ethiopian Refugee Association in Haringey (ERAH). Other organisations they said they had been in contact with were the Ethiopian Community in Britain, and the Ethiopian Refugee Association in Lambeth. Some had prior contact with all three. The high numbers in contact with the Haringey organisation may be due to the sampling method used in the project. One other mentioned an 'Oromo community organisation', and another had contacted an Ethiopian Refugee Help-line.

The participants were also asked in their interviews what their experiences had been with the Ethiopian community organisations, and whether they had found them helpful and able to respond to their needs. The participants gave the following main reasons for contacting the community organisations:

Box 10.2: Reasons for contacting Ethiopian community organisations

- To seek help and advice to sort out housing or financial problems
- For help with accessing education and training
- To have opportunities for socialising with other Ethiopians
- To read Ethiopian newspapers and other reading materials

Some participants took more advantage of the social and communication side of their services, such as described by this male participant:

[The] organisations invite us to listen to people who come from Ethiopia. ...And to take part in community gatherings. They are doing a pretty good job in bringing people coming from back home together with the refugee community. ...The Ethiopian Community organisation... has bought selected books for reading. We borrow these books whenever we want to. There are newspapers and magazines it is possible to borrow. Such services are very important and exciting' (70m: 455).

Others needed more formal services to help with social and other problems. The participants recognised that the organisations did not have housing or financial resources to give to them, however, several said that the organisations were good at directing people to other appropriate service. One of the female participants described her own experience thus:

'Whenever I have a problem and seek some advice I go to this place and they always find solutions for my problems. ... Like the other day, I did not have a social worker but there was a problem I needed to discuss with a social worker. So I went to this community and through them, I was able to find one. Whenever they have events they invite me. The relationship I had with them and our current relationship is really fine' (045f: 457).

This linking role was reiterated by another participant who said:

'The point is not whether they are effective, supportive or not. The heart of the matter is that Ethiopian refugees need organisations to go to for advice and information. If they could not get support financially, they could show them the direction where to get support. For example, if someone needs a solicitor, they could tell a client where to find a solicitor' (058m: 618).

Comments about the Organisations

Half (50%) of the comments given about the Ethiopian community organisations were positive. Ten participants (25% of those in contact with them) said the organisations were supportive. One of the participants specified who could most benefit from them when she said, '*...this project is very helpful, especially for new arrivals, and particularly for unaccompanied minors as it is very difficult to be separated from family*' (062f: 367).

Two (n=2) of the younger participants felt that the Ethiopian community services did not provide a youth friendly service. One of them said, '*...They are not very approving of young people... I think they don't have faith in the young people here*' (92f: 499).

Another felt that the Ethiopian community organisations 'were very limited'. She compared them negatively with Somalian organisations:

'There are good Somalian organisations in this country. You know they have family planning clinics, antenatal clinics, AIDS awareness clinics but we do not have any thing like these for the Ethiopian community. Why? Because number one we do not want to admit that we have the problems. We all say, "we are fine", but we are not fine and every one knows that we are not fine. It seems that it is too much shame and too much responsibility for any body to go and do it' (030f: 433).

She went onto say that she preferred to get help from English organisations and that she had not had any contact with Ethiopian community organisations for the following reasons:

'I think the first reason is some people feel embarrassed to go to Ethiopian community for help. Because they might know the person and think that person will go and talk about them to their wife, husband or friends. They might also think the Ethiopian organisations may not be intelligent and aware of many things or helpful as the English organisations. Because English people whether they are right or wrong

they give the impression that they care a lot. For example, they say the right things to you, they phone you the right times just to make you feel that they do care about you that you do not often get from the Ethiopian organisations' (030f: 450).

Fear of lack of confidentiality in Ethiopian organisations and an assumption about the superiority of English organisations seems to be based on a lack of experience with Ethiopian organisations. However, there was a second participant who had contact with Ethiopian organisations in the UK who believed they were 'corrupt', as they were in Ethiopia.

Suggestions for Improvement

Some suggestions were made, as to how the Ethiopian community organisations could be improved. The most common suggestion (given by eight (n=8) participants) was that they should advertise themselves and their services more:

'...There are also some isolated Ethiopian people who do not know anything about them [the Ethiopian community organisations] and what support they can actually give them. So they should be informed... through leaflets or magazines' (045f: 480).

Another participant highlighted the problems for those who have been dispersed and do not live in London. She said these people were particularly disadvantaged and suggested the services of the community organisations should be extended beyond London, maybe through a help-line. Another suggested an Ethiopian newsletter. Three participants suggested that the organisations should hold more social events, such as holiday celebrations.

The needs of young Ethiopian refugees and how the community organisations might help them were described by two of the participants. One suggested the organisations should provide 'youth clubs' which would be 'an appropriate environment for youngsters to meet'. He also suggested 'internet training'. More training facilities generally were also suggested. Another said,

'...[The organisations] have to plan to help Ethiopian youths to live together in a hostel or with a landlord with an affordable rent so that they can get out of the benefit system and work and help themselves. The community has to give an advisory service and encourage them.... They have to help the youths to develop their confidence' (060m: 409).

Another suggested that the clients could benefit more if Ethiopian community organisations were to co-operate and collaborate more with each other.

Box 10.3: Summary of suggestions for improvement

- Advertise services more
- Telephone help-line or other extension of service outside London
- Produce an Ethiopian newsletter
- Provide youth clubs
- Hold more social events e.g. to celebrate Ethiopian national holidays
- Help youths towards independence
- More training facilities
- More collaboration between various Ethiopian organisations

Informal Support Networks

Participants were asked who or where they go to for help and support when they feel sad or unhappy. Of the seventy-three who answered the question, the largest proportion (60%) said they turned to friends. A low proportion (14%) said they turned to a relative. Of seventeen participants who answered this question that were married, only two (n=2) said they turned to their spouse for support, and nine (n=9) said they turned friends. Many participants did not have family in the UK that they could seek support from.

When asked who they go to when they have a problem with health or social welfare, again the majority (66%) of the ninety-seven who responded said they sought help from friends. These figures highlight the importance of friendship to Ethiopians in the UK. Why this is so is described succinctly by one of the male participants:

'Having relationships with other people helps to ease stress or tension. When you tell your disappointment to a friend, he would listen and

encourages you to forget it. A friend could give you courage and comfort. When you tell your friend something that gives you headache, and circulates in your mind, you would be relieved and ultimately it could be forgotten. A solution to the problem could be found. As a result of this you could be happy' (040m: 542).

A significant proportion of participants sought help from a solicitor (38%), or from other formal services (24%) including interpreting services. The issues around social networks and relationships will be discussed further in chapters 11 and 12.

Discussion

This study has given some insight into the factors that might prevent Ethiopian refugees in the UK from effectively accessing welfare or health services. These included the reported tendency to be shy and ashamed of asking for help from strangers and obtaining their rights, and their being unaccustomed to utilising formal support services in Ethiopia. This could account to some extent for their under-utilisation of day services such as day nurseries and day centres in the UK. Such organisations may be a new concept to Ethiopians who would have turned to family, friends and other community members in Ethiopia.

Informal support of friends in the UK was very important and would often be the first to be contacted when problems occurred. However, social isolation was a major issue for many of the participants, a large proportion of whom were single or living alone. They may therefore be particularly at risk of suffering from the effects of unmet social and emotional needs. Ethiopian community organisations were reported to be an essential source of support for many. They helped reduce isolation, and provided information, guidance and a link into statutory welfare services. However, as many asylum seekers' experienced torture, persecution, sexual, and civil rights abuses in Ethiopia, many had difficulties trusting others. English welfare organisations were preferred by some because of their assumed political impartiality. Ethiopian community organisations need to build trust with potential service users as some

feared repercussions from disclosure. Both community and statutory support services are needed and there was some indication that they work well in collaboration.

As regards assisting those who have been dispersed to other parts of the UK, outreach work in other cities has now been initiated by at least one of the Ethiopian community organisations.

Chapter 11

Social Experiences

Introduction

Settling in the UK posed many challenges for the participants, not only in terms of securing the fundamental necessities of life such as housing and employment, but also in adapting to a very different cultural and social system. This chapter will describe the social experiences of the participants as it relates to their settling in the UK, and compare and contrast these experiences to their social experiences in Ethiopia.

The participants were asked in what ways life differs in the UK compared with Ethiopia and how they were settling in the UK. Their responses are reported on here and relate to the following:

- Family Life
- Neighbours
- Friendship
- Social Life

Family life

Of the ninety-eight (n=98) participants that were describing their own experiences in the interviews, two-fifths (41%) said that their family life in Ethiopia, and their lack of family life in the UK was especially significant to them. Those who found lack of family particularly difficult included young people under the age of twenty-five who often (but not exclusively) had been students prior to seeking asylum in the UK. This group had usually been living with and was supported by their family in Ethiopia. The difference in lifestyle that they had endured since their arrival in the UK was often described in quite stark terms:

'In Ethiopia there is a different culture. There is a culture of caring and the life of extended family. In this country there is no extended family. The extended family plays a vital role in the life of Ethiopians in many aspects such as during death or celebration. ...Everybody is a parent there. The life inspires. People invest in you. We had a healthy relationship with people. Here there is no extended family, instead there are other things that make you happy or entertain you. There is cinema, theatre, playing games' (081m: 249).

The participants said that in Ethiopia it was expected that the family would carry responsibility for their sons and daughters until they married. They would live with their parents and extended family and have everything done for them, as described by a male participant:

'I had a very, very nice social life when I was back home. My family used to look after me. My responsibility was to work and earn money for a living. Other things were left to my family who was taking care of me. They washed my clothes. They cooked food for the family. What I used to do was to work, eat and sleep' (052m: 264).

Some described how difficult it was coming from such a protected life-style to having to live an independent life in the UK, especially without any preparation. One of the participants described with incredulity the impact this sudden enforced independence had on her:

'I have never been away from my family even for one whole day. But here, I carry a lot of responsibilities. I have to think, plan and decide for myself... whether to do things or not, to go to school or not, which school to go to, I have to decide by myself' (045f: 362).

Others perceived parents in the UK as being cruel in 'pushing' their children to leave home before they married, whereas dependency on the family was expected and accepted in Ethiopia.

Not only was living independently a challenge to the younger participants when they came to the UK, so was dealing with the psychological impact of the loss of family contact. One of the female participants who was aged under fifteen and who lived with a foster family said:

'I used to live with my family when I was in Ethiopia. I know I could never get that back and it makes me so desperately dejected and I miss them terribly. I have no one here that could treat me like my family. Things that I wouldn't be angry with then can easily upset me now. There is no real friend here and for some reason every one lives a solitary life...' (046f: 240).

Neighbours

Although families were reported to be very important, so too were neighbours to the degree that there was little to distinguish them. Neighbours were frequently described as being like 'one big family'. This closeness with neighbours in Ethiopia was contrasted sharply with the lack of friendliness between neighbours in the UK:

'There is a lot of love between people in our country. For example, people will say, "good morning" or "hello, how are you?" and so on and also invite each other for coffee. We would teach children to love each other. [But] to have a family relationship or love of the family doesn't mean that we have to be real brothers or sisters, if we are from the same country, that's enough to be a family. When we live outside of our country most of the time people lock their doors and never see each other' (050m: 273).

Non-Ethiopians living in the UK were also seen as being preoccupied with themselves and as living very private lives:

'Back home, a neighbour is at your disposal in the event of illness, happiness or sadness. A neighbour shares your happiness or sadness. In

the time of illness, he/she cares for me. People are considerate to each other. Here people are worried about themselves. They won't say what is wrong with my neighbour; I have not seen her for a long time. The English people call this type of life individualistic' (025f: 448).

Several participants described finding it difficult to adjust to the individuality and privacy of life in the UK contrary to the way Ethiopians were expected to behave as neighbours back home:

'...over here I suppose I know my neighbour, but I haven't been to her place and she hasn't been to mine, ...but back home neighbours are everything, neighbours are your family, you have to know your neighbours. You invite them in, you sit there like your neighbour's house is like your home, and it is very good, because if there is nobody at home to take care of you, there is always your second home just next door....'
(022f: 304).

Attempts to recreate neighbourliness in the UK were often thwarted by a fear of being misunderstood; this led to some participants isolating themselves.

Friendship

Friendship was also seen as very important for Ethiopians and was reported as giving the following benefits:

Box 11.1: The benefits of friendships

- Overcoming loneliness
- Supporting friends when ill
- Supporting friends financially
- Sharing ideas
- Doing things together for relaxation
- Solving problems together and relieving stress and tension
- Learning from each other (specifically English, UK culture etc)

Some of these benefits, such as supporting one another in illness or helping financially are also the benefits of living with family. Therefore, friendship could be seen as being able to compensate to some extent for a lack of family.

It was felt to be easier to make friends with Ethiopians than other cultures as one female participant said:

'I have no relationship with people from this country/indigenous people. The indigenous people do not mix. They even do not mix with each other. Those of us who came from the same country, we mix and socialise. We look after each other' (025f: 652).

Another said, *'The problem in mixing with people is that it is difficult to come by a person who has a similar character like that of yours. It is difficult to come by listening and considerate people' (026m: 745).*

Some fifteen (n=15) participants said they had Ethiopian friends in the UK, whereas only six (n=6) said they had non-Ethiopian friends. Many did not specify the origins of their friends.

Social isolation and loneliness were reported to be major causes of distress, and there was a frequently voiced assumption that contact with other Ethiopians would ameliorate this: *'In general, I am not as such happy after arriving in this country. I have some problems. Loneliness is one thing. There are not any Ethiopians where I am currently living (053f: 326).*

Another reason given for some of the participants preferring the company of other Ethiopians was that there was no language barrier and they could communicate fully as adults, consequently they felt less isolated. One of the participants described coming to the UK as like having to grow up all over again:

'When we miss social life, we feel loneliness. Here, I am experiencing language barrier. I could not communicate with the community I live in. I have become like a baby. I am trying to learn the new life in this

country. ...I have a problem in adapting to the culture, language and administration of this country' (026m: 254).

The socio-economic system was also reported as creating barriers to making or maintaining friendships in the UK. People were felt to be too busy earning a living to have time for social life. The pace of life was felt to be too fast and money too scarce to be able to travel to see friends, as explained by one of the participants when he said,

'...in this country what I am experiencing is that people do not meet. People are busy. Everybody is living his own life. Most of the people go to work. People have no time to having fun and other things' (069m: 360).

Ethiopians that had become acculturated to British culture were felt to be difficult to make and maintain friendships with as they were said to change and become what was described as 'selfish' and more like the indigenous people:

'...It was very hard to get used to the new place...and getting in touch with Ethiopians and learning their way of life here. It also takes time to relate even to your own people because when you are new you assume that people think and behave like it used to be in Ethiopia. However some of them who have been here for a long time have changed. This made communication more difficult. For me this was unexpected because I assumed that people still relate to each other and support one another like it used to be in Ethiopia' (007m: 246).

The altered perception of their Ethiopian compatriots came as a shock and disappointment to new Ethiopian asylum seekers and added to their sense of alienation and confusion. At a time when they had a great need for support they often found it was not forthcoming from their community. This would have been taken for granted in Ethiopia. Not only was support felt to be less forthcoming, some also reported that they did not reach out for help from friends as they had before. This was described as having potentially serious consequences:

'...Even if they have friends they feel they are all by themselves, and having their friends near them is not good enough, they keep all their problems to themselves rather than talking to people about it and they kill themselves. This is because of the system' (003m: 176).

This lack of mutual support between Ethiopians in the UK was often attributed to a lack of trust and suspicion caused by ethnic division in Ethiopia:

'Here, I cannot go anywhere. ...It is very difficult to find a close friend. These days our community is filled with suspicion. There is no trust among the community. ... after the reign of the late Emperor Haile Selassie, the trust among Ethiopians has not been that strong. People are not supporting one another' (070m: 273).

Some of the participants described coming to terms with the differences in the ways of Ethiopians in the UK and how once they had done this, and had changed their expectations, they were eventually able to make friends:

'There was no support that you would expect from friends in times of difficulty. Now I understand that people do change and could not be the same. I also got used to the changes and it became easier for me to not expect too much and get upset by others. Even though it took me so long to learn all these. Now I can easily relate with others and have got friends' (007m: 259).

Social life

To Ethiopians, relationships with family, friends and neighbours are paramount. Social life is an integral part of the Ethiopian culture and much time and energy is dedicated to it. A quarter (n=27) of participants said during their interview that the social life was better in Ethiopia than the UK. This figure would probably increase if they had been asked a direct question. One young man who had lived in the UK for nine years described in what ways he thought the social life was inferior in the UK:

'In Ethiopia there is a good social life. You meet with families and friends during holidays. Here life is fast. You do not meet people. It is only on the telephone. Unless there is a problem, you will never meet here. Social life is a big problem here. If you're sick, unless you have close friends, you could live with no one visiting you for three or four days. If it had not been for the political and economic situation, I prefer to be there. The weather and the social life in Ethiopia are wonderful. I was always happy in Ethiopia' (104MH: 431)

The social culture of the UK was seen as private and lonely and difficult to adjust to. This, according to several of our participants could be so alienating and intolerable as to ultimately lead Ethiopian refugees to suicide:

'In England...the social life is not the same as Ethiopia. What we have been used to in our country and our culture is to eat with our neighbours, to drink with our neighbours and be with our friends. However, in this country the system is everyone for themselves: Those who have been given council flats close their doors and stay in their flats. Those who are in hostels, stay in their hostels, and for us as grown ups to come all of a sudden into such a lonely lifestyle is a cause of stress. You feel many things, you get homesick, you feel lonely, and all these things depress you and stress you, these are the main reasons that many Ethiopians kill themselves. This is because of the social life situation...'(003m: 162).

Difficulty finding suitable sexual partners was also reported by two participants. This was felt to be because they no longer had family or friends to introduce appropriate potential partners to them, a social circle in which to meet them and because of the shortage of Ethiopians in the UK. A female participant described her predicament thus:

...it's almost like a lottery, like, well you know if I have to really go out with an Ethiopian, well I don't know who he is, I don't know where he comes from, obviously I know he is from Ethiopia, but you know, you don't

know his back ground you know. You only told what he tells you, you can't verify anything.... ...[And] over here it is, it's as they say, it is a jungle out there with few animals in it' (078f: 391).

Discussion

Ethiopian life revolves around a collective culture based on the extended family and blurred boundaries between families (neighbourhoods). Whereas Ethiopian communities in the UK are disjointed and lacking due to the incompleteness of families (there are a disproportionately small number of children and elders in the UK), the geographical distance between them, the poverty they endure, and the individualistic life style that is imposed upon them.

Friendship was reported to be important to Ethiopian migrants as a source of support and social life that could compensate to some extent for the absence of family. However, many reported difficulties in finding friends because of the style and pace of life in the UK, the lack of money, and lack of opportunities for socialising. Many also felt it was important to have friends from the same culture but that these were more difficult to find, as were sexual partners of Ethiopian origin. Loneliness was a common experience that sometimes had fatal results.

Chapter 12

Beliefs and Experiences of Health and Sickness

Introduction

This chapter will describe and explore the beliefs and experiences of health and sickness of Ethiopian refugees and asylum seekers in the UK. The participants were asked what it means to them to be healthy, to explain why a person is healthy, why people get sick, what they do to get better if they were ill, and who is the main carer in the family. The participants were also asked about their use of health services and their health problems. Their responses form four overarching themes regarding their beliefs and experiences:

- Prerequisites and Indications of Health
- Sickness Causation and Prevention
- Health Status of Ethiopian Refugees
- Seeking Health Care

The prerequisites and indications of health

As with all people, whatever their cultural backgrounds, Ethiopian asylum seekers and refugees hold a number of beliefs about what an individual requires to be healthy and what indicates that the individual is healthy. For Ethiopian asylum seekers and refugees these include:

- ▶ Happiness
- ▶ Ability to fulfil material needs and ambitions
- ▶ Harmonious relationships
- ▶ Personal qualities/attributes
- ▶ Physical well-being

- ▶ Mental well-being
- ▶ Spiritual well-being
- ▶ Healthy environment

The concepts listed above are presented in the order of importance to Ethiopian asylum seekers and refugees. Whilst beliefs about health are embedded in cultural upbringing the importance placed by Ethiopian asylum seekers and refugees on different beliefs may have changed through the consequences of migration outlined in other chapters.

Happiness (*Desta*) is an important prerequisite and indication of health for 68% of the participants. For the majority of them healthiness *is* happiness and happiness *is* healthiness.

'Healthy means being happy' (001f: 22).

'Happiness means when someone is healthy' (038f: 76).

Happiness either contributes to health or is an indication of health. A feeling of happiness indicates to the person themselves that they are healthy; *'To be healthy means to feel happy'* (069m: 56). Whilst showing happiness also indicates to others that a person is healthy, *'a healthy person looks happy'* (025f: 98).

Achieving happiness

For some Ethiopian asylum seekers and refugees happiness is achieved through external means such as satisfying material needs.

'Happiness could be as a result of material or non-material. It means having the right frame of mind...or it can be material satisfaction such as basic necessities (such as) transport, food, shelter [and] clothing' (081m: 73).

For others happiness is found internally.

'Happiness means you are content and when you feel pleased inside and [with] other things around you' (075m: 104).

A happy person therefore utilises his internal means to achieve the external means.

'He talks about his daily achievements. He is satisfied with his performance. A happy person plans what he is going to do tomorrow. He is enthusiastic to work wholeheartedly with a high spirit. If there were obstacles on the way in life, he would handle [them] wisely and move forward to fulfil what the community expects of him' (025f: 110).

What is happiness?

The connection between happiness and healthiness for Ethiopian asylum seekers and refugees is seen in their explanations of the meaning of happiness. The following concepts of happiness parallel some of the above concepts of healthiness:

Box 12.1: Definitions of happiness

- Happiness is fulfilling dreams, ambitions and basic needs
- Happiness is harmonious relationships
- Happiness is not to be depressed, stressed or worried
- Happiness is physical well-being
- Happiness is mental well-being

For the majority of the participants happiness means fulfilling ambitions and being successful in life.

'Happiness means to be able to fulfil your dreams.... To be able to achieve something which you want to achieve in life' (069m: 75).

For the some of the participants happiness is achieved through fulfilling basis needs, that is *'to be clean...to wear good clothes...to be able to be employed and earn a decent income...when you eat and drink what you like'* (034f: 125). For one respondent success in life is about the achievement of basic needs through work.

'Happiness is when everything you thought about and you wanted in life has happened. You have got a job. You have enough money to survive' (076f: 57).

A really important characteristic of happiness is harmonious relationships with other people, in particular friends and family. Having family and friends, sharing ideas, communicating and enjoying time with friends and family (071f: 88) *'is happiness by itself'* (053f: 94).

The crucial aspect of relationships with others is love and loving other people. Thus happiness means *'having a good understanding or love with friends'* (041m: 89). It is also important to be good to others.

'Happiness means when someone speaks something good...and is acceptable and pleasant to other people' (033f: 76).

Enjoyment with others is also important for happiness.

'Happiness means laughing, having fun and doing what makes us happy. A happy person has laughter, fun and smiles with other people. These factors...increase the feeling of being healthy. Having fun by itself brings happiness' (070m: 83).

A happy person is *'someone who is not depressed/worried'* (040m: 131). Although acknowledging this, one respondent could be happy despite being worried; *'Personally to be happy is not to worry too much.... I can't help being worried all the time about trying to get a decent job...about money...but I am still happy in a funny way with all the stress, with all the worries'* (078f: 41).

The connection between achievement and fulfilment, and worry is explained.

'If your dreams are fulfilled according to your wish without worries it means that you have succeeded in achieving something. This means that

you have fed your mental well being with happiness.... The food to our mental well being is success, bright future, satisfaction and happiness in life. This is like feeding oneself with food' (026m: 189).

Happiness also means physical well-being. Either a happy person is someone 'who is physically fit, who can use his body as he likes' (026m: 180), or 'you haven't got any illnesses' (076f: 64), 'someone who is not ill feels happy' (054f: 109).

Happiness is also mental well-being. This can mean 'to be free from negative feeling/attitude' (055m: 89), or 'mental satisfaction...confidence...enjoying ones performance...self-respect...valuing yourself or your life' (068m: 89).

In direct relation to being a refugee one respondent said that 'To live in the country where you belong to, by itself is happiness' (062f: 107).

Ability to Fulfil Material Needs and Ambitions

Healthiness is achieved through a good quality of life.

'Being healthy depends on the quality of your life. You will be ridden by illness if you have a poor quality of living. Even if I was otherwise healthy, my wellbeing is not complete as long as I have a poor quality living. But if I have a fully furnished house and a good standard of living, then, from that will come good health' (028f: 31).

This is achieved through fulfilling basic needs and ambitions: 'If someone is able to eat, drink, work, study and do whatever the person likes, and fulfil the dream one has ...I call that healthy' (001f: 30). The fulfilment of basic needs is particularly important. 'If we get all the basic things we could be healthy. I mean by basic things, food, shelter and clothing' (055m: 127). For a few people it is important that a person is self-sufficient. If a person '...is able to support himself then we can say that person is healthy' (006m: 49).

Being able to work fulfils both material needs as well as ambitions for 62% of participants. Of these about a third (20%) described this as being able to work

effectively or productively, about a quarter (25%) described this as working hard, and 7% described this as being able to work with pleasure. Two (n=2) people linked working to earning money; *'It means working and earning money.... The most important thing is money. If someone has no money he would suffer depression'* (053f: 138).

For some participants healthiness is achieved through being able to study and to study hard and effectively.

Harmonious Relationships

A healthy person is someone who *'...lives with other people peacefully and in harmony'* (053f: 80). A healthy person is someone who has a *'...good relationship with his friends'* (011m: 47), *'workmates'* (031m: 161), *'...neighbours, local community.'* (044m: 97), *'society'* (049m: 41).

'If we don't have a good relationship with others and we decide to be distant from others, then we will be isolated and depressed' (050m: 68).

A person who has good relationship with others is someone who *'...deals with people with happiness, love and peace....'* (051f: 57). *'She is very close to her friends. She enjoys their company and entertains her friends warmly. Her friends love her. She also loves them and tries to make them happy'* (053f: 115). Another aspect of a good relationship is *'...communicating well with people'* (081m: 69). It is also shown through enjoying the company of others as one female and one male participant suggested; *'A healthy person...enjoys the company of his friends. He has fun and laughter with them'* (053f: 78); *'...getting on well with friends'* (023m: 45).

An important aspect of this for about a quarter (25%) of the participants is supporting or being considerate of family, friends or neighbours. This consideration is sometimes based on love. One male participant said, *'We could be healthy if we are considerate/thoughtful'* (055m: 126).

As well as personal relationships a person's relationship with the community determines their health. '*Healthy means to get on well with the community in which you live*' (014m: 21).

For some participants seeking support is also an aspect of healthiness. '*A healthy person gets advice from his friends*' (053f: 78). A few participants believe that they will be healthy if they could be reunited with their families back home.

Personal Qualities/Attributes

The participants identified a number of different qualities and indications of a healthy person (Box 12.2).

Box 12.2: Qualities and Indications of a Healthy Person

In order of frequency

A healthy person (is):

- Independent
- Thinks well of others
- Has a positive attitude
- Able to enjoy life / is satisfied
- Honest /genuine
- Motivated
- Confident
- Independent
- Hopeful
- Responsible

As well as these qualities, some participants believed that healthy people are respectful, unselfish, unaggressive, are able to retain their culture, and are able to overcome problems and improve their life.

Physical Well-being

Physical well-being includes the absence of illness, physical ability and eating and sleeping well.

Absence of illness/sickness

For half (50%) of the participants the absence of illness/sickness is an indication of health.

'A healthy person is someone who is not ill' (024f: 43).

For one respondent a healthy person is '*...someone who has never fallen ill*' (009f: 36). One respondent described a healthy person as '*...someone who has no physical or mental illness*' (025f: 38). Some are more specific and describe health as not getting a serious illness such as '*...cancer or HIV/AIDS*' (076f: 38). For three (n=3) participants this was also indicated by lack of pain. But for one respondent is person can be considered healthy even though may be suffering an illness; '*...when some one is ill with cold and which is easily identifiable and did not have any problem with his/her internal organs we could say that they are healthy*' (008m: 46)

Physical ability

Thirty eight per cent (38%) of the participants described healthiness as being physically able. This is described as being physically fit or doing physical exercise by 41% of these participants and being alive and vibrant by 54% of these participants. '*Healthy means to be alive, vibrant*' (034f: 72).

For others healthiness is indicated by a person's physique. They are physically fit, have a good physical build or are free from physical disability.

Eating and sleeping well

For 38% of the participants a person is healthy if they '*eat properly*' (003m: 40), '*eat well*' (033f: 100) and '*eat good food*' (054f: 118). For 17% of the participants a person is healthy if they '*sleep properly*' (003m: 41).

Sexual performance and ill health

One respondent stated that '*In a sexual encounter between a man and a woman, if a man or a woman fail sexually they are considered ill*' (025f: 136).

Mental Well-Being

Mental well-being is a prerequisite and indication of health for many of the participants, as described in chapter 13. Ethiopian asylum seekers and refugees described health in holistic ways and do not separate physical health and mental health. Since chapter 13 deals exclusively with mental health, this chapter will only make references to mental health when it is being described in relation to physical or general health.

Spiritual Well-Being

For many of the participants '*Spiritual well-being is also important*' (025f: 128). Either through religious practise or because '*Health is a gift of God*' (103MH: 500) or the '*will of God*' (015m: 308). As was discussed in chapter 9, the majority of the participants considered their religion as most important to their lives. Many of the explanations offered are clearly linked to their belief that their religion helps keep them healthy. For example they stated that religion gives them hope, energy, peace of mind, strength, happiness, comfort, courage, opportunities to meet with friends, strength to refrain from doing bad things, protection from evil and it even cures them from disease. One participant expressed it thus:

'My religion is central to my life, it is my breath, my soul. It saved my life from absolute destruction. It helped me to revive and live again. It contributes to my well being now' (102MH).

Healthy Environment

One tenth of participants said people could be healthy if they lived in a clean environment and some of these specified the importance of clean air. The importance of a clean house and of good personal hygiene was described by some: '*To be healthy means living in a safe and clean environment. ...To be healthy means, to be clean or having good personal hygiene* (043f: 66).

Discussion

Berhane *et al* (2001) conducted a study to explore the health situation of women in rural Ethiopia. They found that women had a very broad understanding of health although for most rural women health is a disease-free state. But they also emphasised that health is the ability to work and perform tasks expected of a woman, like taking care of the children and keeping the house, the clothes and the surroundings clean. Being healthy was also a social responsibility and those who could not keep healthy were regarded as failures. The prerequisites for good health were wealth and harmonious relationships. Education was also seen as an important factor, partly because it leads to awareness of illness and advice seeking. When asked to give examples of healthy women, health was viewed as an ideal state and not remotely possible in where they lived.

Whilst it is impossible to compare the health beliefs that the Ethiopian migrants held in Ethiopia with those that they hold in the UK, this study indicates that happiness may be a more significant prerequisite and indication of health for Ethiopian refugees and asylum seekers. Interestingly wealth and ability to work and harmonious relationships are important both in Ethiopia and the UK.

Sickness causation and prevention

Ethiopian asylum seekers and refugees hold a number of beliefs about sickness causation. These beliefs may be influenced by their experiences both in Ethiopia and in the UK. The beliefs about the causes of sickness are presented in order of importance.

- ▶ Disease
- ▶ Food
- ▶ Climate and environment
- ▶ Accidents
- ▶ Poor socio-economic conditions
- ▶ Depression

- ▶ Stress
- ▶ Unhealthy behaviours
- ▶ Social isolation/loneliness
- ▶ Supernatural causes and 'superstitions'

For Ethiopian asylum seekers the causes of sickness are not the opposite of the prerequisites to health. Whilst happiness is the primary 'cause' of health, disease is the primary 'cause' of sickness.

Chapter 5 provides additional information regarding the beliefs of sickness causation as well as details on a number of cultural and self-care behaviours practiced in Ethiopia aimed at sickness prevention. Chapter 13 provides a detailed analysis regarding mental health and illness.

Disease

Over half (57%) of the participants said that disease causes sickness. Most of these participants believe that '*...a cause of sickness would be disease, which results from germs and viruses*' (045f: 209). Disease is caused by contaminated food (see below), lack of clean water or sanitation and poor personal hygiene, and can be transmitted through sexual intercourse, blood and air. Some communicable diseases were mentioned (e.g. HIV/AIDS, TB, Hepatitis B, Influenza, Cold) and one respondent mentioned cancer. Lack of cleanliness and sanitation is the most important cause of disease. One participant stated, '*If a person is not clean germs multiply on his body and eventually cause illness*' (043f: 204).

Food

Over half (57%) of the participants said that eating the wrong foods or lack of the right foods causes sickness. Sickness can be caused by '*...eating contaminated food*' (017m: 231). They are also sick because of '*...lack of proper diet*' (005f: 83). For a few participants the lack of availability of fresh foods in the UK is a problem. One female participant said, '*In our country people do not usually get sick; we eat natural and fresh food*' (005f: 83). Another added,

'People could be ill from unsuitable food...because they couldn't find their traditional meals then they will have a new kind of food which is different from what they were brought up with' (002f: 152).

In chapter 10, in the section which deals with the impact of poverty, considerable evidence is presented which indicates the participants' belief that sickness is caused by shortage of food whilst at the same time 'good food' is a means of preventing illness and of helping the healing process; a male participant said, *'If I get ill back home, I would eat good food to get better or overcome my illness. If my illness does not improve with food, I would go to the health unit' (069m: 217).*

Climate and Environment

Over half (57%) of the participants said that sickness can be caused by climatic or environmental factors. This is mainly due to *'...the air we breathe' (008m: 116)*, which is polluted. Another participant stated that *'...cars pollute the air and may cause diseases such as pneumonia and other lung diseases' (025f: 303).*

The majority of the Ethiopians who took part in this study believed that the cold weather causes influenza. A number of them reported that the inability to adapt to the weather, the weather changes, the heavy rain and flooding, swampy areas with malaria infested mosquitoes can all cause sickness. Sun, causes skin cancer.

Accidents

Forty-three per cent (43%) of participants said that accidents cause sickness.

Socio-economic Factors

A quarter (26%) of participants said poverty was a cause of ill health as it affects a person's ability to eat a balanced diet, keep clean, pay bills, and find suitable shelter. The effects of unemployment and consequences of poverty were reported to cause ill health.

'...if someone is not working, he gets stressed,.... He cannot do what he wants and he cannot buy [things]. Unemployment affects the social life of the person. This in turn affects his health' (073m: 134).

Chapter 10 elaborates further on the links between poverty and ill health.

Depression

Thirty-five per cent (35%) of participants said that depression can either cause sickness in that '*...they can get sick easily if they are depressed*' (049m: 114), or that depression is a sickness in itself caused by factors such as loneliness (see theme on social isolation/loneliness below).

'...if you are living alone it could cause depression' (052m: 146).

Other factors which cause depression include financial worries, living in a foreign country, cultural barriers, housing problems, low self esteem, unemployment, lack of success, lack of fulfilment, sleeplessness, homesickness, language barriers, social upheaval, lacking basic necessities, immigration and illness in itself. One female respondent reported that, '*If someone successfully completes his education, and is unable to get a job he could be ill as a result of stress/depression*' (057f: 180), whilst a male participant provided this explanation: '*Depression means when a person wants to do something but could not do it. As a result of this he gets mental illness which is called depression*' (019m: 193).

Stress

Thirty-five per cent (35%) of participants said that stress is a cause of sickness. '[Sickness] *'...could also be due to stress that is caused by a gap between what we expect and what we are getting from the social environment*' (008m: 117).

Unhealthy Behaviours

For over a quarter of participants (28%) illnesses can be caused by behaviours such as having sex with many partners, prostitutes or without using a condom (STDs/HIV/AIDS), drinking alcohol, taking drugs, smoking cigarettes or not taking exercise. One male participant expressed this succinctly by saying that a person will get sick,

'...if you drink a lot you will damage your liver, if you smoke a lot your lungs will be affected, if you have many sexual partners then you will catch sexually transmitted diseases. These things, therefore, come from one's own mistakes due to carelessness' (006m: 110)

Social Isolation/Loneliness

For 26% of the participants social isolation and lack of support can affect health. For migrants the problem is *'...being isolated and alien in a foreign country'* (081m: 35) and *'...being a foreigner it is very hard to mix with a new community and this could lead to mental illness'* (006m: 85). This leads to loneliness which is a particular problem for Ethiopian migrants.

'Ethiopians especially suffer from loneliness caused by family separation and living alone. This could expose them to serious illness and is why many Ethiopians are suffering from mental illness' (017m: 261).

As described above loneliness can lead to depression. Loneliness is also seen as an illness in itself. *'The disease that loneliness causes to our health is not easy to cure either by swallowing tablets or by having injections. It hurts'* (026m: 550). On a practical level *'If one does not have somebody to get help from and to share problems with... then one will become ill'* (009f: 56). Or *'If someone is ill and has no friends who look after him, his illness would be aggravated'* (057f: 174).

The importance of having social networks was also explored in chapter 11.

Supernatural causes and Superstitions

Thirty percent (30%) of participants gave supernatural explanations of sickness. These included God or spirits. *'All illnesses come from Him [God]. He causes diseases that cause physical damage...and death'* (020m: 152).

Satan or malevolent spirits can also cause sickness. They are also attributed to magical explanations where another person uses magic in a malicious way. Some participants described these explanations of sickness as superstitions and felt that

'...if you believe something makes you sick it definitely will' (045f: 225), and that they '...are harmful to health' (038f: 286).

A few participants acknowledged that while they did not believe in these 'superstitions' other people did. 'I heard about [Buda] when I was young, however through education and by travelling abroad I found out that this thing does not exist' (058m: 191). One respondent who claimed not to believe in the evil eye had witnessed its affects and was frightened by it. Another participant associated beliefs about 'Buda' with Satan; 'Satan comes through such things to mislead us' (073m: 214).

One respondent believed that the medicine given to someone who has the evil eye ('buda') causes ill health.

Others

Others causes of illness included self-neglect (16%), including seeking health care too late or not at all; inherited disease (11%); and iatrogenic causes (10%). Iatrogenic causes that were reported included inappropriate medication, use of non-sterile equipment, and bad effects of traditional medicines (7%).

Causes of illness for the participants

The survey revealed a number of causes of illness for the participants (Table 12.1). The most frequent causes were stress/worry, lack of money, housing problems, boredom, family problems and unemployment.

Table 12.1 What makes you feel ill?

| Reported causes of ill health | (N=100) % |
|-------------------------------|--------------|
| Stress/worry | 61 |
| Lack of money | 48 |
| Housing problems | 37 |
| Boredom | 35 |
| Family | 34 |
| Unemployment | 32 |
| Pollution | 25 |
| The area you live in | 18 |
| The food you eat | 16 |
| Little exercise | 9 |
| Smoking | 8 |
| Alcohol | 3 |

There were no statistically significant differences between men and women as to the reported causes of their illnesses, apart from men more frequently blamed smoking as a cause of ill health (15% versus 2%; $p < .05$).

Other factors that made the participants ill included feeling isolated, lack of spiritual life, uncertainty of asylum decision and lack of English.

Sickness prevention

Respondents reported that sickness can be prevented by avoiding addictive or harmful substances such as alcohol or cigarettes, avoiding stress, adhering to HIV prevention practices, eating a balanced diet, and in particular having knowledge about healthy lifestyles:

*‘What affects the health and social wellbeing of Ethiopians living in this country is lack of information not the availability of health and social services’
(097E: 42)*

Discussion

Sickness is an unwanted condition in one's person or self (Hahn, 1995). The anthropological notion of sickness defines it from the sick person's perspective. What counts as sickness is determined by the perception and experience of the bearer. Beliefs about sickness causation appear to be influenced by a number of factors including social, cultural and political influences, level of education and experiences of sickness.

The respondents indicated that Ethiopian refugees and asylum seekers are likely to hold a range of beliefs about health and healing that derive from traditional Ethiopian culture and from Western medicine. Sometimes these beliefs could be held simultaneously and may even be contradictory as indicated by discrepancies between expressed belief and actual behaviour. They also indicated that health beliefs are likely to vary between those who lived in urban versus rural regions of Ethiopia. Our study indicates that many of the respondents were probably from urban regions. Berhane *et al's* (2001) study of the health of rural Ethiopian women found that particularly older women used some kind of traditional measures to promote their health. Modern ideas of health promotion and disease prevention were not widely known by rural women who tended to utilise traditional practices of praying and slaughtering animals as both preventative and curative measures.

However, Beyenne (1992) has warned against assuming that educated Ethiopians living abroad do not hold Ethiopian beliefs or revert to them in times of illness. Hodes (1997) has presented a number of case vignettes of Ethiopians who had migrated to Israel. He found that Ethiopians held a number of health beliefs including that epilepsy is caused by evil spirits, acquired by touching a seizing person and that hepatitis is caused by a bat or bird flying over a person.

Whilst the respondents of our study indicated that Ethiopian migrants have a number of traditional beliefs about sickness causation these beliefs may be modified when exposed to Western beliefs. Ethiopians in the UK believe that psychological factors

such as stress or depression, as well as socio-economic, physical, spiritual and environmental factors cause ill health.

Health status of Ethiopian refugees

The survey revealed that most of the participants described their health as very good or good in the last year (see Fig. 12.1). Nearly half (46%) of the respondents had had a physical health problem in since arriving in the UK (see Table 12.2). Some respondents had more than one health problem. Most of these health problems were physical. The major physical health problems were headaches, migraine or colds and the major mental health problem was depression.

Fig. 12.1: How participants described their health this year

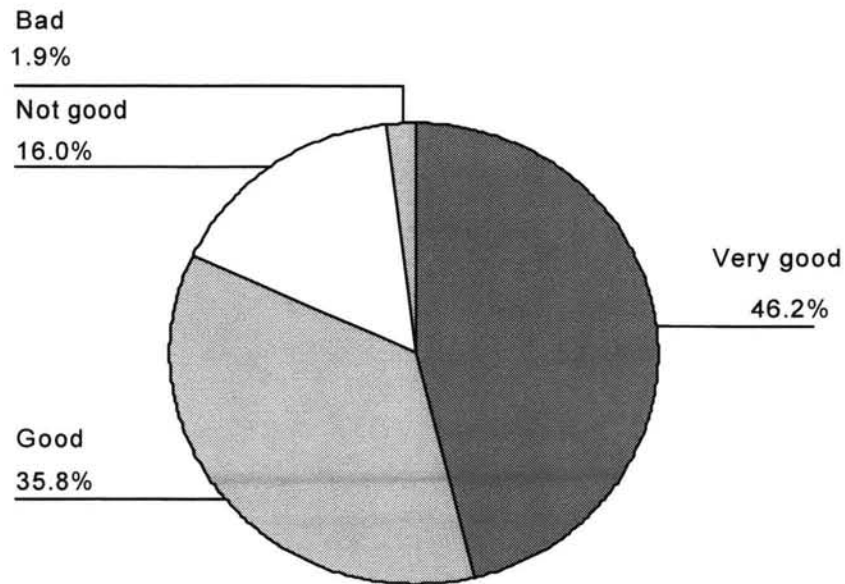


Table 12.2: Physical and mental health problems suffered by participants since they came to the UK

| Physical health problems | N | | |
|---------------------------------|----------|-------------------------------|----------|
| Headaches or migraine | 9 | Epilepsy | 1 |
| Cold | 5 | Hay-fever | 1 |
| Hypertension | 5 | HIV Positive | 1 |
| Back-pain | 5 | Leg pains | 1 |
| Diabetes | 4 | Pneumonia | 1 |
| Gastritis | 3 | Iron deficiency | 1 |
| Dental problems | 3 | Weight loss | 1 |
| Asthma | 3 | Sleeplessness | 1 |
| Tuberculosis | 3 | Minor problems | 1 |
| Gynaecological | 2 | | |
| Heart failure | 1 | Mental health problems | N |
| Kidney infection | 1 | Depression | 6 |
| Rhinitis | 1 | Stress | 3 |
| Earache | 1 | Mental illness | 4 |
| Allergy | 1 | Mental health problem | 2 |
| Gall stones | 1 | Drugs & alcohol | 1 |
| Accident | 1 | | |
| | | | |

Data missing from four participants

Discussion

Kemp (1993) has outlined some features that appear constant amongst different refugee groups. Their health in general is compromised and there is usually immense psychosocial and often spiritual distress. The health status among asylum seekers and refugees in general is a complex of physical, environmental and psychological factors (Taylor and Gair, 1999).

Like most refugees, Ethiopians have come from a poor country which is experiencing conflict. Factors in Ethiopia may affect their health in the UK. Some of them may have suffered from inadequate sanitation and insufficient clean water in the process of flight. Some have suffered imprisonment and torture (see chapters 8 and 13). The fact that Ethiopian asylum seekers and refugees have defined their health as good is also reported in other studies. Haringey Council (1997) found in their survey of refugees in Haringey that 90% of the respondents reported that they were physically healthy on arrival and 83% remained so. This could be because refugees tend to be young and

can be seen as 'survivors' to have got this far (Taylor and Gair, 1999). A study in Newham suggested that the perceived health of refugees appeared to deteriorate over a period of time in the UK (Gammell *et al*, 1993). Carey Wood (1995) reported that one in six refugees were suffering from a physical health problem that was severe enough to effect their way of life. It is not clear whether the number of the participants in this study reporting bad health this year would be greater than the number of them reporting bad health on arrival.

Health problems on arrival may be exacerbated by the social and economic conditions in the UK. Vallely *et al* (1999) found that poverty, social exclusion, reliance on food vouchers and unsuitable, overcrowded accommodation were key social factors perceived as having a significant impact on the health of refugees in Croydon. As seen in chapter 10, Ethiopian asylum seekers and refugees, like other refugees, suffer disproportionately from unemployment and housing problems. It is well recognised that unemployed people have poorer health than those in work and are up to 30% more likely than the population as a whole to have a longstanding illness or disability (IPPR, 1993). The effects of poor quality housing or homelessness have been linked with respiratory and gastro-intestinal disease, problems in pregnancy and childbirth, mental illness, respiratory disease (including TB) and communicable diseases such as lice and scabies (Conway, 1998).

Vallely *et al* (1999) also found that there was lack of access to culturally appropriate foods, compounded by the system of support through the provision of food vouchers affected the health of refugees in Croydon.

It is not possible to link the health problems given by the Ethiopians in the UK to specific causes but many of their health problems are affected by their experiences as refugees (see chapter 10 and 11) and many are closely related to their mental well-being (see chapter 13).

Seeking health care

The participants were asked to describe what they do when they are sick, how was this different than when they were in Ethiopia and who was the main carer. The results are presented in the following sub-themes:

- ▶ Health care seeking in Ethiopia
- ▶ Experiences of health care in Ethiopia
- ▶ Health care seeking in the UK
- ▶ Experiences of health care in the UK
- ▶ Comparisons between Health Care Seeking in Ethiopia and the UK
- ▶ Carers

Health Care Seeking in Ethiopia

The table below presents the type of health care that the participants sought in Ethiopia. Some respondents had sought more than one type of service therefore the numbers who sought this service exceeds the number of participants. Some of the issues discussed in this section are further elaborated in chapter 5.

Table 12.3: Health care sought in Ethiopia

| Type of service | Number of participants who sought this service |
|----------------------------|--|
| Traditional medicine | 53 |
| Hospital or medical doctor | 44 |
| Self-care | 27 |
| Family or friends | 27 |

Ethiopian asylum seekers and refugees sought different health care depending on their illness, the cost and the availability of services. Those living in urban areas had greater access to biomedical services and were more likely to use those.

‘What a person who lives in rural Ethiopia where health units are far apart, and what a person who lives in one of the towns where there are health units tend to get better is quite different. Those who live in the countryside need to travel a day or so to get to the health unit, so they go

to traditional healer when they are ill...If the patient is living in urban area, he would go to the health unit for medical attention like that of the people of this country (UK)' (025f: 325).

It is not known whether the participants came from rural or urban areas but over half of the participants said that they used traditional medicine or remedies in Ethiopia. In Ethiopia they had either used such traditional medication as leaves, roots or seeds such as '*Dama Kasie*', eucalyptus, '*T'ena Adam*', '*Dingetegna*', '*Yeduba Fire*' (cucumber seed) or '*Bahersaf*'. The participants had also used traditional Ethiopian remedies including egg yolk and hot milk, tea with ginger or '*Akari*', '*At'mi't*', (special porridge), garlic, honey, applying butter to the head (for a headache). These self-administered medicines and remedies are usually taken for minor illnesses such as influenza, colds or tape worm.

For many illnesses (including serious ones) participants would have prayed, bathed in or drunk holy water ('*Tsebele*'). One respondent kept '*Emät*' (blessed earth) in the house whilst another mixed it with holy water and rubbed onto a painful area. These may have been used in conjunction with other treatments including western medicine. Some participants have visited spiritual or traditional healers. For fractures or dislocations some participants would seek the help of a bonesetter ('*Wegesha*'). For illnesses caused by evil eye ('*Buda*') one respondent was given traditional medicine by a traditional healer.

The reasons that someone may have visited a traditional healer include shortage of health facilities, drugs and doctors.

'There are certain conditions that determine whether I can get treatment from the hospital or traditional healers. The availability of drugs, number of doctors and their competence and my own health determine where I should go for treatment. If these things were available in the hospital, I would be treated in the hospital. If not I would go to the traditional healer' (026m: 380).

Money is also a reason according to this participant who said, *'Back home, if they have the money, they would take the person who was ill to the health unit. If there were no money, they would go to traditional healer'* (032f: 234).

Forty-five percent (45%) of participants said they would have visited a hospital or medical doctor in Ethiopia. For some this would only be if they had a serious illness.

'What I would have done in Ethiopia, depended on the illness. If the illness were minor, I would be okay with the care I receive from my parents. If it were serious, I would go to the health centre or hospital' (033f: 244).

Whilst for others it would be the first service they would seek. *'If I were ill in Ethiopia, the first thing I would do was to go to the nearest clinic, health centre or hospital'* (038f: 306).

A person might also go to hospital if traditional medicine or self-care had failed or their condition had got worse.

Choosing to visit a hospital may depend on someone's ability to pay. *'...in Ethiopia I will have to try the traditional medicines first and if it gets worst and depending on my family's capacity to pay for hospital, then I will go to hospital'* (049m: 183).

Self-care, whilst not a service is an important form of health care. Most of the self-caring involves taking traditional medicines or remedies as discussed above. For a few participants, eating special or healthy food is seen as a cure. Two participants mentioned self-administering western medication in Ethiopia.

Family and friends are a source informal care. They give advice, provide care and psychological support. *'The psychological support they (people sick in Ethiopia) get from their families and friends is enormous and helps to overcome their illnesses'* (042f: 417).

Minor illnesses are treated by mothers, usually with traditional medicines or remedies (see the section on carers below). A few of participants said they had never used traditional medicine. For some this was because they believed it was dangerous.

'I do not believe in traditional healers that prescribe medicines from leaves and roots. The reason is that ...they do not know the amount/dose of medicine that would suffice to cure a certain illness. They do not know about side effects/toxicity of medications. The side effect could kill the patient. There is a problem of lack of cleanliness i.e. their equipment are not clean' (039m: 305)

Experiences of Health Care in Ethiopia

The main negative experiences were shortage of health care facilities, drugs, equipment and well-trained professionals as well as unsanitary conditions at the facilities.

'Back home there is a shortage of medical equipment. The number of doctors is low. Our health units are not clean. We have far too many patients. There is shortage of hospital beds' (056f: 300).

Otherwise a number of participants had problems or had heard of problems with traditional healers. Problems included over-dosage, under-dosage or side effects of traditional medicines, delaying medical treatment for serious illnesses, ineffective or wrong treatment which resulted in no cure, exacerbating illness, or death.

A few participants mentioned positive experiences with doctors despite limited resources.

'...we should be proud of our doctors. With the limited resources we have, they try to save lives and are committed to their profession. In fact they have saved many lives with scarce resources' (058m: 324).

Health Care Seeking in the UK

In the interviews participants were asked what sort of things they do to get better if they are ill. The table below presents the type of health care that the participants reported seeking in the UK. As in Ethiopia some participants have sought more than one type of service therefore the numbers who sought this service exceeds the number of participants.

Table 12.4: Health care sought in the UK

| Type of service | Number of participants who sought this service |
|-------------------------|---|
| General practitioner | 74 |
| Hospital | 34 |
| Self-care | 34 |
| Family or friends | 12 |
| Traditional medicine | 12 |
| Pray to God | 12 |
| Complementary treatment | 2 |

In the UK, the health care sought was reported to depend on the type or seriousness of the illness. A large majority (76%) said that they had or would visit a GP. This was often the first service sought. *'...whenever I feel ill I tend to see a doctor as soon as possible'* (006m: 129).

However, some participants did not seem to understand the primary care system or method of referral: *'If I were sick in this country, I would directly go to the hospital'* (014m: 174).

For mental health problems two participants would *'go to psychiatrists and try to get advice from them'* (049, 147). However, one participant pointed out his preference for spiritual counselling rather than consulting psychiatrists in the event of mental health problems:

'If I were mentally ill, there is no spiritual counsellor for me and we do not have such people from our community. ...Therefore, if I were ill, I would go to the NHS. I would not go to the psychiatrist for counselling. I do not think, the psychiatrist is useful in our situation' (14m: 132).

Self-care was frequently reported to be the first action in minor illness whilst some participants treat themselves by using modern medicines or eating 'good' or traditional foods. Some also said they would consult friends or family before visiting a doctor:

'If I become ill I would rest to get better, I also consult friends about my illness. If my illness becomes serious, I would visit my GP for my illness. I would comply to what my GP says. I would also conform to what my GP tells me. If he refers me to another place or hospital, I still would respect my GP's advice' (011m: 86)

Others were well versed in utilising over-the-counter medication from the pharmacy: *'Well first and foremost I will take things like paracetamol... but if it continues I will go and see my GP and try to get proper medication for my illness'* (004f: 104)

Among many of the participants there appeared to be a good level of knowledge about how to access GP and hospital services, although there was wide variation. Length of time spent in the UK and degree of acculturation is likely to impact on this.

Twelve per cent (12%) of the participants mentioned using Ethiopian traditional medication or remedies which they administer to themselves or their children. *'Whenever my children get sick I give them traditional remedy prepared in the house.... For example if they have got flu then I give them honey, lemon and garlic'* (002f: 254).

These participants also use 'Dama Kasie', Eucalyptus (for influenza or a cold), ginger (antiseptic), 'Tsebele' (Ethiopian holy water), honey, butter (on hair for headaches).

For some of the participants if traditional medicines or remedies did not work then they would visit a GP. Using 'Tsebele' is an important traditional practice during illness.

'When we are talking about 'Tsebele' the white people may not believe us. It has saved the life of many. Even those visiting a 'Tsebele' place who

come on stretcher can be cured immediately. There are many miracles of 'Tsebele' happening. It can even cure the blind person. There are lame people who are cured in Ethiopia. I believe sicknesses which cannot be cured by modern treatment will be cured with help of 'Tsebele'. This is the truth from my own experience. I was suffering from allergy. I went to top Harley street clinic for this allergic condition. I paid one hundred and ten pounds for ten minutes treatment. I was not cured. But I was cured with the help of 'Urael Tsebele'. Therefore, 'Tsebele' has a great remedy power' (104MH: 357).

Fifteen percent (15%) reported that faith, prayer and other religious practices were important to them as a means of healing. One of the female participants described in detail how her faith and religious practices helped:

'...one needs to go to a doctor for illnesses such as the sudden and short-lived kind, stomach-ache, headache, or simple fatigue, I believe in the angels and prayer as well as sacred water (t'äbäl). And so, I pray and I receive 'emät' (a piece of soil from the sacred ground) and sacred water. I get better due to my faith. And I light my candle and implore God and I pray. And that is what I do if my child falls ill. I myself will apply the 'emät' on her. If she suddenly gets ill and becomes feverish, I make a 'selät' (promise of votive offering) to the angel Gabräél or to Mariyam or Mikaél and apply on her body the 'emät' and the holy oil, both of which I have, and she gets better. That is what I believe in. But if it is a very serious one, we will go to a doctor' (028f: 432).

Six (n=6) participants said that they do not use traditional medicine *'if I get sick I don't take traditional medicines; I would rather go straight to hospital'* (060m: 150).

The two participants that had used complimentary therapy had used aromatherapy and acupuncture.

Overall most participants will use western medicine in the UK, and combine it with some traditional remedies. As one respondent put it:

'I wouldn't necessarily go and drink holy water, and hope for the best, ... the first thing would be yes I am going for a medical western treatment, but then the other illness.... I would give the traditional treatment a go rather than to quickly go rushing into Boots' (078f: 95).

Experiences of Health Care in the UK

A number of participants showed good knowledge of the formal health care system in the UK.

'If the illness is serious or emergency, what should be done is to call an ambulance or the police. If the illness is trivial/minor, it is advisable to see the GP on time and book for treatment and wait for attention' (015m: 146).

Participants mainly talked about their negative experiences. The main problem was language.

'Most of the time when I go to see my GP they will provide interpreter. But sometimes when I asked for interpreter they ignored me and because I can't express myself properly in English, I couldn't talk to my GP as I wanted' (063f: 257).

Language problems can lead to serious consequences.

'I was feeling kidney pain, and when I went to the doctor, he did not prescribe the right medicine for me because of my language difficulties and because I did not have anyone to serve me as an interpreter. He was prescribing medicine that was proper for some other illness, but did not give me the medicine for my illness. I just took the prescription and gave it to the pharmacist without knowing the kind of medicine that was prescribed for me. I continued under this circumstances for a long time and ...my kidney got damaged and was removed by an operation' (009f: 67)

One respondent reported that he had had a problem because he could not afford to pay for his prescription. This illustrates that there remains a lack of knowledge among refugees and asylum seekers about their rights to free health care in the UK. This lack of knowledge may extend to some healthcare professionals, particularly those with little exposure to this client group.

A few participants found waiting times at hospitals and GP surgeries a problem.

Prejudice and racism was a problem for a few participants:

'One thing is people do not value ...foreigners lives. They are not willing to sympathise' (081m: 199). 'I think it was mainly because of disrespect and negligence that they were unable to diagnose me earlier' (001f: 154)

'He (the GP) did not write me a referral to the hospital even once. Throughout the five years, he examined me and prescribed the medicine. ...During all that time he never sought an interpreter in order to understand what I was saying. For that reason, it was only on the basis of my pointing that he prescribed the medicine for me. Later it was discovered that it was anti-depressant that he had been giving me. It was with my kidney performing only three per cent that I finally reached the [hospital] doctors. If he had sent me in time, all this would not have happened' (009f: 182).

Others reported that they suffered from poor treatment, although it is not clear whether this is due to prejudice and racism or simply bad medical practice. One participant said, *'My mental illness was aggravated as a result of the wrong medication' (013m: 63).*

A few participants reported that they had positive experiences with their GP. *'I have not experienced any problem with the GP, when I went for treatment. Their reception and the health services were satisfactory. In fact it was lovely' (038f: 321).* Another said:

'If I get ill I would go to hospital.... When I talk to the doctor I can talk to him openly without hiding anything from him because he is the only one who can understand my situation, diagnose my illness and solve my problems' (007m: 120).

The survey revealed that overall 97% of the participants were registered with a GP. Of the two men that said that they were not registered, one could not find a GP and the other does not have a permanent address.

Table 12.5: Health services used in the UK

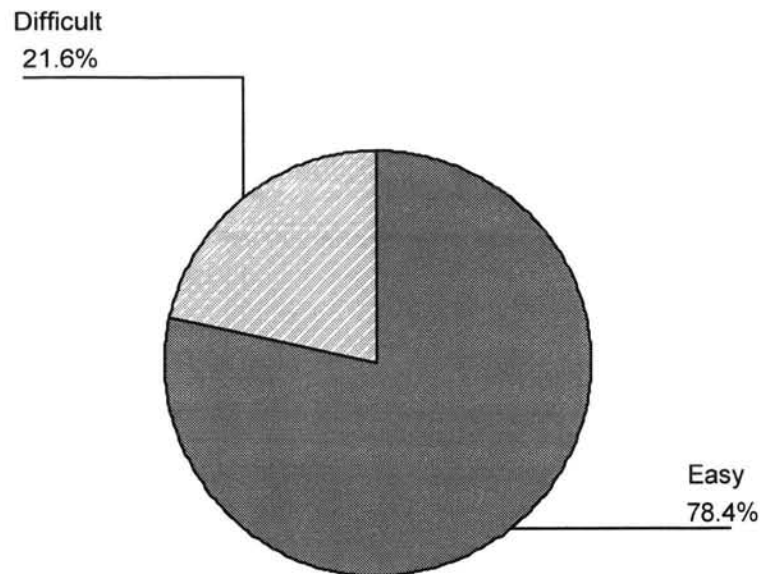
| Health service | N | (%) |
|--------------------------------|-----|--------|
| Registered with a GP* | 102 | (97) |
| Dental services | 38 | (35.8) |
| Hospital outpatient | 20 | (18.9) |
| Hospital inpatient | 16 | (15.1) |
| Emergency services | 14 | (13.2) |
| Well woman clinic (women only) | 6 | (10.9) |
| Home visit by health visitor | 11 | (10.4) |
| Family planning clinic | 10 | (9.4) |
| Baby clinic (men & women) | 9 | (8.5) |
| Antenatal clinic (men & women) | 8 | (7.5) |
| Counselling | 5 | (4.7) |
| Home visit by nurse | 5 | (4.7) |
| Well man clinic (men only) | 2 | (3.9) |

** One participant did not respond*

The only statistically significant differences in use of health services between men and women, other than those that are gender specific were: more women had used family planning services (15% versus 4%); and more had been visited by a nurse (9% versus none), or a health visitor (18% versus 2%).

Over three-quarters (78%) of the respondents found the health services easy to use (see Fig.12.2).

Fig. 12. 2: Are the health services easy or difficult to use?



Comparisons between Health Care Seeking in Ethiopia and the UK

When asked whether they would do anything different if they were ill in Ethiopia than in the UK, some respondents said they would do the same:

‘In both cases I would do the same. I will go straight to hospital and see a doctor. I do not think I will do differently because I am here or there. The only thing I would do is to see my doctor there is no other alternatives’ (006m: 120).

Others reported that it would be different, traditional medicines being used in Ethiopia and the GP in the UK:

‘If I become ill in London, I would go to my GP. They will find a cure for my illness. I will be given a prescription. If it is in my home country, I would use herbs from the near by or backyard. For example, I would use Dama Kasie’ (013m: 81).

Most participants acknowledged that UK has more health care facilities, drugs, equipment (especially advanced technology) and health professionals than Ethiopia.

Despite the shortages of these in Ethiopia two participants thought that health care was better in Ethiopia.

Overall they found that health services are more easily accessed in the UK and a few participants found that they were treated quicker than they would have been in Ethiopia.

'...it is easy here (UK) to get health services. There are many doctors in the locality. You do not need to travel a long distance for health services... If you go in the morning for treatment, you could finish and return in the morning. They have enough drugs' (072f: 207)

One respondent felt that,

'The rich and the poor get equal services from the NHS. It is outstanding in this regard. In our country, those who access modern health services are the rich and urban dwellers or who live close to the towns. The vast majority of the population who lives in rural areas and the poor cannot pay for medications. Therefore, they cannot access health services' (025f: 383)

Around a third (29%) of participants felt that there is less informal support and care available in the UK than Ethiopia. This support, usually given by family or friends but can include neighbours as well, is not available in the UK because the participants are isolated and cannot communicate with their English speaking neighbours. As one of them stated, *'If I get sick back home, I would be looked after by my family or I might be taken to hospital by my family. But in this country no one will follow me to hospital' (086m: 243)*

A few participants felt that there is a better chance of being cured in the UK. On the other hand a number of participants complained that some traditional medicines or remedies are not available in the UK.

Carers

The survey revealed that for most participants mothers are the main carers when someone is sick (see Table 12.6). This particularly the case because ‘...*the mother is closer to the children and can understand her children very easily*’ (049m: 95). The mother’s role is usually to cook, wash clothes, bathe the child, administer medication and provide psychological support. On the other hand the role of the father (or male carer) is mainly to take the sick to the hospital and to obtain the medication.

Table 12. 6: The main carer of the sick

| Carer | Number of participants |
|-------------------------|-------------------------------|
| Women in general | 85 |
| Mothers | 79 |
| Girls | 20 |
| Sisters | 9 |
| Grandmothers/Aunts | 5 |
| Men in general | 49 |
| Fathers | 47 |
| Brothers | 4 |
| Community/neighbours | 23 |
| Family | 13 |
| Spouse | 12 |
| Both parents | 11 |
| Self | 4 |
| Friends | 3 |

Discussion

Healing is the redress of sickness and healing is a sequence of events. Some of which are deliberately caused, other are unintended (Dunn, 1976). The healing sought by Ethiopian asylum seekers and refugees may depend on their illness, beliefs and the accessibility of services.

The priorities of refugees vary according to their length of stay in the UK. Health care is not usually the first priority for refugees and asylum seekers when compared to accommodation, education and employment (Clinton-Davis and Fassil, 1992). This

preoccupation with housing, employment and financial worries on arrival may delay contact with the health service. This is further exacerbated by language problems.

Hendessi and Bank-Anthony (1997) found that refugees and asylum seekers in Croydon only sought help from health professionals when they were seriously ill.

Kemp (1993) argues that access to care in the UK is often the greatest health problem and a low priority is placed on health problems and care by refugee agencies. The first step in accessing health services in the UK is registration with a GP. All female and 94% of the male participants were registered with a GP. Other studies have shown quite high rates of registration but these studies, like this one, have surveyed people accessed via refugee community organisations and have thus been biased towards more established asylum seekers. Despite the high rates of GP registration found amongst more established refugees, use of primary care services is lower because of language barriers (Gammell *et al*, 1993).

It is widely recognised that as well as other minority ethnic groups, asylum seekers and refugees experience racism, language difficulties and cultural misunderstandings (HEA 1998, Taylor and Gair, 1999). There is also a lack of awareness about the needs of asylum seekers and refugees amongst health practitioners (Grant and Deane 1995, Jones, 1999). Jones (1999) has found that many asylum seekers and refugees do not receive the information they require in order to access and use services and this may continue long after their arrival in the UK. This study has revealed that Ethiopian asylum seekers and refugees, particularly women have problems accessing health information despite the majority of them having lived here over 5 years (see chapter 2). Furthermore, some seem to lack knowledge about their right to healthcare, something which is compounded by the equal lack of knowledge on behalf of some health care professionals.

The Audit Commission (1993) found that in addition to all the problems faced by patients who speak English, non-English speakers need access to interpreting, translation and advocacy support facilities to ensure improved access and use of health services. Despite this being an urgent recommendation made by the HEA's

Expert Working Group on refugee health in 1998, this problem continues to exist for the Ethiopian asylum seekers and refugees interviewed in this study.

The issues for secondary care for asylum seekers and refugees are less well documented. The main issues that have been reported are lack of cultural awareness and sensitivity by health care workers (Jones, 1999).

Jones (1999) has found evidence that refugees in Enfield have difficulties finding a dentist who will treat them on the NHS, and in Enfield and Haringey there are increasing numbers of refugees who are not registered for primary dental care under the NHS. This, according to Jones is due to a combination of socio-economic factors, lack of information, language barriers and supply side changes. As around only one third of the Ethiopian asylum seekers and refugees interviewed in our study had used dental services, it seems that these factors may be affecting them also.

In terms of the use of traditional medicine by Ethiopian migrants, Hodes (1997) found that Ethiopians migrants in Israel have more confidence in traditional medicine than in western medicine and that most people will seek holy water or treatment from a traditional healer before considering western medicine. This maybe because in Israel Ethiopian migrants have good access to traditional healers (Nudelman, 1995) whilst in the UK, where the Ethiopian population is younger and less cohesive, traditional healers are less common.

In the study with rural Ethiopian women Berhane *et al* (2001) found that access to health facilities in rural Ethiopia is limited. Around a quarter of the women surveyed had never visited a health care unit. Despite this, whilst they are still highly dependent on traditional methods of healing, there is a growing preference for modern health services. Rural Ethiopian women rely on traditional methods for a number of reasons including: limited access to health care facilities, lack of transport, women's lack of access to family money and lack of satisfaction with the health care system as well the accessibility and cultural acceptance of traditional healers. Preference for modern health care is also dependent on the type of the illness and the cost.

Young (1986) describes how the Amhara people classify healers into four categories: a) Surgeons (bone setters, uvula and tonsil cutters and tooth extractors); b) Herbalists; c) Spirit healers (whose powers come from access to demons, spirits of the church, *zar* spirits and familiarity with magic); d) Cuppers, midwives and tattooists.

There are differences in the healing that Ethiopians seek in the UK with an emphasis on Western medical care in the UK, and traditional healing in Ethiopia. This is mainly because of the availability of these services in each country but may also be a reflection of the acculturation process. It is clear in this study that Ethiopians in the UK do, as time passes, and through education and access to information, adopt some of the host country's values and beliefs about Western biomedicine.

Chapter 13

Beliefs and Experiences of Mental Health Problems and Experiences with Helping Agencies

Introduction

This chapter will describe and explore the beliefs and experiences of Ethiopian refugees and asylum seekers in the UK in relation to mental health and illness. The data on mental health reported on here includes interviews with all the asylum seekers and refugees in the study, five of whom had recognised mental illnesses, and interviews with 'expert' participants, some of whom worked closely with those with mental health problems. Findings that relate to the following aspects of mental health will be presented:

- Mental health problems in Ethiopian refugees and asylum seekers
- Beliefs about 'mental health' and 'mental illness'
- Explanations of mental health problems
- Psychosocial explanations of 'mental illness' and distress
- Expressions of 'mental illness' and distress
- Help seeking for mental health problems
- Experiences with mental health services in the UK

Mental health problems in Ethiopian refugees and asylum seekers

As any other exiled group, Ethiopian asylum seekers and refugees are susceptible to mental illness because of their traumatic experiences prior to seeking asylum (see chapters 3 and 8), difficulties adjusting to a new culture (see chapters 7, 9, 10 and 11), and the material and social deprivation often suffered by asylum seekers and refugees (see chapters 10 and 11). There is also evidence (Ali, 1999) that a

significantly higher proportion of Ethiopian refugees commit suicide and self-harm than other African communities from a similar geographical background. Despite mental health problems among Ethiopian refugees being recognised by their community organisations as a major issue, it has attracted relatively little research. One of the expert participants gave an estimate of the size of the problem:

'Mental illness is one of the major issues. ...There are large numbers of Ethiopians in mental health institutions. Since my background is mental health, I was doing research that was looking for risk factors for suicide. During that time actually, I was able to find about 25 Ethiopians who committed suicide in less than 10 years. Which means for one suicide there are three or more attempted suicides. So the number of people who attempt to kill themselves is still very high. Those who are under mental health institutions are still high. So mental health is one of the issues' (097E: 385).

When asked to describe the health problems they had had since moving to the UK, 15% reported that they had had a mental health problem such as stress, depression or 'mental illness' since coming to the UK. However, the formal rates of mental illness among Ethiopian asylum seekers and refugees (as in any cultural group) would vary according to whether sufferers come forward for help and treatment or not. Certain symptoms may not be perceived to be problematic and requiring of medical attention but as needing social or other non-medical intervention. Definitions of 'mental illness' vary between cultures, as one of the participants pointed out:

'...when you come here, because of cultural issues, or minor illnesses, or mismatch the situations when people get stressed, they can be categorised as people with mental illness. Because of this we have a lot of Ethiopians with mental health problems' (97E: 342).

More indicative of the real incidence of mental health problems were gleaned when participants were asked what made them feel ill, sixty-one percent (61%) said stress /worry did. When asked if they felt sad or unhappy for long periods of time, forty-five percent (45%) said they had.

Beliefs about mental health and mental illness

Many of the participants in this study have described 'healthiness' as meaning physical, mental, emotional, spiritual, and social wellbeing. Health was therefore described as a holistic concept, and mental health was seen as being a necessary component of 'health'. This was illustrated by the finding in this study that forty percent (40%) of participants described being healthy as meaning 'to be free of stress' which was a similar proportion who said 'to not have an illness'. Mental health was described in behavioural terms, as a set of 'can do's', such as being able to handle a crisis, and in terms of subjective experience such as being free of stress, or 'mental satisfaction' (box 13.1 and box 13.2).

Box 13.1: Mental health in behavioural terms means:

- responding sensibly
- being reasonable
- not imposing ones ideas on others
- communicating well
- interacting with others
- integrating and adapting
- fulfilling one's needs or desires
- taking responsibility
- being independent
- overcoming problems
- being able to handle a crisis
- being able to talk about problems & to listen
- being able to analyse situations

Box 13.2: Mental health as a subjective state means:

- not having mental illness
- being free of stress
- avoiding stress
- having a clear bright mental state
- having mental strength
- being able to know right and wrong
- viewing things in a balanced way
- thinking for ones health and wellbeing
- having mental satisfaction
- not having a trauma
- being mentally well
- being confident
- being mentally active

It is argued that the sufferer's and the healer's cultural schemata determine the shape and meaning of the illness or disease, its treatment and the outcome (Castillo, 1997). One of the participants described the difference between Ethiopians and British people in how mental health and illness are perceived and understood:

'In Ethiopia the situation is different.... There is mental sickness, but not to a number like this. The situation is different and it is a different

problem. There are very rare cases. That is for different reason. There is different solutions...' (02MH: 435).

This culture-bound concept of mental illness is now beginning to be acknowledged in Western medicine. Similarly individuals revise their ideas about concepts of mental illness over time and with experience. Another participant illustrated this change when she said,

'... since I have been in this country it is different for everything, for every illness there is scientific explanation for almost everything, so it kind of makes the things that happen back home a bit silly, I think' (22f: 146).

The participants appeared to not only identify a difference between the UK and Ethiopian definitions of what constitutes 'mental illness', they also indicated exposure to new mental health problems that some of them said they were unfamiliar with in Ethiopia. The following extract describes how one of the participants observed Ethiopians becoming vulnerable to 'Western illnesses' when they came to the UK:

'...In this country (UK) there is what is called "depression". When we were back home we did not hear what depression was about. We had no knowledge about depression. However, when we see refugees who came to this country . . . they leave their families or parents behind. They experience a lonely life here. They have no one to turn to for advice. They have no one to share ideas with. They have no one to consult' (025f: 268).

The social structures in Ethiopia were seen therefore to prevent loneliness, a major cause of depression. Another participant posited another explanation suggesting it may be because 'depression' manifested itself under a different guise in Ethiopia:

'The first thing is, you know not acknowledging as a problem or mental health issue. We just consider it as unhappiness. We have a very limited

knowledge of mental illness among Ethiopian refugees, this is one of the reasons' (099E: 312).

Another explanation is that the full extent of depression is hidden because of the stigma attached to mental illness in Ethiopia.

The participants reported that Ethiopians in England are not the same as Ethiopians in Ethiopia. Ethiopians in the UK are exposed to different social situations and cultural beliefs than at home. Importantly, many participants reported being without social support from family and friends and consequently they reported suffering loneliness and isolation. Stress and depression was reported to result from this and it was believed it could progress to an 'illness', as described by one of the participants:

'The reason people get ill? Ok from what I have seen in this country there are many types of illnesses-from being lonely, that means they haven't got many friends. Because of work there is stress and this type of illness there is a lot of it in this country. I have heard from some people that the illness that is affecting them [the indigenous people] is affecting us now' (093m: 111).

One of the participants said, '*...loneliness in itself is one disease' (061f: 70).* The confusion as to how to conceptualise mental illness – whether it is an undesirable social state such as loneliness, or really an 'illness' is also apparent in the following statement:

'I don't know if you call it "illness" when people get lonely in this country, and a lot of Ethiopians get lonely after being used to the way life back home, it is very sad, and I suppose they try to kill themselves and everything' (022f: 171).

The emotional problems caused by the exigencies of a stressful life were seen to be 'normal'. As an expert participant said when describing the experiences of being an asylum seeker or refugee, '*... [it] really shakes people from top to bottom, so it can*

lead to some kind of psychological, emotional problems. This is perfectly normal because people have been through lots of things' (100E: 413).

However, Ethiopians in this study distinguished between these 'normal' reactive emotional states and 'mental illness' in that the latter would be called 'madness' in Ethiopia:

'In Ethiopia we define mental health very widely. [However] there is only one word that defines mental illness, that is 'madness'. When we say madness, the person becomes violent, he tries to throw off his clothes... and attacks others. At this stage we say he is mentally ill. Until that stage he won't be excluded from the community' (97E: 398).

'Mad', people were described as behaving in socially unacceptable ways and were consequently isolated from the community in Ethiopia or marginalised by their families. Whereas those who suffered from stress or other more obvious reactive emotional states were not reported as having been excluded. Similarly in the UK, people who suffer from mental disorders that cause them to behave in socially unacceptable ways are likely to be isolated from the community by being incarcerated in mental institutions. Isolation from the community in Ethiopia may be explained by the social stigma attached to mental illness, the fear of 'madness' and the shame it can bring if it is made public. This was apparent in a statement made by a participant who had himself been given a psychiatric diagnosis in the UK:

'You see people called mad people on the street [in Ethiopia] doing crazy things and people are laughing at them. To me to think about it now is immoral. I think it happened in the third world countries. I think even over here it happens to people' (105MH: 268).

Explanations of mental health problems

- ▶ Supernatural Explanations of Madness
- ▶ Deviance

Supernatural Explanations of Madness

The reason that 'mental illness' or 'madness' carries a stigma in Ethiopian culture was reported to be due to the belief that it is the work of the devil and a punishment for sins. The sinner may not necessarily be the patient, but one of the family members, or other close relative. One of the participants described the effect of the stigma thus:

[In Ethiopia] '...anyone that has mental illness is regarded as a mad person. So, no one wants to admit. No one wants to be branded as a mad person. So, everyone with any symptoms of depression and some kind of mental illness would like to avoid being seen as one of the mad people back home. So, they would be forced to be secretive to their friends, relatives, even to the professionals when they suffer from that type of illness (095E: 583).

A number of psychiatric symptoms and physical disorders are thought by many Ethiopians to be caused by 'Zar' possession. Hodes (1997) writes that 'Zar is a form of East African spirit possession that is more common in women'. Evil eye 'Buda' is also thought to be a cause of mental illness:

'I think they could cause illness. I believe they cause mental illness. This is as a result of belief. As mentioned earlier, there are superstitious people in our society. Those who do not believe in superstition would not be effected. However, those who believe in superstition would be affected by Buda /evil eye' (057f: 219).

Depression was also described as a mental illness and it too was seen to carry a stigma in Ethiopia, as well as those mental illnesses classified as 'madness'. However, depression, according to one of the participants, takes on different meanings in Ethiopia in that it is perceived as having both natural and supernatural causation and remedies:

'... when someone is depressed in Ethiopia, people say it is an illness caused by Satan [‘yesetan likift’ in Amharic]. When the person who was struck by Satan uses “tsebele” [holy water] he would recover from his illness. When the person who was ill, takes bath with “tsebele” and drinks, he would recover from his illness. The person becomes well and gains his former health. This by itself is the truth about “tsebele”’ (070m: 206).

This participant went onto explain his psychosocial understanding of depression when he said, *‘there are many things as to the causes of depression’. We know that African families are extended families. When we come here we leave children back home. We may leave the mother behind. We may leave friends behind’...*(070m: 217).

Deviance

Another participant, who had lived in the UK more than five years, reflected on how people in Ethiopia could be labelled as mentally ill if they voiced opinions that were out of keeping with the ‘norm’:

‘...if somebody is saying things out of the ordinary or the norm they would automatically assume that you have got like some kind of the devil in you, or that kind of stuff, and you need to be -to be cured. You need to go to, like a church or something like that and ... you will be cured by prayer and holy water. I think in some cases it could work, but I think sometimes I feel like they go overboard, they don't give the people a chance. I mean all of us don't have the same ideas and the same beliefs, so I think they need to give people room to express their views without being labelled as mentally ill...’ (092f: 114).

This participant was of the view that it should be acceptable for people to hold and voice alternative beliefs and not be labelled ‘mentally ill’. Being so labelled can be seen as a form of social control aimed at suppressing and ostracising those who hold ‘subversive’ beliefs. Fear of being ostracised and stigmatised is likely to help ensure conformity to cultural and political norms.

Psychosocial explanations for mental illness and distress

The participants reported many causes of stress, depression and other mental health problems, that they as asylum seekers and refugees in the UK are vulnerable to and included the following:

- ▶ Reactions to trauma (of war, rape, torture, persecution and witnessing atrocities)
- ▶ Grief reactions
- ▶ Culture shock
- ▶ Difficulties integrating
- ▶ Loss of social status
- ▶ Social isolation

Reactions to Trauma

An important factor for mental ill health among Ethiopians is the flashback of imprisonment, torture and rape. Such incidents have caused many to suffer from post-traumatic stress disorder, as described by one of the expert participants:

'...refugees that have gone through the experiences of the ills of war, suffer from all sorts of emotional problems. ...there are refugees who have seen their loved ones killed, property destroyed, others tortured and raped. Though, they managed to escape to safety from the horrors of war, they continue to suffer from its effects. Aside from the physical hurt, the psychological problem lingers on affecting the health and wellbeing of the refugees resulting in trauma, fear, and depression' (094E: 100).

Chapter 8 describes more fully the traumas suffered by the participants.

Grief Reactions

The participants described having to endure many losses on migrating to the UK, such as loss of contact with relatives and friends, loss of employment and a stable home. Their ability to come to terms with their new losses was complicated by

factors central to being a refugee. These factors include their pre-migratory experiences, such as the death of loved ones; the trauma of torture and persecution; the lack of an adequate support network; and their degree of adaptation to the UK culture. One of the participants reflected on how he accepted his losses by recognising the gravity of the reasons for seeking asylum and the inevitability of him having to make many sacrifices:

'I am not happy. However, there is nothing that I could do. I applied for asylum to save my life. I know life is not easy. I cannot get everything at once. I mean it takes time. I have lost many things. However, I am surviving with what has remained' (069m: 393).

Grief was recognised as a cause of mental illness, as an expert participant explained:

'When people fail to challenge the problems they face [due to grief] the pressure builds up and affects the psychological make up of the individual, gradually leading to serious mental illness' (095E: 385).

When participants were asked if they felt sad or unhappy for long periods of time; almost half (45%) said they did. Interestingly, there were no differences between those who had been in the UK less than five years compared with those who had been in the UK five or more years in response to this question. When asked why they felt sad or unhappy, the most frequent responses were because they missed their family and because they missed their country (n=15 participants). Others mentioned loss of friends, loss of livelihood, loss of a 'good life', and loss of 'privileges' as some of the reasons for being unhappy or sad.

Culture Shock

For many Ethiopians, preparation to flee is not systematically organised and neither physical nor psychological preparation is made. They may have little knowledge of what life is like in the country in which they are seeking asylum. What knowledge they have may be distorted and idealised. Expectations may be high and few are prepared for the reality which may be particularly difficult to deal with in the first few

months. During this time they experience rigorous immigration checks, language problems, racism, lack of knowledge about the new support system, different weather, different attitudes to work and time, and different belief systems to name but a few of the things that create culture shock for the asylum seeker. One of the participants described living in the UK as stressful like starting a new job.

Coping with culture shock is a big challenge for many Ethiopian asylum seekers, particularly perhaps for those who arrive in adulthood. Holding onto their own traditional way of life was described as a means of protecting themselves from the stress the UK culture induced:

'They like to keep their culture, values and beliefs intact in the midst of enormous cultural shock. The shock will stay for long. The story is different when it comes to the younger generation, where the cultural shock faded expeditiously...' (098E: 76).

One of the participants explained what he did to hold onto his own culture:

'...using your language, talking to your children in your own mother tongue, attending your anniversaries, participating in social gatherings, making contact with your own people, visiting friends, knowing the bereavement process and bereavement procedures, the way of comforting and the norm regarding bereavement. This type of thing is not something that you would get in the British way of life. That is the positive thing that we have to keep' (095E: 341).

Difficulties Integrating

An expert on Ethiopian refugees described why they find it difficult to integrate into British society, and how the stress of this can lead to mental illness:

' ... Ethiopian refugees who come from the traditional society where social relationship and family bondage is very strong, find it difficult to integrate, to communicate with the British society, where they do not

know the system, where they do not speak the language, where the sense of privacy is highly valued...' (095E: 378).

Another participant added how important it was to mental health to be accepted by the host society, to have good relationships with friends and neighbours and to avoid being 'marginalised'. He explained that not achieving this could lead to loneliness and then to depression which he described as a 'serious illness' (052m: 146).

Loss of Social Status

For Ethiopians, education and employment are the means to privilege and status. There is a belief among Ethiopians that the more you are educated, the more your job is secure and the more you are privileged. Many Ethiopian asylum seekers in the UK were of high standing in Ethiopian society in terms of their political status, education, and relative wealth. They were the centre of local and national attention. Some of them were actually the elite in their community with a significant amount of influence, power and privilege. The sudden change of status from being an Ethiopian citizen of high standing to an asylum seeker in an alien social and physical environment was reported as being a strain on physical and mental wellbeing:

'The experience of refugeedom by itself is a very, very shocking experience. People lose their identity, their culture and they lose everything. So, they are status-less in this country. They are nobody whether they are Ethiopians or anybody. This experience really shakes people from top to bottom' (100E: 409).

Social Isolation

Having the support of friends and family who one could turn to for help with problems or simply to socialise was reported as being very important for the mental health of Ethiopians, both in Ethiopia and the UK (see Chapter 11). Loneliness was frequently cited as the main reason for people getting depressed and mentally ill. One of the participants described the impact loneliness can have on Ethiopian refugees;

'Ethiopians especially suffer from loneliness caused by family separation and living alone. This could be exposed to a serious illness. This is why

many Ethiopians are suffering from mental illnesses. It is because of loneliness. If you have noticed, many Ethiopians go where they can meet other Ethiopians, to share ideas than sitting at home and watching TV. If you take myself, most of the time I go where I can meet Ethiopians to avoid loneliness. Since I came from a large family, I enjoy chatting and talking to people. Therefore, I do not like loneliness; I am scared of it' (017m: 261).

Two participants described their social isolation as being compounded by difficulties in finding a suitable (Ethiopian) sexual partner:

'Before I came here I was having a girl friend in Ethiopia. In here, there were many problems. I had no girl friend. There is a problem among Ethiopian girls here. Life is not easy to get a girl friend here. It was not possible to bring my girl friend either. It was a problem' (04MH: 144).

Having fun and laughter was reported to be important to being happy and mentally healthy, but some reported that it was hard to be happy and have fun in the UK. A young participant under the age of 25 mentioned how life as a refugee in an alien environment affected his day to day happiness thus:

'In this country, if I laugh once in a month it is great. I mean if I laugh from the bottom of my heart/true laughter once a month. Back home I used to laugh every day. I was happy all the time. I was happy, even when I had no money. I was happy, in spite of not wearing good shoes. I was happy, I had friends, I had a family. There are many things that were making me happy' (068m: 290).

Expressions of mental illness and distress

Several participants were asked to elaborate on what they understood by the term 'depression': a summary of their responses is listed in box 13.3. These

descriptions seem similar to how Western psychiatry would describe depressed people.

Box 13.3: Characteristics of a depressed person

- avoids people, the community, is aloof
- is not happy with anything
- feels hopelessness
- tends to weep and usually holds back tears
- is preoccupied with their own worries
- cannot sleep
- is economically /financially in mess
- plans and schedules are not consistent
- feels guilty
- is not peaceful with himself
- could even hurt himself
- it is difficult to do day to day work
- cannot study effectively
- has a poor appetite
- has no concentration
- ideas are dispersed
- does not care about anything
- cannot remember (as is pre-occupied with worries)

One of the participants painted a vivid portrait of a depressed person when he said:

'A depressed person is usually alone. He avoids people. He feels hopelessness. He avoids the community or he is aloof. He feels loneliness. Most of the time he tends to weep and usually holds back tears. These are the signs of depression. He is suffering from sleeplessness. His body needs rest. He thinks over certain issues continuously. These issues were something that worried him in life. As a result of this he cannot sleep.... He spends his time worrying about something and is miserable. The issues that depress him cause worries to him leading to sleeplessness' (026m: 118).

The above description of a depressed person contrasts markedly from the description given below by a person that was diagnosed in the UK as having suffered from a psychotic illness:

'As I told you earlier, my illness was started when the Satan identified a place in me. He wins my mind. Then, this enemy [the Satan] was knocking my window, my wall and scratching the ground like a cat does. I was intrigued about what it was. While I was still on this situation and after some time, I heard voices wherever I go. The voice is calling me. It is calling my name. I was intrigued by the voice. When I enter to the Tube [Underground] it follows me. Wherever I am, the voice is there. Whether I am with someone or not it doesn't matter. This voice followed me. After a while, I just said, never mind, it must be the voice of God. Then, I started talking with the voice' (103MH: 118).

Help seeking for mental health problems

- ▶ Help Seeking in Ethiopia: Support from Family and the Community
- ▶ Help Seeking in the UK
- ▶ Religion
- ▶ Counselling
- ▶ Ethiopian's Reluctance to Seek Formal Help

Help Seeking in Ethiopia: Support from Family and the Community

Many participants described the Ethiopian society as being more supportive than the UK society. They described Ethiopian social structures, such as the extended family as protecting people from loneliness to an extent that depression does not exist in Ethiopia. They reported that back home they would have had every opportunity to share their worries and to be supported. Whereas in the UK such support was usually unavailable, as one of the participants described:

'If I was depressed here...people like my friends might come and see me for a day or two, but after that they will go on with their lives. I am not blaming them because they have to work and those who study have to study. Life goes on for them. ...If they come and see me it would be once in a while. They can't stay with me all the time and look after me like a

baby; it is not their fault. But if it was in our country there are a lot of families around you. It is the same in every household; many members of a family live in the same house. Therefore I don't even think there is any depression in our country, I have never heard of any. But if there is, it must very rare, and to deal with it your family and other companies are there for you... (003m: 184).

Another participant reiterated this when she said:

'In Ethiopia it is different because you get a lot of attention and care and this helps you as an emotional support and makes you feel better. This is the most important thing you miss when you are here' (029f: 100).

Therefore in Ethiopia, families, friends and neighbours play a very significant role in maintaining good mental health and in preventing mental illness. Society is considered not responsible for the sufferer once their illness is at the stage of 'madness' when the immediate family takes care of the sufferer. The social structures that enable this were reported to be largely absent from British society for Ethiopian migrants.

Help Seeking in the UK

Not having access to the type of help they are accustomed to in Ethiopia can leave the migrant in a vacuum whereby they may resort to alcohol or 'khat' (a stimulant) or other drugs, as one of the participants explained:

'...when most Abeshas [Ethiopians] are emotionally/mentally ill [in the UK], they become desperate and there is no one to turn to and they start drinking alcohol and do other things. ...An Ethiopian cannot get to see someone whom he could consult in the event of problems. We do not have such personalities at the community, family and at the church level. Therefore, if I were ill, I would not go to the NHS because there is no spiritual counsellor for me. We do not have such people from our community. I would not go to the psychiatrist for counselling. I do not think the psychiatrist is useful in our situation' (014m: 129).

Western drug treatments for mental health problems were largely reported by the participants not to be wanted by Ethiopians suffering mental distress in the UK. Not once did any participants in our study mention anti-depressants as a possible cure for depression or tranquillisers as a remedy for stress. Political solutions for problems that caused stress were the answer, according to one of the participants:

'I didn't know that they have a medicine towards stress. The only medicine for stress is to get a solution for the problem. That is what I think right. I do not think they will help me for my stress because my reasons are different. They cannot correct them. The only body that corrects my problem is the government. That is what I can say' (106MH: 198).

Another participant reiterated this view when he said, *'The disease that loneliness causes to our health is not easy to cure either by swallowing tablets or by having injections'* (026m: 550). Talking with a supportive person was reported by several participants to be helpful for someone suffering from depression or stress and this seemed to be highly valued, as described by a young female participant:

'It is good to have somewhere to go to and talk to their problems with. They need help like communities. You can find your own community in your area. You go and talk about your problems about homelessness, health and mental problem. So, if you contact your community for these kinds of problems, your problems will be less' (082f: 126).

Another participant described how he, in the absence of someone to share his feelings with, would write his feelings down:

'But the best way to me to relieve from stress is trying to communicate whenever it is possible, of course, if there is someone there to communicate with. Otherwise, I try to communicate to myself through writing down my feelings and contemplate things in my mind' (105MH: 143).

Those who do not have access to family, friends, Ethiopian community resources or good personal resources may be particularly vulnerable to the dangers of suffering in silence. This may be compounded by Ethiopians' reluctance to seek help from formal helping agencies.

Box 13.4 provides a summary of the answers listed in order of frequency given by the participants when asked to list the ways they cope with stress. As can be seen the most frequent answer was 'praying', followed by 'crying' and 'talking to a friend'. Very few participants mentioned the use of a counsellor, and only two stated that one of their low priority choices would be to see their GP. None of them mentioned the use of traditional or modern medicines.

Box 13.4: Coping with stress (in order of frequency)

- Through praying (and going to church)
- Through crying
- Talking to friends
- Taking physical exercise (walking, working out etc)
- Listening to music, watching TV and reading newspapers
- Smoking
- Drinking
- Trying to be strong
- Thinking the problem over, trying to resolve it
- Sleeping
- Eating too much
- Making oneself busy
- Talk to someone at the Ethiopian community organisation
- Shouting a lot, not keeping feelings in
- Spending money
- Writing papers
- Playing with one's children
- Seeing a counsellor
- Seeing the GP

Religion

Some participants reported that they had sought help to deal with their problems and loneliness by going to church or other spiritual places:

'It is only yourself that you have to deal with any problems you are facing. You are alone by yourself even when you are ill and apart from seeing your GP you will be by yourself suffering the pain of loneliness. This in some cases might lead to taking life. It is possible to look after yourself if you are strong enough by taking rest and also going to spiritual place like church' (067f: 144).

One of the participants had received help from various sources in the UK for their mental illness, including modern medicines and traditional remedies. However, he reported that he had found his religious faith to be the crucial factor in his recovery:

'The big thing for my mental health improvement is my belief in Jesus Christ. I accepted Jesus Christ as my Lord and as my saviour. He has healed me from my mental disorder. Because, after I came here people were trying different things. As I told you before, like occult things. Even mental health scientific medicines. But it doesn't make things perfect... I go to Church every day. I pray myself and meditate' (102MH: 302).

Another participant's recovery was attributed to both 'natural' things like finding a wife, and getting his rights to remain, and the 'supernatural': his belief in God and Tsebele (holy water):

'God has helped me. With the help of the tsebele and my good friends' advice and support at the time of my difficulty. Yes, I am fine now. I have a wife. She has contributed for my good health. I am working now. I have got my Home Office papers. Things that are necessary for me are now fulfilled. When all these things getting better, I started good life (104MH: 293).

Advocacy and Counselling

The participants were asked if they felt unhappy or sad for long periods of time and if so, would they like to talk to someone who is trained in working with refugees (as opposed to a psychiatric counsellor) about their feelings of sadness /unhappiness. Of the forty-eight (n=48) participants who said they were unhappy /sad for long periods,

three-quarters (75%) said they would. However, only five percent of participants reported actually using 'counselling' services.

Ethiopian's Reluctance to Seek Formal Help

Ethiopians suffering from mental health problems in the UK were reported to be unlikely to seek help from formal care agencies such as GPs or counsellors, only family members or friends were felt to be suitable to consult. One of the expert participants explained the reason for this:

'They (Ethiopians) are very secretive people and they do not discuss their problems with strangers. It is not considered appropriate to discuss one's problem with strangers in Ethiopia. So, they tend to build pressure on themselves. As a result of this they may go into depression which could cause mental health problems again' (096E: 47).

Although other Ethiopians were regarded as an ideal source of support, there was a recognition that they too may be suffering from stress and consequently have inadequate emotional resources or strength to offer them:

'When I am stressed I do not go to the doctors, this is not only me, even all the people I know don't go to the doctors or psychiatrist when they are stressed. What they do is keep what they want to themselves or they talk to their friends. Most of the time, because many Ethiopians, especially these days are in the same situation they cannot help each other. All that happens is understanding and encouragement between each other. Apart from that nothing else happens. This is another cause of stress' (003m: 121).

Stigma about mental illness and a fear of authority may also contribute to Ethiopians' reluctance to seek help for mental health problems in the UK. Talking over personal details and experiences may be reminiscent of 'interrogation' by immigration officers. Absence of a suitable confidant and early support and help was reported as being likely to exacerbate the seriousness of their condition to the point that they may ultimately need emergency treatment:

'Here [in the UK] there is no one to be consulted. He has no one to tell his worries to. He has no means of explaining his illness. Therefore, he somehow would go to a health unit after it is already late. ...Late presentation is one of the problems. The reason is that we Ethiopians are accustomed to keeping our problems to our families and ourselves. ...Especially, if the problem is associated with psychological/ mental illness, it is considered as a serious illness and people do not seek consultation because of the stigma attached to this' (014m: 237).

Those refugees who have no family and none or limited contact with the Ethiopian community and its organisations are likely to be particularly vulnerable to mental distress and illness. Few reported that they turned to formal helping agencies in the UK when they felt sad or unhappy. Indeed, only five percent (5%) of the participants said they had received formal counselling. However, the participants may have varying understandings of what constitutes 'counselling'.

Experiences with mental health services in the UK

Five (n=5) of the participants on the study had been diagnosed as having a mental illness and had received psychiatric treatment of some kind. Many more reported significant levels of stress and depression. Those who had a past psychiatric diagnosis were asked additional questions relating to their experiences of this. These participants described varying degrees of engagement with the mental health services. Some had been admitted under section, all had been medicated.

One of the participants suffered from what appears to be a psychotic disorder that commenced soon after his arrival in the UK. He described how Ethiopian therapies were sought for him by other Ethiopians and how these were felt to have had a detrimental effect on his mental health:

'I totally became abnormal and sick.... At that time, I haven't got any treatment because they themselves [the family I lived with] were not

civilised. Though, they are Ethiopians, they believed in occult and traditional things. They were very closed to seeing other things. Their solutions for my sickness was to give prayer or worship to occult, which in our culture is called 'Wuqabii' or 'Awlia'. That was their treatment for me. They didn't take me to the Hospital. Their treatment made me more mad, more sick and more unhealthy' (102MH: 109).

He went on to explain how this continued for two years until some friends identified another possible solution, the Christian fellowship. He described how they prayed for his healing and for his disorder and supported him financially and materially. Despite this, his situation did not improve. They concluded eventually that he should be taken to a mental health hospital. However, this did not yield immediate results because he believed his immigration status (exceptional leave to remain) denied him rights to free healthcare:

'The first day, I went by Ambulance to the local hospital. ...they gave me some sleeping tablets. The next day they took me to the GP. The GP saw my situation. And he referred me to the [another] hospital. But, before that, my friends who looked after me have tried to find me a place at different hospitals. Because of my immigration status, I had no benefit. Due to my immigration situation, it was difficult for two or three hospitals to admit me. They knew that my situation was bad. But they didn't agree or they didn't take me. ...they didn't take me as per the referral of my GP. So my friends took me to [another] hospital. At that moment, I haven't got any benefit.... I have only got work permit. Therefore, it was difficult for me to get NHS treatment. Despite the fact that they know all this, the hospital took me as a patient for the first time' (102MH: 153).

That this patient saw the reason for not being admitted to hospital as being due to his immigration status suggests that some refugees and asylum seekers, and indeed some healthcare professionals may be unaware of asylum seekers' entitlement to free healthcare in the UK.

Another participant described how he had felt coerced into complying with the psychiatrist and agreeing to have his depot injections:

'I know that I took the injection only to qualify for sickness benefit entitlement. You only get the sickness benefit if you take the injection. ...But my mind says to me, why do you do this? Therefore, I decided to stop the injection. I told the doctors that Christ will cure me. As a result of this misunderstanding, I stopped the injection for a while' (103MH: 368).

Discussion

To date there is little formal knowledge regarding the incidence and nature of mental health problems among Ethiopian refugees in the UK, although there has been some work that shows high levels of suicide (Ali, 1999). However, this study has identified that there is a considerable amount of mental distress within this community. Ethiopian refugees and asylum seekers are prone to mental health problems as a result of traumatic pre-migratory experiences. Once in the UK many also suffer social disadvantage and poverty; social isolation; difficulties integrating; cultural variations in help seeking behaviour and lack of knowledge about their entitlement to free healthcare in the UK. All these factors act either as causes of mental health problems or barriers to their resolution. Furthermore, the findings of this study add weight to findings reported by other studies (Aldous et al, 1999).

Of significance was the finding that most participants did not have the support of family and that many reported that their main source of support was their friends, their religion and Ethiopian community organisations. Those with no family in the UK, few friends and little or no contact with Ethiopian community organisations are likely to be particularly at risk of mental health problems. The socially isolated may also be more likely to deteriorate to the point of suicide or to require hospitalisation. Ensuring that patients have appropriate and adequate social support before being discharged back to the community may help prevent relapse. It is also important that

service providers are aware of refugee and asylum seekers' entitlement to free health care.

Mental health practitioners and others involved in assisting Ethiopian refugees and asylum seekers with health or welfare issues can provide more culturally appropriate and effective help if they have some knowledge of Ethiopian health beliefs and culture. Particularly important is the recognition of Ethiopians' reluctance to discuss their problems with strangers, the stigma they attach to mental illness, and the importance of employment and social life to their mental well being. Policies that aid Ethiopian refugees quickly into suitable employment, that assist integration, and help them find social support such as through the Ethiopian community and its organisations are therefore important.

Chapter 14

Conclusions and Recommendations

This report has aimed to portray what it is like being an Ethiopian refugee or asylum seeker in the United Kingdom today and the complex way in which historical, political, social and economic influences interact and impact on their experiences. The report is based on personal accounts of these experiences. The research team, which had a large contingent of Ethiopian refugees, are committed to ensuring that the information will be used to benefit refugees and asylum seekers from Ethiopia and elsewhere.

The key consumers for this report are health and social care service providers in the UK, including voluntary Ethiopian community organisations, and policy makers. We hope that, as well as providing evidence for suggested change, the report has enlightened and informed its readers about Ethiopians and their culture and how this impacts on their lives in the UK. Such knowledge should promote a greater understanding that will lead to more culturally sensitive policy, practice and attitudes among health and social welfare practitioners.

Whilst many studies have concentrated on providing important insights into the socio-economic circumstances of asylum seekers and refugees, this study aimed to probe deeper and wider, attempting to illuminate the complexities of their interactions with the host culture in relation to health and social well being. To do this it was necessary to explore Ethiopian asylum seekers' reasons for coming to Britain; their transit here; their experiences of settling in the UK; the differences between Ethiopian culture and British culture; their health beliefs and behaviours; and their experiences with health and social care agencies. All of these aspects of their lives are inextricably interwoven. For example, we have shown how cultural beliefs impinge on help-seeking behaviour, which in turn impacts on health and social outcomes.

That action should be taken on the findings was an expressed wish of many of the participants when asked what they felt about the project:

'Research by itself has no harm. However, it can only serve its purpose when it is used for good causes. If it is not consumed properly and remains on paper it is not useful. It has to serve its purpose. The most important thing is to put it into practice' (042f: 757).

Most of the participants on the study felt very positive about the research project and stated what they saw as the potential benefits to Ethiopian asylum seekers and refugees. The benefits listed below relate to identifying the social and health problems and solutions of Ethiopian refugees and asylum seekers, improving understanding of their culture and circumstances amongst the host population, and improving the relationship between themselves, and themselves and the host population:

Box 14.1: How might the research project be of benefit?

- help future newcomers /useful for those who might face the same difficulty
- help bring Ethiopians together
- help others understand and support Ethiopians
- explain the political process of our country to other people
- the people of the UK will understand what is happening in Ethiopia to innocent people
- allow a positive relationship between the Ethiopian community and the individual people
- help Ethiopians to understand ourselves
- [help identify] where they can get a proper job /get settled / stress free life
- [give Ethiopians] a chance to open up their sorrows
- [identify] why suicide affects Ethiopians
- will relieve many people from hardship and stress / depression
- [identify] preventive methods for depression and loneliness /mental illness
- indicate solutions to health problems

Cited from the interviews

One of the participants explained how he felt the research project was essential for his community as it gave an opportunity to speak out about their problems and to identify appropriate solutions:

'Yes, it will benefit our people. Unless someone speaks out about his illness, no one knows about his illness. Unless he says, I have pain here and there, and speaks out about his illness, it is impossible to know his illness. He cannot get the right treatment. He cannot be cured. If we do not speak to concerned people about our problems, we cannot get solution or help. So we hurt ourselves in silence' (079M: 415).

The participants have bravely broken their silence, it is now important that their voices are heard.

Reasons for leaving Ethiopia and modes of escape

The reasons given for leaving were varied but centred on fear for their safety or the safety of a minor. Many had suffered political imprisonment and torture, or their family or associates had and they feared the same fate. People in the UK often view asylum seekers and refugees with suspicion, believing that they really come to the UK for economic reasons. We hope the accounts in this report will help dispel this myth and help people to view refugees more sympathetically.

Immigration

The most pressing issue around immigration for the participants was the length of time they had to wait for their asylum applications or appeals to be heard. This caused great stress to many, which was compounded by their enforced poverty and lack of occupation.

Ethiopian culture values respect for authority and modesty and these factors may contribute to difficulties convincing immigration officials of the genuineness of their application for asylum.

Adapting to UK culture

Levels of acculturation were diverse and were not always dependent on the amount of time spent in the UK. Things that acted as barriers to integration included language, unemployment, and major cultural differences. Males expressed greater distress having more often lost social esteem and the privileges bestowed upon them in Ethiopia where there is greater male domination than in the UK.

Social experiences

Friendship was reported to be the most important facet of social life in the UK as friends could provide support in the absence of family and neighbours. However, some complained of feeling isolated and lonely because of a lack of friends, little contact with other Ethiopians and lack of trust between them, not having enough money to socialise, unemployment, and fear of being misunderstood by the host society because of language and cultural differences. Having friendships and a social life were also felt to be difficult because of child-care responsibilities, the pace of life in the UK, the primary importance placed on work and the geographical distance between people.

Experiences with employment

Ethiopians highly value being able to work which they see as essential to health and well being, and as a sign of health. Employment, as well as bringing many social and health benefits, also appears to improve the likelihood of integration. However, like many other refugee groups they suffer from a disproportionately high level of unemployment and from the consequences of this.

They have the same barriers to employment as any other refugee group including language, lack of (valid) qualifications, lack of experience in the UK labour market, discrimination, and lack of knowledge of the employment market. Those who were particularly likely to be unemployed in our sample were those who had been granted Exceptional Leave to Remain and those who were aged over twenty-five who had been in the UK less than five years. The latter group was small and the findings might not bear out in a larger sample. However, although over time more tend to find work, many also return to education (sometimes as an alternative to employment).

Female Ethiopian refugees with dependent children may be additionally disadvantaged in the labour market as they are unlikely to have family members who can care for their children while they work. They may also not earn enough to afford formal childcare or they may not know how to access it.

Education

Fluency in the English language has been shown by other studies to be a primary predictor of employment among refugees and this was supported by our study. Although a significant proportion already had university degrees, diplomas or vocational qualifications there were others who wanted to study for them in the UK but could not afford to. Improving the chances of finding suitable employment by undertaking (further) educational courses was a major goal of many of those in our study, and indeed just over half of them were studying. However, some said that stress such as that caused by waiting for the Home Office decision on their application for asylum made concentration on studies difficult. Others said they did not receive appropriate educational guidance. Unaccompanied minors may be particularly disadvantaged by the stress of being apart from their families. They may also be reluctant to ask their foster parents for support and assistance with their studies. Refugees and asylum seekers therefore may need to work much harder to progress alongside their peer group.

Health beliefs and help-seeking behaviour

Ethiopians have a holistic view of health believing that mental, physical and spiritual health are all interconnected. Of particular note is the great emphasis they place on the link between happiness and good health. They also recognise the impact that socio-economic factors, poor quality food and stress and depression can have on physical health.

Whilst generally very happy with the health services in the UK, some participants voiced concerns about their lack of information about health care services, the problems of language and the lack of culturally appropriate care. A significant number of them used self-healing and traditional practices before seeking help from professional health care workers.

Mental health

Stress was felt to be a primary cause of depression, and depression and stress were believed to be a major cause of poor physical health. Meeting spiritual as well as emotional needs was felt to be important to mental health. Avoiding loneliness and isolation through the support of friends, religion, or Ethiopian community organisations were felt to be the main determinants of good mental health in the UK. Ethiopians in their homeland are accustomed to living in a culture based on close family and neighbourhood networks. Many participants therefore had difficulties adjusting to what they perceived to be an individualistic, independent, and work orientated culture in the UK. Ethiopian community organisations provided culturally appropriate respite from the stress of social isolation. Employment and achieving one's goals and aspirations were also regarded as very important to mental health. Policies that help refugees quickly into suitable employment would have a positive impact on their mental health.

Help -seeking for stress and mental health problems is complicated by the fact that mental illness is stigmatised in Ethiopian society, consequently Ethiopians are reluctant to discuss their problems with strangers. This is likely to impact negatively on their uptake of mental health services such as psychiatry and counselling. There was a preference for counselling from people specifically trained to deal with refugees and asylum seekers. Ethiopians may need encouragement to seek expert help for mental health problems and to express their feelings when they do. They are also likely to need a lot of reassurance about confidentiality.

Recommendations

| Immigration issues | Solutions / recommendations | Suggested agencies for action |
|--|---|---|
| <ul style="list-style-type: none"> Negative attitude to Ethiopians including racism and discrimination. | <ul style="list-style-type: none"> Dispel myths through informing the public of reality. Support Ethiopian media. | <ul style="list-style-type: none"> Media. Educational establishments. Ethiopian community organisations. |
| <ul style="list-style-type: none"> Ethiopians may have difficulty convincing immigration officials of genuineness of application. | <ul style="list-style-type: none"> To be aware of Ethiopian tendencies to be shy and unassertive and of the corresponding body language. | <ul style="list-style-type: none"> Immigration Nationality Directorate and Officers |

| Employment issues | Solutions / recommendations | Suggested agencies for action |
|---|--|---|
| <ul style="list-style-type: none"> Poor English language skills. | <ul style="list-style-type: none"> Improve accessibility to courses e.g. packed lunches for those in hostels on courses. Childcare facilities in educational establishments. | <ul style="list-style-type: none"> Half-board housing providers. Colleges of Further Education and other educational providers. |
| <ul style="list-style-type: none"> Lack of knowledge about the employment system. | <ul style="list-style-type: none"> Information & advice in English and Amharic on how to get work. | <ul style="list-style-type: none"> Employment services. |
| <ul style="list-style-type: none"> Lack of valid qualifications. | <ul style="list-style-type: none"> Fast track courses/ special schemes. | <ul style="list-style-type: none"> Universities and colleges. Professional bodies. |
| <ul style="list-style-type: none"> Discrimination and racism. | <ul style="list-style-type: none"> Individuals can seek advice but need to know how. Workplace monitoring and reporting of violations. | <ul style="list-style-type: none"> Commission for Racial Equality. Ethiopian community organisations. Employers and employees. |
| <ul style="list-style-type: none"> Immigration status (Exceptional Leave to Remain) causes problems in finding work. | <ul style="list-style-type: none"> Incentives for employers to take on people with Exceptional Leave to Remain. | <ul style="list-style-type: none"> Dept. of Employment. Employers. |

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|--|--|--|
| <ul style="list-style-type: none"> ▪ Exploitation as illegal workers and ignorance about the Law pertaining to the employment of refugees and asylum seekers. | <ul style="list-style-type: none"> ▪ Advise asylum seekers how to claim permission to work six months after application. ▪ Employers to be aware of the Asylum and Immigration Act 1999. | <ul style="list-style-type: none"> ▪ National Asylum Support Service. ▪ Ethiopian community organisations. ▪ Employers. |
|--|--|--|

| Education issues | Solutions / recommendations | Suggested agencies for action |
|---|--|--|
| <ul style="list-style-type: none"> ▪ Lack of advice re appropriate courses or training. | <ul style="list-style-type: none"> ▪ Advice in Amharic. | <ul style="list-style-type: none"> ▪ Local Education Authorities. |
| <ul style="list-style-type: none"> ▪ Poor 'pay off' for additional qualifications/upgrading. | <ul style="list-style-type: none"> ▪ Advise regarding risk of poor pay-off and what are the alternatives. | <ul style="list-style-type: none"> ▪ Careers Advisory Services. |

| Housing issues | Solutions / recommendations | Suggested agencies for action |
|--|---|---|
| <ul style="list-style-type: none"> ▪ Low levels of satisfaction with housing for those in private accommodation (dirty, overcrowded, unsafe etc). | <ul style="list-style-type: none"> ▪ Housing standards to be monitored in private hostels, hotels and Bed and Breakfast accommodation. Action taken if violated. | <ul style="list-style-type: none"> ▪ Environmental Health Dept. ▪ Housing Officers ▪ Social Workers. |
| <ul style="list-style-type: none"> ▪ Inappropriate housing e.g. mixed sex/ ethnicity households /hostels/B&B. Minors accommodated with foster parents of inappropriate ethnic or religious group. | <ul style="list-style-type: none"> ▪ To take account of religious and cultural background of person. Ask minors what their preferences are regarding the ethnicity and religion of foster parents. ▪ Awareness of Ethiopian ethnohistory. | <ul style="list-style-type: none"> ▪ Social Workers. ▪ Housing Officers. ▪ Housing Agents. |
| <ul style="list-style-type: none"> ▪ Lack of money for deposits and for rent on being granted Refugee status or Exceptional Leave to Remain leading to homelessness. | <ul style="list-style-type: none"> ▪ Establishment of a loan scheme. ▪ Other solutions to be investigated. | <ul style="list-style-type: none"> ▪ Local authorities. ▪ Establishment of a new body? |

| | | |
|--|--|---|
| <ul style="list-style-type: none"> ▪ Intrusion of landlords/ladies into accommodation without notice. | <ul style="list-style-type: none"> ▪ Tenants to be made aware of their rights and landlords aware of rights of tenants. | <ul style="list-style-type: none"> ▪ National Asylum Support Service. ▪ Housing Officers. |
|--|--|---|

| Finance issues | Solutions / recommendations | Suggested agencies for action |
|--|--|---|
| <ul style="list-style-type: none"> ▪ Many refugees and asylum seekers struggling financially. | <ul style="list-style-type: none"> ▪ Help younger migrants with budgeting skills. ▪ Improve employment outcomes. | <ul style="list-style-type: none"> ▪ Ethiopian community organisations. ▪ Employment and educational advisors. |
| <ul style="list-style-type: none"> ▪ Cannot open a bank account with asylum seeker's documentation: leads to problems with potential employers and getting loans. | <ul style="list-style-type: none"> ▪ Alternative(s) to be investigated. | <ul style="list-style-type: none"> ▪ National Asylum Support Service. ▪ Refugee Council. ▪ Banks & building societies. |

| Social welfare service issues | Solutions / recommendations | Suggested agencies for action |
|--|--|--|
| <ul style="list-style-type: none"> ▪ Inappropriate treatment of asylum seekers by some service providers due to lack of understanding of their culture and the law. | <ul style="list-style-type: none"> ▪ More attention to cultural issues and needs and rights of asylum seekers in training of professionals. | <ul style="list-style-type: none"> ▪ Universities and other educational establishments. ▪ Social services in collaboration with voluntary organisations. |
| <ul style="list-style-type: none"> ▪ Some asylum seekers /refugees unaware of Ethiopian community organisations / leaflets not in Amharic. | <ul style="list-style-type: none"> ▪ Information leaflets in Amharic about sources of support and advice provided on entry into UK. | <ul style="list-style-type: none"> ▪ Refugee Council. ▪ National Asylum Support Service. ▪ Ethiopian community organisations. |

| Health issues | Solutions / recommendations | Suggested agencies for action |
|---|--|--------------------------------------|
| <ul style="list-style-type: none"> ▪ Health problems related to poverty, unemployment and bad housing. | <ul style="list-style-type: none"> ▪ See Finance, Employment and Housing issues | |

| | | |
|---|--|--|
| <ul style="list-style-type: none"> ▪ Health problems related to poor nutrition/culturally inappropriate food. | <ul style="list-style-type: none"> ▪ Information on Ethiopian foodstuff suppliers. ▪ Nutritional advice. ▪ Provision of culturally appropriate food in full/half board accommodation. ▪ Cash for food. | <ul style="list-style-type: none"> ▪ Ethiopian community organisations. ▪ Dept. of Health. ▪ Private hostels, Bed and Breakfasts, and reception centres. ▪ Home Office |
| <ul style="list-style-type: none"> ▪ Lack of knowledge among health workers regarding Ethiopian traditional healing practices. | <ul style="list-style-type: none"> ▪ Information for health care workers on traditional healing practices. | <ul style="list-style-type: none"> ▪ Research Centre for Transcultural Studies in Health. ▪ Ethiopian community organisations. |
| <ul style="list-style-type: none"> ▪ Information about the NHS needed in Amharic. | <ul style="list-style-type: none"> ▪ Information leaflets in Amharic to be available on arrival in UK. | <ul style="list-style-type: none"> ▪ Home Office. ▪ Refugee Council. ▪ Ethiopian community organisations. |
| <ul style="list-style-type: none"> ▪ Inappropriate care and treatment due to language/communication barriers. | <ul style="list-style-type: none"> ▪ Provision of professional interpreters who speak Ethiopian languages. | <ul style="list-style-type: none"> ▪ Dept. of Health in collaboration with other organisations. |
| <ul style="list-style-type: none"> ▪ Culturally insensitive health and social care services. | <ul style="list-style-type: none"> ▪ Cultural competence training for all health workers (including NHS Direct) and social care workers. | <ul style="list-style-type: none"> ▪ Experts in cultural competence. |
| <ul style="list-style-type: none"> ▪ Poor utilisation of dental services. | <ul style="list-style-type: none"> ▪ Information leaflets concerning dental health and services in Amharic. | <ul style="list-style-type: none"> ▪ Dept. of Health. ▪ Ethiopian community organisations. |

| Mental health issues | Solutions / recommendations | Suggested agencies for action |
|--|---|--|
| <ul style="list-style-type: none"> ▪ Stress and depression caused by socio-economic circumstance, disadvantage, racism, discrimination, difficulties adapting to new culture, immigration status etc. | <ul style="list-style-type: none"> ▪ Attention to above recommendations. ▪ Greater recognition of the psychosocial and cultural needs of asylum seekers and refugees through training in cultural competence. | <ul style="list-style-type: none"> ▪ Centre for Transcultural Studies in Healthcare. ▪ Health and social care providers. |

| | | |
|---|---|--|
| <ul style="list-style-type: none">▪ Social isolation and loneliness leading to stress and depression. | <ul style="list-style-type: none">▪ Reduction in social isolation by increasing employment, English language skills and contact with Ethiopian organisations. | <ul style="list-style-type: none">▪ Home Office.▪ Dept. of Employment.▪ Ethiopian community organisations. |
| <ul style="list-style-type: none">▪ Stigma about mental illness among Ethiopians leads to lack of help seeking. | <ul style="list-style-type: none">▪ Encourage more openness and sharing of problems.▪ Service providers to be aware of the stigma.▪ Provision of specialist refugee counselling services. | <ul style="list-style-type: none">▪ Ethiopian and other media.▪ Health and social welfare providers,▪ Ethiopian community organisations. |

References

- Acheson, D. (1998). **Independent inquiry into inequalities in health report**. London. The Stationary Office.
- Ahmad, W.I.U. (1993). **Race and health in contemporary Britain**. Buckingham: O.U Press.
- Aldous, J. Bardsley, M. Daniell, R. Gair, R. Jacobson, B. Lowdell, C. Morgan, D. Storkey, M. & Taylor, G. (1999). **Refugee health in London**. London. The Health of Londoners Project.
- Alexander, Z (1999). **Study of black, Asian and ethnic minority issues**. London. Department of Health.
- Ali, M. (1999). **Examination of risk factors associated with suicides among refugees, with particular emphasis on Ethiopian refugees in London, 1990-1996**. London. Unpublished Masters Dissertation. University of London.
- Audit Commission (1993) **What seems to be the matter? Communication between hospitals and patients**. London: HMSO.
- Audit Commission (2000). **Another Country: Implementing dispersal under the Immigration and Asylum Act 1999**. London. Audit Commission.
- Baker, C. Arseneault, A. & M. Gallant, G. (1994). Resettlement without the support of an ethnocultural community. **Journal of Advanced Nursing**, 20, p.1064-72.
- Bariso, E. U. (1997). **The Horn of Africa Health Project**. London. North Thames Regional Health Authority.
- Basch, C.E. (1987). Focus group interview: An under-utilised research technique for improving theory and practice in health education. **Health Education Quarterly**, 14(4), p.411-448.
- Berhane, Y. Gossaye, Y. Emmelin, M. & Hogberg, U. (2001). Women's health in rural setting in societal transition in Ethiopia. **Social Science and Medicine**, 53, p.1525-1539.
- Berry, J.W. & Kim, U. (1988). Acculturation and mental health. In P. Dasen, J.W. Berry & N. Sartorius (eds). **Health and cross-cultural Psychology**. London. Sage.
- Beyene, Y. (1992). Medical disclosure and refugees: Telling bad news to Ethiopian patients. **Western Journal of Medicine**, 157, p.328-332.
- Carey Wood, J. Duke, K. Karn, V. & Marshall, T. (1995). **The settlement of refugees in Britain. Home Office Research Study 141**. London: HMSO

References

CARF 48, (February/March 1999). **Racism and the press in Blair's Britain.** Available from: <http://www.carf.demon.co.uk/feat22.html>

CARF 55, (April/May 2000). **Stop this bogus tabloid nationalism.** Available from: <http://www.carf.demon.co.uk/feat39.html>

Castillo, R. (1997). **Culture and mental illness: A client centred approach.** USA. Brooks/Cole Publishing Co.

Central Intelligence Agency. (2001). *The World Factbook* [online]. Available from: <http://www.odci.gov/cia/publications/factbook/geos/et.html>

Chomsky, N. (1993). Media Control. Excerpts from **Alternative Press Review.** Fall 1993. Available from: <http://www.zmag.org/chomsky/talks/9103-media-control.html>

Clinton – Davis, L. & Fassil, Y. (1992). Health and Social problems of Refugees. **Social Science and Medicine** 35(4) p.507-513.

Conway, J. (ed) (1998). **Prescription for Poor Health: The crisis for homeless families.** London: SHAC, Shelter, London Food Commission, Maternity Alliance.

Denzin, N.K. (1989). **The Research Act: A theoretical introduction to sociological methods.** (3rd edition). New Jersey: Prentice Hall.

Department of Health (2001). **Tackling Health Inequalities - Consultation on a plan for Delivery.** London. DoH.

Department of Health, Education, and Welfare (1978). **Ethical Principles and Guidelines for the Protection of Human Subjects of Research (The Belmont Report).** USA. The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research.

Dunn, F. (1979). Behavioural aspects of the control of parasitic diseases. **Bulletin of the World Health Organisation.** 57, p.499-512.

Ehret ,C.(1979). On the antiquity of agriculture in Ethiopia. **Journal of African History.** 20(2), p.161-177.

Elliot, P. (1998). Hidden talents. **Health Service Journal.** 108 (5622): 28 (17 September 1998).

Enfield & Haringey Health Authority (2000): **Report on the health implications of the new Asylum and Immigration Bill.** London. E&H HA.

Fekete. L. (2001). **The dispersal of xenophobia. A special report on the UK and Ireland.** Institute of Race Relations. Available on line at: <http://www.irr.org.uk/dispersal/> (Accessed 24/01/01)

- Gamaledin-Ashami, M. (1993). **A report on the study of homelessness among young people from the horn of Africa in selected areas of London.** London. Charity Projects.
- Gammel, H. Ndahiro, A. Nicholas, M. & Windsor, J. (1993). **Refugees (political asylum seekers) service provision and access to the NHS.** London. College of Health.
- Glover, S. Gott, C. Loizillon, A. Portes, J. Price, R. Spencer, S. Srinivasan, V. & Willis, C. (2001). **Migration: an economic and social analysis.** London: Home Office, RDS Occasional Paper No 67.
- Grant, C. & Deane, J. (1995). **Stating the obvious factors which influence the uptake and provision of primary health care services to refugees.** London: Brixton Challenge and Lambeth, Southwark and Lewisham Health Authority.
- Hahn, R. (1995). **Sickness and Healing: An anthropological perspective.** London. Yale University Press.
- Haringey Council (1997). **Refugees and Asylum Seekers in Haringey - Research Project Report.** London: Haringey Council.
- Health Education Authority (1998). **Promoting the health of refugees. A report of the HEA's Expert Working Group on refugee health: its present state and future directions.** London. Immigration Law Practitioners Association.
- Hendessi, M. & Bank-Anthony, B. (1997). **Health needs and experiences of refugees in Croydon.** Report of a Research Project. Croydon: Linx Social Policy Consultancy.
- Hodes, R. (1997). Cross-cultural Medicine and Diverse Health Beliefs, Ethiopians Abroad. **Western Journal of Medicine.** 166, p.29-36.
- Huka, G. (1996). **Ethiopian Health Support (EHS): service provisions and organisational strategy.** London. EHS Group.
- Immigration and Asylum Act 1999.** London. The Stationery Office.
- Institute for Public Policy Research (1993). **The Justice Gap.** London: IPPR.
- Johanson, D. & Maitland, E. (1981). **Lucy: The beginnings of humankind.** New York: Simon and Scuster.
- Jones, J. (1999). **Refugees and Asylum Seekers in Enfield and Haringey: A health needs assessment/service provision – Recommendations for Health Authority action.** London. Enfield and Haringey Health Authority.
- Kemp, C. (1993). Health services for refugees in countries of second asylum. **International Nursing Review.** 40(1), p.21-24.

References

Kitzinger, J. (1994). The methodology of focus groups: the importance of interaction between research participants. **Sociology of Health and Illness**. 16(1), p.103-121.

Library of Congress (2000). Ethiopia – A country study.
Available from: <http://lcweb2.loc.gov/frd/cs/ettoc.htm> (accessed 03/07/00)

MacLachlan, M. (1997). **Culture and health**. New York. Wiley and Sons Ltd.

McSpadden, L. & Moussa, H. (1993). I have a name: The gender dynamics in asylum and in resettlement of Ethiopian and Eritrean refugees in North America. **Journal of Refugee Studies**. Vol. 6(3), p.203-225

Mesfin Wolde-Mariam (1972). **An introductory geography of Ethiopia**. Addis Ababa: Berhanena Selam Printing Press.

Middleton, D. & Edwards, D. (1990). **Collective remembering**. London. Sage.

Muchie, M. (1999). The disuniting of Ethiopia through the ethnic entrepreneurial project. **Ethiopia Register**. Vol.6, p34-38.

Mueke, M. (1992). New paradigms for refugee health problems. **Social Science and Medicine**. 35 (4) p.515-523.

Nazroo, J. (1997). **The health of Britain's ethnic minorities**. London. Policy Studies Institute.

Nudelman, A. (1995). Health behaviour and traditional healing among Ethiopian immigrants in Israel. In Kaplan, S. Parfitt, T. & Semi, E. (eds) **Between Africa and Zion: Proceedings of the first international congress of the society for the study of Ethiopian Jewry**. Jerusalem. Joint Distribution Committee. p.203-210.

Pankhurst, R. (1992). **A Social History of Ethiopia: the Northern and Central highlands from early medieval times to the rise of Emperor Twedros II**, Trenton. New Jersey. Red Sea Press.

Papadopoulos, I. Tilki, M. & Taylor, G. (1998). **Transcultural care: A guide for healthcare professionals**. Salisbury. Quay Books.

Patton, M.Q. (1990). **Qualitative evaluation and research methods**. New York: Sage Publications.

Refugee Council (2000). **Information for Asylum Seekers**. London. Refugee Council.

Refugee Council (2000): **Facts about refugees and asylum seekers. Refugee Council Briefing Paper**. April 2000. London. RC.

Robinson, V. (2001). **Jewels in the Crown: The contribution of ethnic minorities to life in post-war Britain**. London: Moneygram International.

References

Smaje, C. (1995). **Health, Race, and Ethnicity: making sense of the evidence.** London: Kings Fund.

Taylor, G. & Gair, R. (1999). A review of the literature on the health of refugees and asylum seekers. In Aldous, J. Bardsley, M. Daniell, R. Gair, R. Jacobson, B. Lowdell, C. Morgan, D. Storkey, M. & Taylor, G. (1999). **Refugee health in London.** London. The Health of Londoners Project.

Tesch, R. (1990). **Qualitative research: Analysis types and software tools.** London: Falmer Press.

The Guardian, and **The Sun**. All issues of both newspapers in the month of February 2000 and 2001 were analysed

The Home Office (1998). **Fairer, Faster and Firmer – A modern approach to immigration and asylum.** London: The Stationary Office.

The Human Rights Act 1998. London. The Stationery Office.

Tibebu, T. (1995). **The making of modern Ethiopia 1896-1974.** New Jersey. Red Sea Press.

Tool, M. J. & Waldman, R. J. (1993). Refugees and displaced persons. War, hunger, and public health. **JAMA.** 270 (5), p600-605.

UNHCR (The United Nations Commission for Refugees). Available on <http://www.unhcr.ch>

United Nations (1991). **Demographic Yearbook 1989.** New York: United Nations.

USAID Ethiopia Profile 1995. Available from:
http://www.usaid.gov/regions/afr/country_info/ethiopia.html

Vallely, A. Scott, C. & Hallums, J. (1999). The Health Needs of Refugees: Using rapid appraisal to assess needs and identify priority areas for public health action. **Public Health Medicine**, 1(3), p.103-107.

Young, A. (1986). Internalising and Externalising Medical Belief Systems: an Ethiopian Example. In Curren, C. and Stacey, M. (eds). **Concepts of Health, Illness and Disease: A comparative perspective.** Oxford/Providence: Berg Publishers Ltd.

Zewde, B. (1991). **A history of modern Ethiopia:1855-1974.** Ohio. James Currey, Ohio University and Addis Ababa University.

Useful websites

Research Centre for Transcultural Studies in Health, Middlesex University
<http://www.mdx.ac.uk/www/rctsh/homepage.htm>

The Ethiopian Community in the UK
<http://www.ethiopiancentre.org/abouteccuk.htm>

The Ethiopian Community in Britain
<http://www.ethiopiancommunity.co.uk/index.html>

The Refugee Council
<http://www.refugeecouncil.org.uk/>

The Immigration and Nationality Directorate of the Home Office
<http://www.ind.homeoffice.gov.uk/>

Joint Council for the Welfare of Immigrants
<http://www.jcwi.org.uk/contacts/otherorg.html>

The Immigration and Asylum Bill
<http://www.parliament.the-stationery-office.co.uk/pa/ld199899/ldbills/091/1999091.htm>

Office of the High Commission for Human Rights: Convention relating to status of refugees
http://www.unhchr.ch/html/menu3/b/o_c_ref.htm

UN human rights declarations: including the Geneva Convention
<http://www.hrweb.org/legal/undocs.html>

United Nations High Commissioner for Refugees
<http://www.unhcr.ch/>

The Ethiopian Embassy's fact file on Ethiopia
<http://www.ethioembassy.org.uk/fact%20file/factfile.htm>

'The World Factbook': facts about Ethiopia produced by the CIA
<http://www.odci.gov/cia/publications/factbook/geos/et.html>

The U.S. Agency for International Development (USAID)
<http://www.usaid.gov/horn/ethiopia/USAID/health.html>

USAID information about trafficking of women and children
<http://WWW.usaid.gov/about/women/trafficking.html>

Appendix I

Training Materials

The E.M.B.R.A.C.E UK Project

The Ethiopian Migrants, their Beliefs, Refugeedom, Adaptation, Calamities, and Experiences in UK.

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Guidelines for Interviewers on how to get the best out of your in-depth Interviews (devised by Mark Newman)

The interview method being used on the project is the depth interview. Depth interviewing is a method used in qualitative research. The primary marker of qualitative research is the focus on the subjective meaning of participants. We want to know what the subject thinks, feels, what frames of reference they bring to the topic how they interpret things. The task of the researcher is to avoid imposing the researchers' structures and assumptions.

- **This means that we are interested in the Subjects perception of events not the interviewers**

The interviewer is the research instrument. Therefore the quality of the data is almost entirely determined by the interviewer. Good in-depth interviews require skill, technique and a genuine interest and concern on the part of the interviewer.

Preparation for the interview

- Make sure that you have all the equipment, pen , paper, tape recorder , tapes, spare batteries; check that it all works.
- Make sure that there is an appropriate private, comfortable space available for the interview.
- Arrive in good time so that you can set out the room, set – up your equipment and have a moment to get focussed on what you are doing.
- Arrange the room so that you and the interviewee sit at the same height and can easily maintain eye contact, preferably without a table or desk between you. You need to create a relaxed comfortable environment for the interviewee who is and needs to feel your equal.

General Information on interviews

i) What kind of questions to ask

You will be using the Aide Memoir prepared especially for the project. This should be treated as a framework of areas that the interview should focus upon rather than a specific set of questions to be asked at every interview. You need to think about the wording of a question in each particular interview and/or different ways of asking the same question.

ii) How much detail do we want

Our aim is to explore peoples' experience in depth. It is particularly important therefore that you remember that what may appear obvious to you as an Ethiopian, will not necessarily be understood by a non-Ethiopian audience. For example if an interviewee says to you "you know what how we Ethiopians feel about.....", you must get them to explain what they mean. You could for example say "Yes, but how would you explain that to someone who is not Ethiopian"

iii) How long will the interview be

Difficult to predict but will be longer than you expect. Be honest with potential interviewees if they ask say about an hour. HOWEVER, PLEASE AIM TO FINISH WITHIN 35-45 MINUTES.

iv) Sequence of questions

The questions on the aide memoir do not have to be used in any particular order. Be flexible interactive and sensitive to language and concepts used by participants. It is a good idea to start with easy questions that are non-threatening or not too invasive. This helps you build up a relationship with the interviewee. It also establishes a context for subsequent questions about opinions/ feelings/ knowledge.

Questioning technique

The most important part of the interview is the wording of the questions.

How to word a question (CONS)

Clear, - What do you want to know about - opinion OR feeling OR experience?

Open, - avoid dichotomous questions i.e. YES/NO questions - Ordinary conversation is littered with dichotomous questions that we just ignore and assume are open. In the interview situation researcher must avoid this, as the interviewee is not sure what you want.

How do you know when you are using dichotomous questions? You probably are if you are talking more than the interviewee is. If you blank out the interviewers words from the transcript does what is left make sense?

Example of dichotomous question “did becoming a refugee change your life?”

Neutral - means that person can tell you anything without engendering favour or disfavour, or getting a shocked, angry or embarrassed response

Example of non- neutral response - “ oh that must have been terrible”

Single - in conversation we often ask multiple questions e.g. “ tell me all about it, I mean what was the place like, how was the food, how much did cost....”

This causes confusion in interview situation as neither the interviewee and yourself won’t remember what it is you asked.

Improving the depth and clarity of the interview

There are various questioning techniques you can use to help gain more depth or clarity from your interviewee:

a) Presupposition statements

These are useful if you want to discuss something that which maybe culturally or socially proscribed. You assume that the interviewee has done this thus reducing any guilt/ stigma attached e.g.

“Tell me about the sexual relationships you have had in England”

b) Use of the interviewee’s vocabulary when asking questions

You will need to give this special consideration when interviewing in Amharic
E.g. we might use the term mental health: An interviewee might talk about their ‘spirit’.

c) Use of prefatory statements

These help set the scene for a question can give interviewee time to think about response e.g.

“I would like to move on in time a bit if I may to the period when you arrived in England. What happened to you when you first arrived?”

d) Use of role-play e.g.

“If you or your family became seriously ill in Ethiopia what would happen? Describe what I would see if I was a visitor to your house at this time”.

e) The use of probes

Probes are verbal or non verbal techniques for encouraging (or discouraging) the interviewee and clarifying a particular response

i) Detail oriented probes - who, what, why, when

ii) Probes to keep them talking

- non verbal - nodding, silence
- verbal “ tell me more about”

iii) Elaboration probes

- clarify “ I’m not sure that I understood that could you clarify what you mean by”
- contrast “ how did the experience of X compare with the experience of Y”

Controlling the Interview

It is essential that the interviewer maintains control of the interview - time is precious both to you and the person you are interviewing. It is disrespectful to allow them to carry on giving you lots of information that you know you won’t use.

There are primarily three ways in which interviewer retains control. If you have a highly verbal respondent who gets off track you can:

- interject with questions
- non verbal - stop writing etc.
- divert back politely

Appendix 2

The Embrace UK Project Questionnaire

The E.M.B.R.A.C.E UK Project

**The Ethiopian Migrants, their Beliefs, Refugeedom, Adaptation,
Calamities, and Experiences in UK.**

*A collaborative project between the Ethiopian Refugee Association in Haringey
and the Research Centre for Transcultural Studies in Health, Middlesex
University*

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QUESTIONNAIRE

Questionnaire based on:
Centre for Inner City Studies, Goldsmiths' College (c1993): **Refugees in the Inner City. A Study of
Refugees and Service Provision in the London Borough of Lewisham.** Lewisham Refugee
Network.

CONFIDENTIAL

THERE IS NO CONNECTION WITH THE HOME OFFICE

1. PERSONAL DETAILS

1.1 Are you MALE or FEMALE?.....

1.2. What is your age? Please tick your age group in the box below.

| | |
|-------|--|
| 12-15 | |
| 16-25 | |
| 26-60 | |
| 61-65 | |
| 66+ | |

1.3. Where were you born? (Please specify name of town and / or country)

1.4. What is your nationality?

1.5. What is your ethnic origin? Please tick the relevant box below.

- Amhara Oromo Tigre Gurage Sidama
 Mixed (please specify) _____
 Other (please specify) _____

1.6. What is your mother tongue?

1.7. What other languages do you speak?

1.8. How long have you lived in(state Borough).....(state time period)

1.9. How long have you lived in Britain?

1.10. What is your immigration status? (Please tick in the box)

| | |
|-----------------------------|--|
| Temporary admission | |
| Exceptional leave to remain | |
| Indefinite leave to remain | |
| Refugee status | |
| Holding deportation order | |
| Other (please specify) | |

1.11. Are you (Please tick)

| | |
|-----------|--|
| Single | |
| Married | |
| Divorced | |
| Widowed | |
| Separated | |

1.12. Do you live alone? YES NO (please circle your response)

1.13. If NO, who lives in your house?

| | Tick | NUMBER (Where it applies) |
|----------------|------|---------------------------|
| Husband | | |
| Wife | | |
| Children | | |
| Father | | |
| Mother | | |
| Father in Law | | |
| Mother In Law | | |
| Brother | | |
| Sister | | |
| Grandparent | | |
| Other relative | | |
| Friend | | |

1.14. Do you have any dependants? YES NO (please circle your response)

If YES, please write number eg 6

| DEPENDANT | NUMBER |
|-------------------------|--------|
| Spouse | |
| Children | |
| Others (please specify) | |

2. HOUSING

2.1. Which specific area of the Borough do you live in?.....

2.2. Are you:

| | State how long |
|----------------------------------|----------------|
| A council tenant | |
| A housing association tenant | |
| A private tenant | |
| Living in bed and breakfast | |
| An owner occupier | |
| Squatting | |
| Homeless | |
| Living with relatives or friends | |
| Other (please specify) | |

2.3. How many rooms have you got? Do not count bathroom and toilet. Please circle the right number e.g. 4

0 1 2 3 4 5 6 7 8 MORE (please circle your response)

2.4 Are you satisfied with where you live?

YES NO (please circle your response)

If NO, please state

why.....

2.5. How many times have you moved house since you arrived in Britain?

1 2 3 4 5 MORE (please circle your response)

2.6. In which Borough or Town did you move a lot?

1 2 3 4 5 MORE (please circle your response)

2.7. Have you used any of these services?

| SERVICE USED | Tick |
|-----------------------------|------|
| Homeless Persons Unit | |
| Neighbourhood Offices | |
| Private Sector Housing Unit | |
| Rehousing Unit | |

2.8. What did you think about these services?

3. EMPLOYMENT

3.1. What did you do for a job in your home country?

.....

3.2. Are you: (Please tick)

| | |
|----------------------|--|
| Employed | |
| Unemployed | |
| Student | |
| Doing voluntary work | |

3.3. If employed, what is your job?.....

3.4. Is your job: (Please tick)

| | |
|-----------|--|
| Full-time | |
| Part-time | |
| Temporary | |
| Permanent | |
| Shiftwork | |

3.5. What are the biggest problems for you about getting a job?

(Tick as many boxes as you like)

| | |
|------------------------------------|--|
| Immigration status | |
| Little/no UK experience | |
| Little English | |
| Discrimination | |
| Qualifications not valid in the UK | |
| Need more qualifications | |
| Other (please specify) | |

4. EDUCATION AND TRAINING

4.1. Please write the qualifications you had when you came to the UK.

.....

4.2. Which of your qualifications are recognised in the UK?

.....

4.3 Are you studying?

YES NO (please circle your response)

| If YES, what are you doing: | (Please tick) |
|---|---------------|
| A youth training scheme | |
| An employment training course (ET) | |
| An ESOL course with adult education | |
| An ESOL course at a college | |
| A course at a college (e.g. BTEC, GCSE) | |
| A course at a university | |
| Other (please specify) | |

5. BENEFITS

5.1 Please tick the benefits you get.

| | |
|------------------------|--|
| Vouchers | |
| Income support | |
| Family credit | |
| Housing benefit | |
| Unemployment benefit | |
| Sickness benefit | |
| Crisis loan | |
| Community care grant | |
| Social fund loan | |
| Child benefit | |
| Council tax rebate | |
| No benefits | |
| Other (please specify) | |

5.2. Did you have any difficulty in claiming benefits?

YES

NO (please circle your response)

If YES, please write the problems

.....

.....

6. HEALTH AND SOCIAL SERVICES

6.1 Are you registered with a local doctor?

YES

NO (please circle your response)

If NO, please state why:

6.2. What health services have you used ?

(Please tick)

| | |
|--|--|
| Ante natal clinic | |
| Baby clinic (including immunisation) | |
| Family planning clinic | |
| Well woman clinic | |
| Well man clinic | |
| Hospital in patients (stay in hospital) | |
| Hospital out patients (visit for treatment) | |
| A nurse has visited you | |
| Health visitor has visited you | |
| Dentist | |
| Emergency services (ambulance, casualty department) | |
| Counselling (talking to a trained person if you are unhappy) | |
| Other (please state) | |

6.3. Are the health services easy or difficult to use?

EASY

DIFFICULT (please circle your response)

6.4. How was your health this year? (please tick)

| | |
|-----------|--|
| Very good | |
| Good | |
| Not good | |
| Bad | |

6.5. Please write any health problems or illnesses you have had since you moved to the UK .

6.6. What makes you feel ill ?

Please tick

| | |
|----------------------|--|
| Little exercise | |
| Little money | |
| What you eat | |
| Unemployment | |
| Housing problems | |
| Alcohol | |
| Boredom | |
| Family | |
| Smoking | |
| Stress/worry | |
| The area you live in | |
| Pollution | |
| Other: (please list) | |

6.7. Do you feel sad or unhappy for long periods of time?

YES NO (please circle your response)

Please state why.....

6.8. Who do you go to for support when you feel sad or unhappy?

Please state.....

6.9. Do you feel you would like to talk to someone who is trained in working with refugees about these feelings?

YES NO (please circle your response)

6.10. Do you use any of these services?

(Please tick)

| | |
|------------------------------|--|
| Day nurseries (for children) | |
| Day centres | |
| Home care | |
| Meals on wheels | |
| Other (please list) | |

6.11. Do you have any contact with a social worker?

YES NO (please circle your response)

If YES, please give details:

7. INFORMATION AND ADVICE

7.1. Do you have problems with:

(Please tick)

| | |
|-----------------|--|
| Immigration | |
| Education | |
| Housing | |
| Benefits | |
| Employment | |
| Health | |
| Social Services | |

7.2 When you have a problem do you get: (Please tick)

| | |
|---------------------------------------|--|
| help from a friend | |
| advice from an office | |
| someone to go with you from an office | |
| an interpreter from an office | |
| a solicitor | |

8. TELL US ABOUT YOUR CULTURE

8.1 How important is your language to you and why? (please state which Ethiopian language you speak)

8.2 How important is your religion to you and why? (please state your religion)

8.3 Please tell about the cultural traditions and customs you practise.

8.4 Tell us about your diet.

8.5 Tell us about your friends.

8.6 Tell us what you do for leisure.

8.7 Tell us how do you cope with stress (βσχητ/besechet) in your life.

8.8 What special things do you bring to life in(the place you now live)

(For example your skills such as child care, cooking, teaching, your mother tongue, your personal abilities and qualities such as friendliness and the richness of your culture)

THANK YOU VERY MUCH FOR TAKING PART IN THIS SURVEY.

Please return this questionnaire to the person who issued it to you.

Appendix III

The EMBRACE UK Project Interview Schedule

The E.M.B.R.A.C.E UK Project

The Ethiopian Migrants, their Beliefs, Refugeedom, Adaptation,
Calamities, and Experiences in UK.

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Aide Memoire for Interviews

*Q1 What does it mean to you to be healthy?

- Looking for **beliefs and values**
- Looking for **personal** meanings
- Try to get them to use the first person '**I**' rather than 'you' or 'they' throughout the interview.

*Q2 Can you think of **someone** who is healthy? Explain why you think this person is healthy.

- Try to get them to talk about a **specific person** ie family member or friend, neighbour etc
- Look for factors which contribute to health

*Q3 If there is sickness in the family who is the person who has main caring role?

- Family and gender roles
- Contribution of extended family or community

*Q4 Why do you think people get sick?

- Causes of illness
- Go beyond germs/bacteria. Look at **natural** causes (food, air etc), **superstitions, supernatural** (god, evil eye etc)

*Q5 If you become ill what sort of things do you do to get better?

- Details about **traditional / folk** remedies

*Q6 Is this different from what you would have done if you were in Ethiopia and if it is in what way is that different and why?

*Q7 How does life in Ethiopia differ from the life you have in the UK?

- Need information about **lifestyles** including socialisation, relationships. Do they have a sexual partner?

*Q8 Tell me why you left Ethiopia and how?

- Describe experience of war/ conflict/ persecution/ suffering

*Q9 How are you settling in the UK?

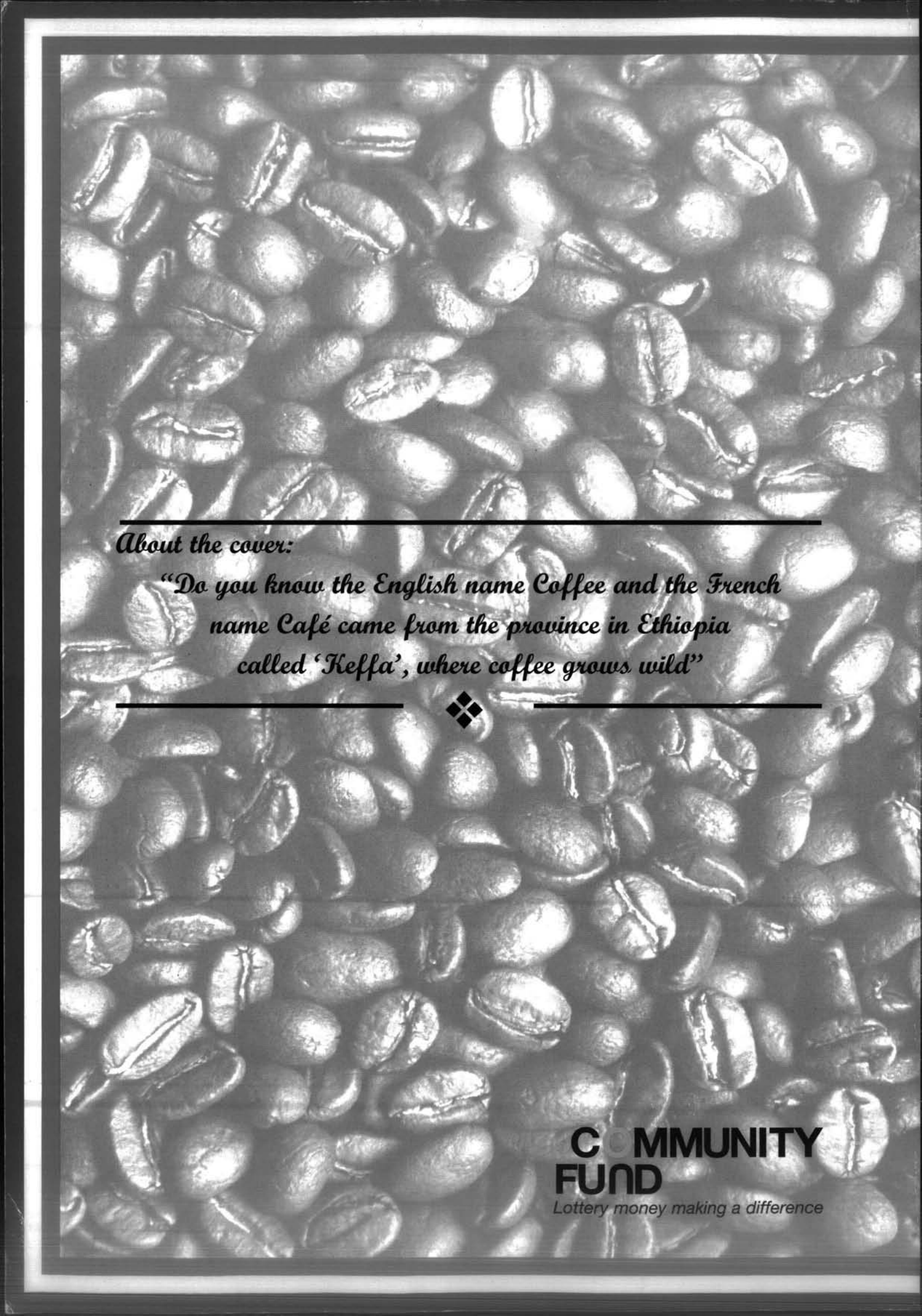
- Finance
- Health
- Work
- Community
- Accommodation
- Access to other services e.g. education and training
- Changes in lifestyle

*Q10 Have you had any contact with Ethiopian Organisations?

*Q11 If yes, what have your experiences been? Did you find them helpful and able to respond to your needs?

*Q12 Any further comments /suggestions which may be useful for this project.

Thank you.



About the cover:

“Do you know the English name Coffee and the French name Café came from the province in Ethiopia called ‘Keffa’, where coffee grows wild”



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