The Evolution of the Tene Briut[1] Model – Developing an Intervention Program for the Ethiopian Immigrant Population in Israel and its Challenges and Implications

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1. Introduction

A 12-year-old girl from an Ethiopian immigrant family was admitted to the emergency department of the Hillel Yaffe Medical Center in Hadera, suffering from abdominal pains. Medical tests showed that her glucose levels were extremely high and she was referred to the diabetes unit. Although she received extensive explanations from the medical staff about the severity of her medical condition she did not return for follow-up treatment. This prompted the medical staff to make a home visit, accompanied by an Ethiopian doctor. This resulted with a decision to use the services of an interpreter for further communication with the girl and her family. However, the interpreter herself did not understand why the girl had to check her blood sugar levels and to inject insulin on a daily basis. This case made it clear to the medical staff that focusing on the family was insufficient, and that their work had to be community-based, because the idea of chronic disease in general, and diabetes in particular, was new to the Ethiopian community. That was the beginning of Tene Briut.

[1] In Amharic *tene* means health and the combination with the word for health in Hebrew signifies health basket, and is compared to a hand-made Ethiopian jewel basket, where a special, precious object is kept. Thus, the name of the project and its logo express the importance we give to preserving and protecting health

1.2 Brief history of the Ethiopian immigrant community in Israel

Since the establishment of the State of Israel in 1948, Jews from all over the world have immigrated to Israel. One ethnic group about which relatively little was known--the Jews of Ethiopia--arrived only recently. Two waves of immigration took place: the first between 1984-1985, following an arduous journey through Sudan, facing bandits, dangerous animals, harsh weather, hunger and disease. Many died on this journey and those who survived were eventually flown to Israel from Sudan. The second wave took place in 1991. Those immigrants traveled from their villages to Addis Ababa, the capital of Ethiopia, but only after several years were they permitted to leave. Within a few hours, 14,000 Jews were airlifted to Israel. In Israel, Ethiopian immigrants were placed in "absorption centers"[2] and subsequently moved to various towns. The dramatic transition from an Ethiopian village to a modern urban lifestyle entailed many cultural and social hardships. As the nuclear family replaced the extended family structure, cultural gaps between parents and children emerged, and the traditional patriarchal system began to erode. Day-to-day existence in Israel differed as well: activities common in Ethiopia were no longer relevant in Israel. Even dietary staples changed drastically. In addition, modes of employment changed substantially; men no longer work in agriculture, many are unemployed or work mainly in menial low-paying jobs. Currently small groups of Ethiopian immigrants continue to arrive and reside temporarily in "absorption centers".

1.3 Creating programs to address the unique health needs of the Ethiopian immigrant population

Clearly the different cultural background of the Ethiopian immigrant minority in Israel and their limited Hebrew language proficiency requires the provision of special resources to address their unique needs.(1-3) Israeli public and government agencies were cognizant of the unique needs of the Ethiopian immigrant population and upon their arrival the immigrants were sent to live in “absorption centers”. Some of the issues that these agencies sought to address related directly to health, in particular issues of hygiene, use of medication,

[2] A place where new immigrants live, as an intermediate stage on their way to permanent housing. They receive physical services, study Hebrew and learn to orient themselves to life in Israel.

HIV, and tuberculosis. Further, when it was clear that there were serious communication challenges in the patient-doctor encounters and that Ethiopian immigrants tend to conceive and manifest their symptoms in ways that differ substantially from what Israeli doctors are used to, (4-5) a program of para-professional healthcare liaisons was initiated and implemented in about a dozen community clinics, as a collaborative effort between a public agency, the Ministry of Health and health services provider organizations. They received special training to help both in interpreting and in cultural mediation (6). The Israel Ministry of Health also created a program of liaisons that mainly focused on HIV and tuberculosis. However, there was clearly still a need to further identify the kinds of challenges Ethiopian immigrants face in the healthcare system and for a program that would focus on diabetes and other chronic diseases. This emphasis was deemed important because for the Ethiopian immigrants these diseases were "new" and often devastating phenomena. The Tene Briut project was initiated when its founding physician felt there was a need for a program that could help create an overlap between the world of healthcare providers and that of the Ethiopian immigrants (7). From the outset of the project the Tene Briut team studied the literature, collected data to identify and document health-related difficulties, and summarized the challenges that emerged in the adaptation of the immigrants from Ethiopia to living in Israel. Following are the five major challenges that emerged:

1. *A drastic change in the Ethiopian immigrants' morbidity profile*: The data indicate that whereas there was a significant reduction in various types of infectious diseases, various chronic diseases and health challenges appeared which had been mostly unknown in this population in Ethiopia (8). These include the following: Obesity (the BMI rose from 17-19 to 24) (9-12); a decline in fitness accompanied by a sharp increase in Type 2 diabetes 0 to 0.4% on arrival in Israel to 17% after ten years in the country (10-12), as well as an increase in Type 1 diabetes (13); an increase in average blood pressure readings and in the number of people suffering from hypertension (9, 12, 14, 15). Among Ethiopian patients with diabetes mellitus, the lipid profile, which had been normal at the time of immigration, is approaching that of other ethnic groups (15-16). Further, a sharp increase in asthma cases has also been documented (17).

2. *Absence of the concept of chronic disease, including diabetes*: Chronic diseases associated with Western countries' lifestyle were literally unknown to the Ethiopian immigrant populations from the rural areas. Thus such diseases were not part of the medical system they were familiar with and their cultural concepts of health and illness. In a study conducted in

the Hadera region only 50% of those interviewed had heard of diabetes and two-thirds only after they had immigrated to Israel. Most did not know of a patient who was managing appropriately his or her medical condition (18).

3. *Under-utilization of health services provided by the National Health Insurance Law*: Findings from study conducted by the researchers affiliated with Tene Briut and sponsored by the Israel National Health Policy Institute indicate that Ethiopian immigrant patients received relatively fewer physical examinations such as blood pressure readings or foot examinations, fewer blood tests and urine analyses, and their metabolic parameters were lower (15).

4. *Communication difficulties between healthcare providers (HCP) and Ethiopian immigrant users*: In the study mentioned above, Ethiopian immigrants tended to rate lower than the comparison group of patients from other backgrounds, in their ability to comprehend their doctor's explanations and in their comprehension of the pharmacist's instructions and they also reported a lower frequency of discussions about diabetes with the nurse. The issue of trust also becomes critical in Ethiopian immigrant-HCP relations, when some Ethiopians feel they are discriminated against, not taken seriously, or not understood.

5. *High frustration among the medical staff treating the Ethiopian immigrant population.* HCP typically comment on their difficulty of communicating with Ethiopian immigrants, both because of the limited proficiency of Hebrew among older and recently arrived patients and because of cultural differences. They are aware that many among the Ethiopian immigrants have different concepts of medical care and diseases and feel unequipped to address these conceptions. Such cultural gaps often result in a misunderstanding of the explanations provided by HCP to Ethiopian immigrant patients about issues such as diabetes and its treatment. Furthermore, many of the Ethiopian immigrants find it difficult to adapt to the administrative aspects of the healthcare system. In addition, economic and logistical factors may reduce their access to healthcare services and to medical technologies that members of other populations utilize more readily.

These particular needs and challenges served as an impetus for the development of the Tene Briut project and its method and activities. In the following sections we present an overview of the project, its rationale and activities, and how it evolved from a project led by a non-Ethiopian physician within a hospital setting to an independent organization led by Ethiopian-Israeli professionals. The description of the activities includes several ethical and moral issue that arose, as well as particular challenges and directions for the future.

2. The Tene Briut project

Tene Briut is a health-promotion initiative aimed to provide the Ethiopian immigrant population in Israel with new concepts and perceptions regarding their health, such as chronic disease, latent disease, preventive behavior and preventive medicine (immunization, early detection, adoption of health-promoting lifestyles). The program was initiated in 1998. One of its goals is to foster a sense of self-efficacy at the individual and collective level, and to promote Ethiopian community members' health through prevention activities and disease management. For this purpose Tene Briut developed culturally-inspired resources that could be used in various settings to disseminate information and to enhance community members' health literacy as well as awareness of early diagnosis opportunities and Western methods of treatment. The outreach activities to the community are done mainly in Amharic, and incorporate in the programs issues that were raised by members of the community. The program is implemented mainly by Ethiopian-Israeli medical professionals. Its activities typically consist of sessions that take place in a community setting in which on-going activities organized by various organizations already take place; for example, sessions with women at well-baby clinics, groups of senior citizens, etc. This approach was adopted as a means to both strengthen the group itself and to promote more effectively the specific goals and objectives of the program by having them adapted to each particular population. In parallel, Tene Briut works with non-Ethiopian HCP to increase their awareness of the cultural factors that relate to Ethiopian immigrants and healthcare, and to enhance their familiarity with the differences in health conceptions and the difficulty Ethiopian immigrants have in utilizing health services.

2.2 Development of the Tene Briut Model

Tene Briut began as a local 'experiment' to identify and help address the problems inherent in providing medical treatment to patients from a different cultural background. It did not begin with a systematic design. Only after work had begun in the field did the genuine need and depth of the particular needs of the Ethiopian population became more evident. The project found itself trying to fill a vacuum, and embarked on a process of establishing an organizational structure. In what follows, we describe six stages of this process and some of the changes made along the way.

Stage 1: *Learning about the community:* We needed to become familiar with the Ethiopian immigrant community beyond the cold medical data. We first appealed to the non-medical professionals (welfare, National Insurance and absorption workers, as well as teachers) dealing with the Ethiopian community. We listened to their stories, experiences, descriptions of events and the difficulties they faced, which gave us a wider and more general view of their lives. These meetings introduced us to key young people within the community, members of Maksam[3] an NGO[4] that provided us with first-hand information about the needs, opinions and concrete problems of the Ethiopian community in its encounters with Israeli culture and society. They helped us understand the difficulties Ethiopian immigrant have in grasping the implications of chronic and latent diseases. For example, patients tended to regard chronic diseases as those that doctors are unable to cure, and this would negatively impact on their esteem for the doctor, who is supposed to be able to cure the illness. Further, a latent disease is not considered real when there are no external symptoms, and one of the activists defined it as "a disease of bad numbers". Maksam members also introduced us to influential members of the community, with whom we met in small groups to deepen our knowledge of Ethiopian culture. Later, some of them helped evaluate the instructional materials developed by Tene Briut.

Stage 2: *Initial information gathering:* In addition to these meetings, a questionnaire-based study was carried out with a representative regional sample of Ethiopian immigrants. The study examined beliefs, perceptions, attitudes and knowledge of health and chronic disease, especially in the realm of diabetes. In addition, physical examinations were performed, including blood tests and urine analyses.

Stage 3: *Setting up a steering committee:* Members of the project's steering committee were chosen from representatives of the Ethiopian community and from major Israeli organizations that come in contact with Ethiopian-immigrants. The committee was composed of representatives from the municipality, the community itself, government agencies, healthcare provider organizations, not-for-profit organizations, the medical center, academia, and philanthropic organizations. The group convened to discuss the case of the 12-year-old girl described above and the difficulties that had arisen in the attempt to treat her. After focusing on needs and goals, members of the group volunteered to serve as an *ad hoc* committee, and eventually became part of the steering committee of the project.

[3] http://www.maksam.org/index.html,
[4] Non-governmental not-for-profit association

Stage 4: *Determining goals for health promotion, research and advocacy:* The overall goals determined by the committee were to ensure that Ethiopian-immigrants used healthcare services to the same extent as other groups in the population and manifested the same level of following recommended treatment regimens. For this purpose four main objectives were specified and for each several activities were designed to address it:

(1) Health care professionals: To enhance the awareness and capacities of HCPs (nurses, pharmacists, physicians, medical administrators, etc.) to provide culturally-sensitive health care to members of the Ethiopian immigrant population. Activities included providing HCPs with information about the Ethiopian community's health-related cultural beliefs and customs and tailored training sessions for professional teams in hospitals, community clinics and training institutions. A recent project allows for HCP to use a medical telephone interpreting service (described in 2.4.6).

(2) Ethiopian immigrant community: To provide members of the Ethiopian immigrant community with new concepts regarding health care (chronic disease, latent disease, preventive medicine, etc.), information about patients' rights and to advance health-promotion activities in the community as a whole: This was to be implemented through a wide range of outreach community activities conducted by the Tene Briut staff, (described in 2.4.1) and a radio program about health in Amharic on the national public radio (described in 2.4.5).

(3) Data on needs: To document healthcare needs of the Ethiopian immigrant community in Israel: Researchers affiliated with Tene Briut, utilized Tene Briut's facilities to engage in research in order to gather data and information about morbidity, and to pinpoint particular health-related needs of the Ethipian community. An important goal is that these data could be utilized to influence policy-makers and affect public opinion.

(4) Influence policy: To influence the public agenda regarding healthcare of the Ethiopian immigrants in Israel. This included influencing the agenda of medical professionals and decision makers. Activities included participation in various professional conferences, news media coverage in the written and electronic media, serving on professional committees, organizing a national conference of Ethiopian-Israeli health

workers to raise consciousness and empowerment (described in 2.4.2) and advocacy activities among legislators[5] and volunteer organizations.

Stage 5: *Recruiting and training of the "core group" of "Health Trustees"*: The group of Ethiopian healthcare professionals who form the heart of the project consists primarily of Ethiopian immigrant nurses (male and female) who worked in their profession in Ethiopia and had successfully been integrated into the hospital system in Israel. In their professional capacity, they had not been familiar with healthcare work at the community level. Also, the project's medical areas of activity were new to most of them. They joined for several reasons. To begin with, many of them were already involved on a daily basis, in bridging the gap between HCP and patients in their own families or departments, and felt committed to the project's goals. Some regarded themselves as lucky to have integrated into Israeli society and felt that they had a mission to represent those who could not do the same. Some had parents with diabetes and believed they would gain a better grasp of the disease and its management.. In addition, most understood the potential for personal advancement through participation in the project. This group received formal training, officially recognized by the Ministry of Health as an in-service course in the field of chronic Western morbidity (diabetes, obesity, hypertension, nutrition, fitness, etc.). In this course they were taught to deal with developing and evaluating educational materials, and they were provided with training in public speaking and teaching. Subsequently they obtained experience in speaking to large audiences. When the course was over there was a graduation ceremony attended by key professional and political figures. The group continued to meet regularly for updates and feedback sessions. Its members also went abroad to study health promotion for minority groups at Vanderbilt University[6] as part of the Jewish Agency's Partnership 2000 program. Members of this group serve as the community's "sensors" and play a vital part in finding suitable solutions and responses to the health promotion challenges. For example, they can identify messages that might reinforce a stigma in relation to a particular disease. The project's evaluation report (described in 2.5) noted that "the health trustees, who are the main human resources of the Tene Briut project, had undergone an empowering experience and were, enriched both personally and professionally… The group received a lot of input…which made them unique compared to many other projects in which Ethiopian immigrants work… the administrators and leaders put a premium on nurturing this

[5] Israel's Parliament
[6] http://www.mc.vanderbilt.edu/reporter/index.html?ID=2447

population, and cultivated a unique group of people capable of making a contribution that extended far beyond the confines of the project."

Stage 6: *Transition from an organization led by a non-Ethiopian physician to an independent organization led by Ethiopian-Israelis:*

The organizational transition of Tene Briut from a medical-center sponsored project that was led by a non-Ethiopian doctor to an independent organization let by an all-Ethiopian immigrant staff illustrates some of the challenges and dilemmas that may take place in the establishment of similar initiatives. Once it was clear the goal was to establish Tene Briut as an ongoing and independent organization, the vision was to eventually turn the executive committee into its managing committee, and that the non-Ethiopian (*franze*[7]) professionals would not be the ones who manage it. This process began to take place after the conclusion of an external evaluation study[8], with the guidance of an organization that supports social-change organizations (SHATIL[9]). Thus, the original steering committee, which at first consisted of nearly all non-Ethiopian Israelis, was turned into an advisory board, and handed over its management role to the Ethiopian staff members. Tene Briut had officially become a registered NGO.

The major challenges associated with this transitoinal process included finding and recruiting administrators who are members of the Ethiopian immigrant community and capable of "working within both worlds". It was important to have staff members who have communication and administrative skills that can enable them to navigate and advance the organization's goals within the Israeli system, as well as to be able to maintain an intimate link with the adult and new immigrant community and their traditional beliefs and sensitivities. Another challenge was to overcome a resistance that recurred among various members of the team itself, who appear to minimize the ability of someone from "their own" (an Ethipian immigrant) to be able to successfully manage and lead the organization. Thus the challenge of initiating an organization that aims to advance the health and welfare of its own minority or immigrant community is twofold: on one hand it needs to strengthen the self-efficacy of members of the larger community to manage health issues. On the other hand it needs to strengthen the self-efficacy of the team members on their ability to successfully mange and lead the organization.

[7] *Franze* is the word the Ethiopians use to describe "others," that is, people with white skins.
[8] Mertens-Hoffman company Sep 2004 …"So far, only a limited effort has been done to further this aim and enable the realization of this goal"..
[9] http://www.nif.org/programs-and-partners/shatil/

2.3 **The Development of culturally–sensitive instruction materials: Pragmatic, moral and ethical issues**

One of the major assumptions underlying the community approach adopted by Tene Briut was that a supportive community can help change unhealthy practices and perceived norms that can be detrimental to members' health. This meant that some of the traditional norms and values held by the community would need to be challenged. For example, in Ethiopia, overeating and obesity had been viewed as something positive and physical activity for adults as undignified. Thus, Tene Briut had to find ways to challenge these conceptions and offer an alternative. The tools it developed to disseminate information included dance, music, drawings and sculpting as well as print media, lectures and videos which were not only tailored to the culture of the community members, but focused on their particular needs as they emerged in meetings with community members (20-21). Thus a traditional storyteller format was used to talk about diabetes. Allegories and examples from daily life in Ethiopia were incorporated into presentations and materials. Materials and discussions also referred to traditional foods and cuisine as well as to the size of the meals, their composition and to the changes that took place since the Ethiopian immigrants' arrival to Israel.

2.3.1 *Developing instructional presentations for the general public*: At the outset of the program there was no clear idea which methods could be used to provide the Ethiopian immigrant population with information about health issues. Because most of the adult immigrants had not been exposed to a formal educational system, the effectiveness of transmitting information and new concepts through lectures was not something that was considered as an obvious method. Nonetheless, it was decided to replace the traditional story-teller with a lecturer and to use computerized presentations with visuals. Thus, formal presentations were created that depicted situations and characters from community life as well as metaphors to explain medical and physiological concepts. The Tene Briut team eventually developed a series of presentations that deal with various topics including nutrition that referred both to traditional Ethiopian diet as well as Israeli food, knowledge of the basic food groups and constructing a balanced diet; physical activity and the use of leisure time and recreation, oral hygiene, and a presentation on diabetes; detection, prevention and treatment as well as possible complications.

2.3.2 *Educational videos:* At the end of the 1990s, during the initial stage of the project and following a specific request from the representatives of the community, we

produced an Amharic-speaking educational video about diabetes, in a narrative form. We learned that as a result of the high unemployment rate, many adults were exposed to long hours of television and video viewing, but there were very few programs available in Amharic. The community representatives claimed that an Amharic-speaking video that would incorporate pictures, scenery, art and music would awaken memories of their former homeland and prompt them to watch it again and again. As a result, one third of the movie said nothing about health or diabetes, but spoke of life in Ethiopia, the journey to Israel and the difficulties the Ethiopian immigrants have in adapting to the new country. Diabetes was presented as one of the major difficulties associated with immigration. The video showed images from the world of agriculture to explain what happened to the body when a person has diabetes. The narrator used many traditional proverbs to reinforce the viewers' responsiveness to his recommendations. The video was well received, elicited strong emotional reactions and after it was shown in community settings members of the community would purchase a copy of the video. Another video was a humorous video addressing the issue of obesity.

2.3.3 *Formative evaluation and on-going assessment*: In order to assess its own activities Tene Briut employs various methods for formative and process evaluation, which is a critical element in the development of intervention materials and resources (22). The on-going assessment is meant to help ensure that the issues and materials are viewed by the intended audience as pertinent, relevant, and that the explanations are understood. The assessment is carried out on the individual and group level and includes interviews, observations and informal discussions. For example, during lectures in the community we documented the questions asked and the answers given including requests for clarification, questions that reflected difficulty in understanding, or the desire for more information than what was provided in the lecture. One case illustrates this process: When Tene Briut began to give lectures on nutrition and the lecturer said that the human body was composed mainly of water, audience members became agitated because the notion that their bodies were mostly water was difficult for them to accept, despite their esteem for the lecturer. Consequently, the presentation was changed, and the concept was presented in a way that would be more acceptable to them. In another case, when evaluating the immediate responses to the instructional movie called "Even a Meadow can be a Jungle" we learned that the video succeeded to raise interest, provide medical information, as well as elicit a strong emotional response and identification among older audience members. This was observed both through

viewers' verbal expression and non-verbal (e.g., leaning toward the screen, placing the hands over the chest, facial expressions and hearing their exclamations after the video was over). In group and individual interviews that followed, participants remembered explanations about the patho-physiology of diabetes that was presented visually and explained verbally in the video and it was evident that they had understood the explanation. Participants recognized the importance of identifying the disease and the damage it was liable to cause. They understood the meaning of a latent disease represented in the video as a leech penetrating the throat of a cow and causing its death with no external symptoms. However, it appeared that the video did not succeed in explaining the chronic nature of diabetes and these findings underscored the need to reinforce this crucial concept during the lectures. Various ethical dilemmas arose during the production of the materials and their distribution, some of which are mentioned in the description of the various materials below.

2.3.4 *Resources for Health Professionals:* One of the resources produced by Tene Briut is a booklet for HCPs on the issue of food and nutrition. Any lifestyle-related intervention in a multicultural context requires a familiarity with community members' eating habits, and the types of foods and the ingredients they consume. Yet, these factors were unfamiliar to the HCP working with Ethiopian immigrants. Tene Briut therefore began with a workshop for clinical dieticians to acquaint them with the types of foods Ethiopian immigrants ate. We then discovered that there was no detailed information about what their diet consisted of, nor of the nutritional values of their foods. Further, there was a need for information on how they prepare their traditional foods in Israel and how often or how much of these foods they actually consume. Therefore, Tene Briut had to carry out its own research, including asking women for their recipes. We learned that traditional foods are a regular part of their diet, but found out that there were substantial changes in the quantity and frequency these foods were consumed in Israel. This is because the wider availability of products that were rare in Ethiopia (such as meat), and the relatively high cost of foods that were inexpensive in Ethiopia (such as fish). Consequently a booklet called "Not by I*ngera*[10] alone: the diet of Ethiopian-immigrants" was produced for Nutritionists. This booklet contains pictures and a description of foods eaten by Ethiopian immigrants, including tables of ingredients and nutritional values, a description of nutrients frequently lacking in the diet, and recommendations for nutritional adaptation. The booklet was developed in cooperation with the nutrition department of the Ministry of Health and was distributed by the National

[10] The Amharic name of their bread like product

Association of Dieticians to every clinical dietician in the country. In addition, the booklet is distributed on demand to clinics that serve large Ethiopian-immigrant populations[11].

2.3.5 *Print materials for community members:* It is increasingly common to provide individuals with print materials with information on health issues, even for populations with low literacy skills. The format used to convey the information was using a narrative style of a series of pictures like a comic strip, in which an older Ethiopian man was depicted (23-25). The colors and style were those that would appeal to the older population, and the tub for washing of the feet was drawn in a way that it would remind the viewer of the custom of washing feet in Ethiopia.

2.4 Tene Briut activities

2.4.1 *Lectures in community settings:* Tene Briut offers lectures and workshops on an on-going basis, in various settings, some of them as single events or as a series of lectures. These activities, held in collaboration with the healthcare clinic liaisons and others are offered to *ad-hoc* or structured groups that meet for other purposes. The major settings are immigrant centers in the various towns[12], community clinics, hostels, community centers, and absorption centers. The activities include a combination of a lecture and a question and answer session. In certain cases, blood sugar levels are tested. This is important for diagnosing new patients, but its main objective is to send the message that there is no stigma attached to diabetes and that it can be diagnosed in a public setting as well. An attempt is made to return to the same groups for several consecutive meetings.

2.4.2 *A National Conference of Ethiopian-Israeli Professionals:* In 2001, in preparation for embarking on a nationwide activity, Tene Briut, in collaboration with the JDC in Israel, Tel Aviv University, the Ministry of Health and Clalit Health Services, organized a one-day conference and workshop, the first of its kind, for Ethiopian-Israeli healthcare workers. The objective was to disseminate information about chronic Western morbidity among the Ethiopian community, to develop new initiatives in promoting health and health education, and to establish a network for these professionals. One challenge was that there was no comprehensive list of Ethiopian-Israeli health professionals. Participation

[11] This booklet can also be downloaded at http://www.health.gov.il/Download/pages/ethiopia.pdf where it appears in graphic format

[12] Urban centers are intended to provide comprehensive responses for the issues important to Ethiopian-Israelis. They are operated by the Ministry of Immigration and Absorption.

in the conference was enthusiastic, and the attendance was triple the number that was anticipated, with 220 individuals attending. One of the most prominent messages to emerge from the discussion was the call to Ethiopian-Israeli health professionals to take the initiative and assume a larger share of responsibility for the quality of life and health of the members of their community and to pay more attention to the issue of mental health.

2.4.3 *"Health Days":* Tene Briut conducts one-day events in community and organizational settings, usually in collaboration with local groups. One of the main purposes of these "health days" is to locate individuals with diabetes and to raise awareness regarding the importance of prevention and early detection of chronic diseases. These events also provide an opportunity to involve the entire local population, including those who are not Ethiopian-immigrants. On health days there are lectures in Amharic, arts and crafts activities for children and young people, fun on inflatable jumping toys, group gymnastics and large-scale testing often performed by volunteer physicians who are themselves immigrants from other countries. The tests include weight, blood-pressure, blood glucose, vision and teeth and sometimes even early breast and colon cancer screening.

2.4.4 *Cooking classes:* The project has initiated, encouraged and supported cooking classes for women in various locations in Israel. These are always held in collaboration with the local women's organizations such as Women's International Zionist Organization (WIZO), Na'amat or in community centers. The objectives of the courses are to acquaint the women with modern kitchen conveniences and traditional and Israeli recipes. The lessons include basic instruction in nutrition, balanced diet, home economics and the importance of physical activity.

2.4.5 *A monthly radio health program:* Because a large majority of the Ethiopian immigrant population has low literacy and Hebrew proficiency skills, in particular the older population and the more recent immigrants, the radio programs in Amaric serve as an important tool for transmitting information to these groups. In cooperation with the government radio station there is a live broadcast in Amharic every month featuring a program about health with topics we decide on and in response to the needs of the Ethiopian-immigrant population. Listeners are encouraged to phone in. A study of the activity of Tene Briut found that the program was very important for the older population, most of whom do not speak Hebrew. A large percentage of them listen to the program and have said that they find it an important source of health information.

2.4.6 *Kol L'Briut* [Call for Health]*: the telephone interpreting service:* In addition to cultural gaps, one of the main obstacles to patient-caregiver understanding is the language barrier. One unique solution has been the work of Ethiopian-immigrant *megashrim* (liaisons) who serve as liaisons as part of the *Refu'ah Shlema* (literally: Full Recovery) project (6)[13] but their number is limited, they are present in less than a dozen clinics and they cannot provide an immediate response when several patients in a clinic need them at the same time. Therefore, it has been decided that a medical telephone interpreting service can provide a viable alternative. Long-distance interpreting services have existed abroad since the 1950s, and they have progressed in keeping up with communications technology (27). Today there are also video interpreting services. Telephone interpreting eliminates geographical distances, and it seen by many as more convenient because it ensures anonymity. This also reduces the interpreter's emotional stress (28).

The idea of providing medical telephone interpreting services was proposed after a study carried out by Tene Briut (15, 19) and brainstorming session with Clalit Health Services and the Ministry of Health. It does not aim to replace the role of the health liaisons. Its goals and role definition are slightly different: to provide a tangible, immediate response to communication needs in the provider-patient interaction. Tene Briut recruited Ethiopian-Israeli nurses to perform this service, thus setting an international precedent, because medical interpreters do not usually work in the field of health care. In collaboration with the Department of Translation and Interpreting Studies at Bar Ilan University, the group received training in healthcare interpreting. The curriculum was chosen after a study of similar courses abroad, and was adapted to conditions in Israel and to the profiles of the future interpreters. It ran for 60 hours and included lessons on medical terminology, differences in perceptions of health and illness in Israel and Ethiopia, strategies of interpreting, note-taking and memory-enhancing techniques and how to correct translation mistakes. A significant amount of time was devoted to simulations of telephone interpreting. The participants' medical background was an advantage, but they had to be reminded not to confuse their own daily work as diagnosticians and HCPs with their role as interpreters, during which they were not supposed to diagnose but rather to give linguistic support to the physician or nurse and the patient. For example, it was necessary to help them learn to resist the obligation some of them felt regarding having to explain to the patient the meaning of the healthcare issue. It was stressed

[13] The project has been in operation throughout the country, although in limited form, for ten years. The liaisons ("*megashrim"*) not only translate, but also promote community health through direct contact and transmit information about the health system and the procedures involved in medical treatment.

that their role was confined to bridge the gap between the parties, linguistically and culturally, and to making sure the patient understood what the caregiver was saying, but not to take on the role of caregiver.

The medical telephone interpreting service has been operating for community clinics in a limited pilot format since May 2007. Before the introduction of the service all participating clinical staffs were introduced to different features of the phone interpreting medium: the lack of eye contact, the importance of briefing the interpreter beforehand, etc and the advantages of using a professional interpreter instead of a family member. Thus, an important challenge is to find ways to enable health care providers to use the service skillfully. The assumption is that they will realize how it can eventually contribute to efficient consultations, reduce the number unnecessary visits, and lower frustration levels on both sides. In addition, the service needs to be advertised within the community and its members should be encouraged to ask for it as part of their right to medical treatment. The objective of Tene Briut is to expand the service to more clinics while establishing the rules for its use, and to examine the possibility of making it available to hospitals.

2.5 Influence and impact

The impact of a program that aims to create changes in awareness among both the population of immigrants and the healthcare system is difficult to gauge, in particular because its goals and objectives have evolved as the program developed. One of the main accomplishments of Tene Briut, as noted by an external evaluation team was that “it put the issue of the prevention and detection of chronic illness in the Ethiopian community on the map” of the Ethiopian community and decision makers in the health care system. The evaluators also noted that Tene Briut created a “box of tools” for this purpose, and trained a group of indigenous professionals to work within the community as role models, advocates and leaders.

2.6 Recognition, cooperation and funding

From its inception, Tene Briut’s guiding principle was to use resources effectively, and to cooperate with any local or national organization that showed an interest in its objectives and activities. The organization works in collaboration with women’s organizations, especially in the cooking classes (WIZO, Na’amat, Hadassah), Rotary volunteers in Hadera

(who helped raise funds for the educational movie), the community television channel, which accompanied and videoed some of the activities, etc. The Tene Briut staff seizes every opportunity to promote itself, including urban health conferences, health-promotion conferences, gatherings of Ethiopian-immigrants, etc. In such cases, a booth is set up with a display of informational materials, a description of the project's needs and summaries of studies.

2.7 Continuity and the future

Tene Briut's continuity depends on the kind of new goals it takes upon itself as an independent organization that aims to promote the health of the Ethiopian immigrant community in Israel. There are both new and old challenges it may embark upon, and it may forge new collaborations, perhaps, with a stronger advocacy orientation. It currently operates an innovative and complex medical interpreting service and conducts dozes of outreach activities monthly. Yet, its programs and interventions may need to be further adapted to the various populations *within* the community, and to be continuously evaluated and updated. To succeed in the latter, Tene Briut may need to maintain and expand its collaborative relations with a wide variety of organizations and agencies. Further, one of its goals is to advance and mobilize awareness of the public--including professionals, public figures, lawmakers and administrators--to the particular needs of the Ethiopian immigrants, and their health rights according to the National Health Insurance Law. This law mandates equity in the provision of health services for all Israeli residents including minority populations. This poses additional challenges to its current mode of operation in terms of advocacy and a social-change orientation. Following are four challenges and dilemmas regarding Tene Briut's future goals and activities:

1. Ethiopian-immigrants form a relatively small segment of the population but they have unique needs. To what extent should a non-government organization such as Tene Briut take upon itself the development of educational materials that perhaps should be created by organizations or government agencies who have the mandate to provide care to Ethiopian-immigrants (e.g., health provider organizations, hospitals)?
2. Tene Briut activities may be fulfilling roles that should be taken by the government or the agencies that are mandated by law to provide healthcare services and receive government fund for this purpose – what is the government's responsibility in terms of services such as interpreting services, educational workshops? What kind of role should an independent NGO take in the provision of such services and what should its

relationship be with government agencies that help fund and these services and supposed to supervise and monitor the quality of the service given?

3. Ethiopian-immigrants are not the only minority group in Israel; there are others with special needs. Should Tene Briut operate independently or form a coalition with similar groups?

4. To what extent should the goals of an organization such as Tene Briut include advocacy and activity to change the social and economic status of Ethiopian-immigrants, and what should be the boundaries of its advocacy goals?

3 Conclusions

This chapter has described the beginning and transformation of the Tene Briut project from an initiative by a non-Ethiopian healthcare provider and a project affiliated with a medical center to an independent organization run mainly by Ethiopian-Israelis. Following are seven underlying principle that can offer implications to other types of interventions that aim to promote the health of minority populations. (1) A developmental process that begins with studying and researching the health-related problems through the analysis of personal experiences, surveys, interviews, of the intended population and articulating them in the goals and objectives of the program. (2) Working in collaboration with the relevant organizations and agencies including; municipal, government, health provider organization, social and welfare agencies, and academia and involving all those concerned in the creation and implementation of a viable model. (3) Integrating influential members of the immigrant or minority community to form a support group for the project's goals. (4) Enlisting professionals from within the immigrant or minority population to take full responsibility for administration of the project and offering them training to enhance their capacities both as presenters in outreach activities to the community and leadership and advocacy skills. (5) Developing and applying a wide range of culturally-sensitive tools that draw on a formative evaluation process that engages people from the community and have an added value to the population beyond particular health messages, so that they are purchased and viewed in their homes. (6) Working on both a local and national level, by taking advantage of mass media outlets that enable reaching individuals and groups, and providing interactive sessions, such as callers to a radio program. (7) Providing training, capacity enhancing interventions and tools for health care professionals working with the immigrant/minority population; this

includes raising their awareness regarding difficulties faced by the immigrant populations in adaptation, acculturation and social discrimination and economic hardships, and to the differences in the population members' ability to avail themselves to healthcare services. This may include the provision of services such as translation, workshops, and warm-lines.

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Bibliography

1. JOINT-Brookdale. (2001). Integration of Ethiopian immigrants in Israeli society: Challenges, policy, program and direction. Executive summary. Unpublished report. Joint-Brookdale (Hebrew).
2. Shira O. (2004). The Socio-economic Integration of the Ethiopian Community in Israel. International Migration, 42,(3) 29-55
3. Weingrod, A. 1999. Patterns of adaptation of Ethiopian Jews within Israeli society", in S. Kaplan, et al. (Eds), Between Africa and Zion, The Joint Distribution Committee, Jerusalem.

4. Reiff, M., Zakut, H. and Weingarten, M.A (1999). Illness and treatment perceptions of Ethiopian immigrants and their doctors in Israel. American Journal of Public Health, 89(12): 1814–1818.
5. Youngmann**,** R**.,** Minuchin-Itzigsohn, S., & Barasch**,** M. (1999). Manifestations of Emotional Distress among Ethiopian Immigrants in Israel: Patient and Clinician Perspectives. Transcultural Psychiatry, 36,(1), 45-63.
6. Nirel, N., Rosen B, Ismail S. (2000). "Refuah Shlemah"-An intervention program for Ethiopian immigrants in primary care clinics: results of an evaluation study. JDC-Brookdale Institute, Research report: RR-357-00
7. Engel, George L (1977). "The need for a new medical model" Science. 196:129–136.
8. Trostler N. (1997). Health risks of immigration: the Yemenite and Ethiopian cases in Israel. Biomedical Pharmacology. 51(8):352-9.
9. Rubinstein A, Goldbourt U, Shilbaya A, Levtov O, Cohen G, Villa Y. (1993). Blood pressure and body mass index in Ethiopian immigrants: comparison of operations Solomon and Moses. Isr J Med Sci. 29(6-7):360-3.
10. Cohen, M P . Stern, E. Rusecki, Y. Zeidler, (1988). A. High prevalence of diabetes in young adult Ethiopian immigrants to Israel. Diabetes. 37(6): 824-8.
11. Rubinstein A, Graf E, Villa Y. (1993). Prevalence of diabetes mellitus in Ethiopian immigrants: comparison of Moses and Solomon immigrations. Isr J Med Sci. 29(6-7):344-6.
12. Jaffe A, Vardi H, Levit B. Diabetes in the Ethiopian Jewish communit of Hadera: Prevalence, Atherosclerotic risk factors. Israel society of diabetes mellitus 2001 (ABS-oral). EASD 37th annual meeting, p403 2001(ABS-post). Third Jerusalem International Conference on Health Policy 2001(ABS).
13. Drori R, Jaffe A. On behalf of the Israel IDDM Registry Study Group. Incidences and age at disease onset of Type 1 Diabetes Mellitus among Israeli Ethiopians are correlated with the duration of exposure to a new environment. Israel endocrine society annual meeting and scientific sessions, 2007 (ABS-oral).
14. Rosenthal T, Grossman E, Knecht A, Goldbourt U. Blood pressure in Ethiopian immigrants in Israel: comparison with resident Israelis. J Hypertens Suppl. 1989 Feb;7(1):S53-5.

15. Jaffe A, Giveon S, Ayecheh S, Guttman N, Quality and quantity of health care services' utilization by Ethiopian versus non-Ethiopian diabetic patients. The National Institution for the Study of Health Services and Health Policy. Final report on 2004 study. Hebrew. http://www.tene briut.org.il/health_care.pdf.

16. Rubinstein A, Grosskop I, Charach G, Levtov O, Geter R, Villa Y, Goldbourt U.Lipids and lipoproteins among Ethiopian immigrants: comparison of operations Solomon and Moses. Isr J Med Sci. 1993 Jun-Jul;29(6-7):354-9.

17. Rosenberg R, Vinker S, Zakut H, Kizner F, Nakar S, Kitai E. An unusually high prevalence of asthma in Ethiopian immigrants to Israel. Fam Med. 1999 Apr;31(4):276-9.

18. Guttman N, Jaffe A. "We didn't have it in Ethiopia!" Preliminary Findings on Attitudes and Beliefs of Ethiopian Immigrants to Israel Regarding Diabetes. Israel society of diabetes mellitus 2001 (ABS-oral). Paper presented at the Annual conference of the American Public Health Association, November 2002.

19. Toledano, Y., Givon, S., Kahn, E., Ayecheh S., Guttman, N., Jaffe, A. (2006). The use of healthcare services by Ethiopian immigrants and the quality of service they get compared to diabetes patients who are not Ethiopian immigrants. In Gur and Bin-Nun (Eds.). A Decade to the Israel National Health Insurance Law. The Israel Health Policy Institute. (Hebrew).

20. Levin-Zamir, D., & Peterburg, Y. (2001). Health Literacy in Health Systems: Perspectives on Patient Self-management in Israel. Health Promotion International 16(1): 87-94.

21. Kreuter M.W.; Lukwago S.N.; Bucholtz D.C.; Clark E.M.; Sanders-Thompson V. (2003). Achieving Cultural Appropriateness in Health Promotion Programs: Targeted and Tailored Approaches. Health Education and Bheavior, 30(2), 133-146.

22. Galavotti, C., Pappas-DeLuca, K. A., Lansky, A. (2001). Modeling and reinforcement to combat HIV: The MARCH approach to behavior change. *American Journal of Public Health, 91*(10), 1602-1607.

23. Rudd, R.E., Comings, J. (1994). Learner developed materials: an empowering product. Health Educucation Quarterly; 21 :33-47.

24. Michielutte, R., Bahnson, J., Dignan, M.B., Schroeder, E.M. (1992). The use of illustrations and narrative text style to improve readability of a health education brochure. Journal of Cancer Education, 7:251-260.
25. Paskett, E.D., Tatum, C., Wilson, A., Dignan, M., Velez, R. (1996). Use of photoessay to teach low-income African American women about mammography. J Cancer Education,11:216-220.
26. Gutttman, N. & Salmon, (2004). Guilt, Fear, Stigma and Knowledge Gaps: Ethical Issues in Public Health Communication Interventions. Bioethics, 18 (6), 1457-8519.
27. Azarmina, P. Wallace, P. (2005). Remote interpretation in medical encounters: a systematic review. Journal of Telemedicine and Telecare, 11 (3), 140-145(6)
28. Gracia-Garci'a R. (2003). Telephone Interpreting: A review of pros and cons. MA thesis submitted to the University of Massachusetts