

Significance of Community Collaboration Relationships: Eritrean and Ethiopian Oromo Perspectives on Caregiving Practices and Strategies, Community Health, And Chronic Disease Prevention, Management and Treatment

A Project Report

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ABSTRACT

The deliverable of my project was to curate participation-observation field notes, semi-structured interview guidelines and questionnaires, and community discussions (via collaborative group sessions) to build awareness and community capital for immigrants that seek and give care. The purpose of my two collaborative group sessions, which were held in the Good Shephard Lutheran Church in Hayward, was to identify, discuss, and evaluate sustainable community health deliverables that Eritrean and Oromo participants want to implement within their respective communities in the near future. This project addressed the needs, concerns, and healthcare-seeking strategies of Eritrean and Ethiopian immigrants in the East Bay, California to enhance community awareness and ability to form coalitions, empower families of caregivers and to facilitate cross-community communication. The overarching goal of this project is to analyze the prevalent chronic diseases that affect these immigrant communities in the East Bay, document their experiences managing such diseases, and highlight the social structures and policies that shape access to services. The chronic diseases under consideration are anemia, cancer, asthma, diabetes, and cardiovascular diseases. In this project, I documented how these immigrants navigate the health care resources available to them in the East Bay, noting their obstacles and resources to disseminate these findings back to the affected communities. The immigrant families in question are expected to be complex, with some members of the family being first-generation immigrants while others native-born citizens. Female caregivers, who might be coping with their own chronic disease, experience the social burden of caregiving disproportionately (Ho 2005, 50). I explored how ethnic identity, age, and national origin shape the concepts of wellness and influence care-seeking activities. This project will also document any differences experienced by such women in managing chronic diseases relative to their male

counterparts. I worked with Eritrean and Ethiopian immigrants in the East Bay to discover how they experience medical plurality in order to build on similar studies in medical anthropology that have informed clinical practice and social services in multiethnic urban neighborhoods. I also identified how local people attribute illness causation, develop health seeking practices, and work within families and ethnic communities to create strategies to manage chronic diseases and provide culturally appropriate caregiving.

CHAPTER 1

INTRODUCTION

The objective of the project was to identify and profile the cultural experiences of health-related beliefs, health-seeking practices, and relevant organizations within the Eritrean and Ethiopian Oromo communities in order to empower the immigrant community to better navigate the American health care system. My deliverable consisted of facilitating open-ended conversations in two community-based gatherings between 16 participants that represent each of the two African immigrant communities. After identifying strategies and practices people deemed either successful or problematic, I collaborated and partnered with the following clients that serve primarily African immigrant populations: Eritrean and Oromo communities at the Good Shephard Lutheran Church in Hayward. These clients served as my research base to recruit people to interview and observe at the beginning of my project.

My clients/partners at the Good Shephard Lutheran Church also provided venues for me to discuss my findings at the completion of the research. These African immigrant communities are situated in a larger multiethnic community, including a substantial African American population. Within this context, I aimed to document how these immigrant communities experience health inequality and social marginalization. I tracked how these communities link their experience of health inequality to wellness, their ability to manage chronic disease, and their access to health services.

Problem Statement

This project has the potential to contribute to the knowledge and understanding, pertaining to concerns of medical anthropological inquiry on the caregiving practices and medical beliefs of Eritrean and Ethiopian immigrants in the East Bay. Although there is an

abundance of peer-reviewed medical anthropological case studies and scenarios on chronic-related diseases among African American communities in East Bay, the complete opposite is the case among Eritrean and Ethiopian communities residing in the same area. The fact that over 40,000 African immigrants, including Eritreans and Ethiopians, reside in the Bay Area, yet continue to be misrepresented and/or underrepresented is a systemic social issue in the United States. This has the potential to be reversed with the collaborative and passionate efforts of medical anthropologists interested in studying these demographic groups.

A medical anthropological approach that identifies sustainable health-based solutions on socially vulnerable groups are an effective way of contributing knowledge to the field. Medical anthropological theorists have argued patterns of human behavior are directly correlated with underlying causes and factors of chronic illnesses and diseases (Winkelman 2009, 36). Medical anthropology studies illuminate how the prevalence of and associated coping mechanisms of chronic diseases varied between diverse demographic groups (Winkelman 2009, 66). Winkelman (2009) argued that an emphasis on analyzing individual and cultural perceptions of coping and caring is essential in successfully managing and treating a life-threatening illness/disease. Consequently, applied medical anthropologists acknowledge the increase of overall life expectancies and living standards in societies is dependent on the equal representation and treatment of all demographic groups within a society (Winkelman 2009, 15).

From sociocultural factors (conceptions of the body) to environmental settings (neighborhoods), the discipline of medical anthropology draws on a mixed-methods, theoretical, and applied approach to analyze the cultural significance of medical plurality (Hughes and Lock 1987, 6). Therefore, medical anthropologists can apply their sociocultural awareness and knowledge of public health issues in minority communities to help improve the overall well-

being of individuals and groups regardless of their background or circumstances. Once ethnically diverse populations are better represented in the context of community health concerns, marginalized communities can potentially benefit from significant decline of health inequalities and disparities. For this reason, my multicultural health project of Eritrean and Ethiopian communities concentrated in the East Bay will facilitate cross-cultural communication.

Identifying Context of Public Health and Caregiving in Western vs Eritrean/Ethiopian Societies

In the Bay Area and other areas across the United States, advocates of Western caregiving and public health typically promote and declare biomedicine as the only acceptable medical science discipline. On the other hand, in many non-Western societies such as Eritrea and Ethiopia, a combination of alternative/traditional and modern medicine is typically applied for someone with a chronic disease or illness. Some Western physicians have difficulty accepting or understanding non-Western medicine, or traditional healing as a result of cultural biased models regarding health (Hahn and Gaines 1985, 36). Part of this argument stems from the idea that due to the development of modern surgery, prescription medications, and healthcare facilities and infrastructure, many aspects of modern medical care have saved the lives of millions of people around the world. However, proponents of a more nuanced perspective on caregiving and public health, such as many Eritreans and Ethiopians, argue they're benefits of utilizing both traditional caregiving services and modern medicine.

The social origin of Eritrean and Ethiopian traditional caregiving ideologies is similar to many cultures across the non-Western world where the health of groups of people are prioritized over the welfare of an individual. To elaborate on the demographic groups of caregivers in Eritrean culture, young people and women are expected to fulfill their citizen duties and roles to

care for their elders, regardless of whether or not they're related to them. Examples of common Eritrean and Ethiopian (Oromo) traditional caregiving services include food preparation and distribution, administering medicine (herbs, plants, or medication), and mid-wives (Bourdillon and Myers 2014, 82). Eritrean and Ethiopian cultural and health practitioners come from various social and economic backgrounds, although the majority of them are women from rural villages in Eritrea and Ethiopia that historically lacked adequate healthcare services. Consequently, Eritrean and Ethiopian men and women have brought their proficient knowledge with regards to caregiving to the Diaspora, resulting in a sustainable cycle of promoting good health and wellness via collectivism.

Eritreans, particularly women and mothers, have long promoted the idea that collectivism was not just responsible for the survival and resilience of the Eritrean people, but Eritrea as a nation. To put this into perspective, many Eritreans strongly believe that the will, tenacity and unity of the Eritrean people, as a collective, was responsible for defeating a very well-armed Ethiopian military in 1991 (Almedom 2005, 310- 314). Despite facing such extraordinary odds, the people of Eritrea prevailed due to the consistent and backbreaking efforts of Eritreans to independence regardless of one's gender, religion, ethnic group, etc. Another important factor to note is the key role Eritrean caregivers had on the victory of achieving independence; in the battlefields, Eritrean caregivers had to attend to thousands of Eritrean soldiers who were wounded and severely ill. The skillset to assess and evaluate chronic illnesses and diseases, as well as life-threatening wounds among Eritrean soldiers were crucial to their recovery and ability of fighting and defeating Ethiopian troops; this skill also transcended to the daily cultural practices of Eritreans in the United States (Connell and Killion 2007, 290).

In contrast, Ethiopian Oromo female caregivers faced a different battle than Eritrean female caregivers, as there wasn't a universal consensus to become a sovereign independent people and nation among the Oromos, as it was with the Eritrean population. However, Ethiopian Oromos faced similar battles with regards to cultural hegemony and gender politics that undermined and hindered the health and wellness of their people throughout Ethiopia (Minahan 2016, 131). As a result, utilizing widespread practices of collectivism helped many vulnerable men, women, and children cope with the deteriorating socioeconomic and health conditions that impacted Ethiopia over the latter half of the 20th century. It's important to note that the Oromo people of Ethiopia are the largest ethnic and linguistic group in the nation with 40-60 million inhabitants (Minahan 2016, 319). As such, this large and vastly growing population continues to be used as a social advantage and cultural practice for Oromo caregivers residing in and outside of Ethiopia.

Cultural practices of Eritrean and Ethiopian Oromo caregiving have resulted in significant praise and credit among the Eritrean and Oromo diasporic population. From Eritrea and Ethiopia to Europe and the United States, Eritreans and Oromos in the Diaspora have expressed the cultural significance of embracing the humanity of individuals, rather than abandoning someone in time of need (Zahorik 2005, 77). Some perceive their caregiving practices as the heartbeat of Eritrean and Oromo national and cultural identity, as well as the moral fabric of Eritrean and Ethiopian society; to many of them, caregiving is just as important as one's religious/spiritual ideals, family, and economic values (Zahorik 2005, 88). However, after decades of settling in the Diaspora, some Eritreans and Ethiopians have learned to simultaneously adapt to Western cultural norms and values while maintaining their own customs. Many reckoned that to achieve success, happiness, and good health in the United States, one

would have to be open-minded enough to accept some of the values of the host nation (U.S. or Europe) that accepted their refugee/immigration status.

Research Questions: Eritrean and Ethiopian Immigrant Experiences on Chronic Diseases

My objective was to also empower those immigrants who had a diagnosis of a chronic illness and their caregivers to better navigate health care in the East Bay. In order to help them refine and focus their resources to achieve that end, I need to identify and document certain issues. I used the following questions to focus my inquiry on documenting key aspects of Eritrean and Ethiopian immigrant health beliefs, health seeking behaviors, and chronic disease management strategies.

1.) What are the medical belief systems, challenges, and practices of Eritrean and Ethiopian immigrants in the East Bay?

Applied medical anthropology has studied and examined how medical belief systems and practices directly impact the experience one has with healthcare practitioners, as well as perceptions of chronic disease prevention, distribution, and management. In the lens of a medical anthropologist, identifying the belief systems and practices of a demographic group is crucial to understanding their health, well-being, and overall lifestyle. This project helped me gain extensive knowledge and insight on the relationship between medical plurality and cultural belief systems, challenges and practices. An example of the above is from one of my collaborative group meeting sessions when eight participants collectively expressed the need for a comprehensive public health approach to solve complex health problems in American healthcare institutions.

2.) What is the experience of coping with and caring for chronic illnesses among the two different African immigrant communities in the East Bay?

Experiences with coping with and caring for chronic illnesses and diseases is diverse and complex; with that being said, it is important to document and analyze individual and community perspectives on health-related problems and systems. For example, some Eritreans and Ethiopians I grew up with informed me how they resorted to traditional healing practices in order to cope with a particular illness/disease, mainly due to the scarcity of health facilities in their local towns, cities, and villages. These personalized views also had similar cultural perspectives on the topic of community and family-oriented caregiving between the Eritrean and Ethiopian Oromo Community. I designed my project so that I could share both the breadth of unique experiences and help the community see their common problems and potential actions.

3.) What is the experience of receiving care among these African immigrant communities with chronic illnesses and diseases and how do they seek care?

Personal and Institutionalized caregiving services (hospitals, clinics, etc.) have made significant strides with improving the living conditions and survival rates of some demographic populations, including Eritreans and Ethiopians. However, with the lack of culturally sensitive programs in biomedical facilities, some African immigrant communities with chronic illnesses/diseases have hesitated to seek care from Western healthcare practitioners. As a result, a high level of mistrust, skepticism, and confusion is prevalent among many Eritreans and Ethiopians who either have a chronic illness/disease or fulfill the role as the caregiver in a particular household or community.

The framework of these three questions encompass the objectives of identifying health care beliefs and practices relevant to the issue of chronic care among Eritrean and Ethiopian immigrants, as well as documenting experiences of coping and caring for people within a context of medical plurality. These questions will also be the cornerstone of my project deliverable,

which is applying ethnographic data to facilitate post-research community gatherings among all of my research participants at a public space of their choosing. To reiterate, the objective of this graduate project is to contribute to a body of knowledge that addresses and evaluates the health-related needs, concerns, and agendas of the Eritrean and Ethiopian Oromo community.

Project Deliverable/Significance

I identified gaps between culturally informed expectations and services by employing ethnographic technique such as participant-observation and ethnographic interviews.

Documenting this gap contributed to the body of knowledge pertaining to healthcare, which can help clinicians and service providers navigate the struggles facing multicultural societies.

Likewise, this research seeks to improve the bureaucracies of healthcare institutions and make them more patient centered. Therefore, I employed a variety of data-collection techniques in order to achieve a coherent picture of their health-based experiences, beliefs, and practices.

I pinpointed and documented concerns, beliefs and practices around chronic disease management, reveal underlying gaps between expectation and experience in health services, and placed that ethnographic data in a larger discussion about the link between wellness and socioeconomic inequality. Eritrean and Ethiopian communities have benefited by learning more about each other, sharing their strategies for successfully managing chronic disease while gaining access to healthcare resources. By working with these African immigrant communities and understanding their experiences their sense of what works and what does not, I was able to identify particular policies and practices that can improve their experiences in chronic disease and care. I also carefully evaluated the needs, concerns, and experiences of these immigrant groups by applying a cross-cultural perspective in public health and illness. By closely examining two distinct populations of immigrants, both commonalities and differences are

expected to surface, and will illuminate the roles of healthcare seeking practices and strategies that documents individual experiences of inequality.

In this project, I also examined how Eritrean and Ethiopian immigrants experience chronic illnesses/diseases. My research objectives are to address the experiences, beliefs, and attitudes of chronic diseases that impact this particular demographic group, which is itself heterogeneous, so that community members and organizations are empowered with a heightened awareness of obstacles and successful strategies. Because of the presence of diverse cultural, linguistic and ethnic groups among the African immigrant community, addressing health-based strategies and interventions must be strategic and beneficial to all of the groups participating in this research.

The estimated 3.1 million African immigrants who reside in the United States have linguistic, ethnic and cultural backgrounds that link them to every corner of the continent (U.S. Census Bureau (U.S. Census Bureau 2018). From Eritrean and Ethiopian communities in East Oakland to Ghanaian communities in New York, the population of African immigrants in the United States are unique, complex, and diverse. The reason why the population of these immigrants are unique, complex, and diverse is due to the mass migration of native-born and first-generation folks that stems from pre and post-independence movements, which overwhelmed the daily lives of millions of people across the African continent (Shillington 2005, 502).

From the late 1950s to mid-1970s, over 45 African nations gained their independence from former European powers; however, the postcolonial process that followed resulted in widespread corruption, economic collapse, and poverty throughout Africa (Shillington 2005, 542). As a result, citizens of newly sovereign, independent African nations became vulnerable to

social, economic, political, and health deterioration, and left as either refugees or migrants. On top of their concerns regarding displacement and assimilation, cultural acculturation became a daily challenge for many African immigrants living in a society (United States) that has historically marginalized people based on race, culture and language (Shillington 2005, 632). Therefore, Eritrean and Ethiopian immigrants face complex problems than just coping with the prevalence and distribution of deadly chronic disease. Such complex problems include dealing with American health policies that contradict widespread practices of alternative medicine and caregiving, particularly regarding the beliefs of Black populations (Bailey 2000, 129).

Roadmap

In Chapter 1, I introduce the topic and purpose of my research, as well as explain community objectives among Eritrean and Ethiopian Oromos that have participated in this project. Research questions, as well as my project background and significance are also pinpointed in this chapter. My research questions and project background then lead to identifying the context of caregiving in Western vs. Eritrean and Oromo societies.

The first half of Chapter 2 introduces a cross-cultural anthropological framework on mitigating chronic illnesses and diseases. Then, Eritrean and Ethiopian analysis' on social origins of specific chronic diseases that impact their respective communities are identified and explored. The chapter concludes with a summary of chronic disease prevention and management, as well as the background literature. The second half of Chapter 2 establishes literature on the anthropology of caregiving practice sand strategies among Eritrean and Ethiopian Oromos. Literature primarily focuses on medical anthropological perspectives on caregiving, as well as the impact of caregivers migrating from their nation of origin to the diaspora.

Chapter 3 is the methodological section of the project that explores research locations/sites, sample size, participant-observation research, semi-structured interviews, and focus group sessions. The chapter then summarizes the findings of the methodological framework that address the project's research questions and project deliverables.

Chapter 4 is on cross-community collaboration and action. The chapter emphasizes community perspectives on promoting public health and caregiving among and between these ethnic communities. Collaborative community activities and programs, as well as sustainable public health campaigns and projects are also discussed in this chapter. Finally, participant observation findings, such as weekly church gatherings, cultural festivals and community picnics/events conclude the chapter.

As the final chapter of the project, Chapter 5 concludes on the fundamentals of anthropology in public health. Also, research study limitations are briefly mentioned, as well as the need for health awareness and literacy in marginalized and vulnerable communities throughout the world. Future collaborative projects in the Eritrean and Oromo communities are also explained.

From identifying health care beliefs and practices relevant to chronic care among Eritreans and Ethiopians to reiterating relevant work conducted by notable medical anthropologists, I pinpointed how these communities of African immigrants can engage in actions to locate and overcome structural barriers that can impede access to care. In the significance of project section, I clarify why it is important to improve health seeking strategies, using nuanced evidence-based ethnographic data of chronic diseases in the Bay Area. In the review of literature section, I provide information on how an understanding of power provides insight into the sociocultural origins of chronic diseases, care, and the lack of caregiving in a

society dominated by the biomedical industry. Finally, in the methodological section, I explained the following tools needed to successfully collect and analyze the data to address the research questions. I outlined my plan for dissemination as I worked with the communities involved to share insights and facilitate cross-cultural conversations.

CHAPTER 2

ANALAYZING CHRONIC DISEASES AND ILLNESSES FROM A CROSS CULTURAL PERSPECTIVE

The caregiving beliefs, practices and challenges among Eritrean and Ethiopian immigrants encompass a wide range of diverse practices and customs. This graduate project requires medical anthropologists to study and analyze the challenges of chronic diseases and caregiving in a multicultural urban context. Medical anthropologists, such as Kleinman (1997) and Almedom (2006), analyze how socioeconomic, political, and cultural issues are directly linked to chronic diseases and healthcare services. These anthropologists have utilized community-oriented interventions to pinpoint and understand the complexities of medical pluralism in multiethnic societies. In the context of conducting anthropological research among immigrant populations such as Eritrean and Ethiopian communities, it is important to apply cross-cultural perspectives in order to elicit illness narratives so that health conditions can be improved. Thus, understanding specific ethnic medical interactions with community members are a fundamental step in improving the care-seeking and care-giving activities among these socially vulnerable individuals and groups.

Anthropological Framework for Mitigating Chronic Diseases

Cultural concepts of self-awareness, self-determination and self-reliance are identified as long-term medical anthropological beliefs and practices that may help mitigate cases of chronic diseases among Eritrean and Ethiopians immigrants in the United States. According to Astier Almedom, an Eritrean-born medical anthropologist, several waves of European colonialism, and the thirty-year war to achieve independence from Ethiopia shaped revolutionary fighters (EPLF) and ordinary citizens to mentally and physically train themselves to cope with their health issues.

These concepts transitioned to actual health policies implemented in Eritrea once EPLF Almedom secured independence in 1991 (Almedom 2006, 137). Based on ethnographic research on Eritrean civil societies from 1941-1991, the debauched treatment of Eritrean citizens through colonial racial policies molded a strong social identity of rejecting assistance/aid from foreign entities, which include health-based organizations (Almedom 2006, 109). From the responsibilities of caregiving to applying self-knowledge on public health terminologies and systems, Eritreans are culturally expected to actively monitor and manage their chronic illnesses. The task to apply self-sufficiency as a means to reverse underlying gaps in health services and social and political constraints, such as socioeconomic inequality, gender roles, and lack of access to healthcare, developed as an ideological phenomenon once the war erupted in 1961. During and after the Eritrean independence war, some former rebels turned immigrants shared their personal experiences of social suffering and war-related trauma once migrating to cities such as Oakland, California.

Arthur Kleinman, a psychiatrist and medical anthropologist that specializes in analyzing the cross-cultural delivery of biomedical care, argues that social suffering and poverty within culturally diverse communities are correlated to the prevalence and distribution of chronic diseases (Kleinman and Das 1997, 276). Moreover, Kleinman developed an ideological framework of eight questions, a medical anthropological assessment that emphasizes the social origins and nuances of sickness and wellness. This assessment was key to documenting the cultural gaps in health care and between distinct communities and caregivers of ethnically different backgrounds. Kleinman framed these eight questions as a blueprint to effectively analyze the alternatives, limits, strengths, and suggestions of cross-cultural health care among ethnically diverse populations (Betancourt and Green 2002, 9). In this project, I captured the

narratives of interactions from caregivers, as well as the people they care for, illustrating how biomedical and individualistic assumptions might be received in pluralistic cultural settings such as the East Bay, California. In many of these narratives, Eritreans and Ethiopians profoundly, and in some cases, painfully expressed their perspectives on the social origins of chronic diseases and illnesses.

Social Origins of Caregiving and Chronic Diseases- Eritrean and Ethiopian Oromo

Perspectives

The social origins of Eritrean and Ethiopian caregiving and chronic disease prevention, management, and treatment lie on their ancestral and traditional practices of social welfare, gender roles, and ethnic/community wellness. To elaborate on the significance of caregiving in Eritrean and Ethiopian culture, young people and women are expected to fulfill their citizen duties and expectations to care for others, regardless of whether or not they're related to them (Aberra, 2014, 10). Preparing and distributing food, cleaning, administering medicine, and midwifery education are the most fundamental social responsibilities of young Eritreans and Oromos and women to carry out in and outside Eritrea. Eritrean cultural and health practitioners come from all social and economic backgrounds, although the majority of them are women from rural villages in Eritrea and Ethiopia that historically lacked adequate healthcare services. Consequently, Eritrean and Oromos have brought their proficient knowledge of caregiving to countries such as the United States, resulting in a sustainable cycle of promoting community health and wellness.

The strong advocacy of community health and wellness among Eritrean and Ethiopian Oromo communities stems from their social and cultural perspectives, as well as personal experiences, regarding chronic disease prevention, management, and treatment. Eritreans and

Ethiopian Oromos have historically faced centuries of social stigma, marginalization, brutality, and genocide as minority populations within a nation/empire (Ethiopian empire) dominated by a single ethnic/cultural group (Amhara). Eritreans have also experienced generations of brutality under waves of colonial powers (Italians, British and Ottomans). From 1890-1941, Eritreans not only experienced brutal forms of Italian colonization, but were guinea pigs of a new 20th century social experiment called “apartheid.” The apartheid policies enacted by the Kingdom of Italy in Eritrea limited, restricted, and segregated native access to adequate, White-owned hospitals and clinics and educational institutions, as well as decent paying, sustainable jobs (Negash 1987, 96). Thus, millions of Eritreans and their descendants were forced to culturally adapt to self-reliance measures in all aspects of social life.

However, unlike Eritrea, Ethiopia remained an independent and sovereign nation in a continent plagued by European colonization. Despite Ethiopia’s successful resistance to colonization, internal oppression by hegemonic ethnic and cultural groups against other tribal entities occurred for generations. According to prominent Oromo historians and activists, the Oromo population has systematically experienced waves of land expropriation, cultural genocide and literal genocide by Amhara-dominated governments led by the absolute monarchies of the following emperors/expresses: Menelik II, Zewditu, and Haile Selassie (Baxter and Hultin 1996, 41). Entire towns, languages, and institutions in Oromia were replaced by Amharic, the official language of modern-day Ethiopia, not to mention the cultural hegemonic perception that the region of Oromia was “undeveloped, backward, and primitive” (Baxter and Hultin 1996, 41). From experiencing social marginalization in the educational and employment sectors to disproportionate rates of chronic diseases outbreaks, Oromos have constantly dealt with major roadblocks to improve their overall physical, emotional and mental health (Dugassa 2003, 149).

In spite of the cultural, ethnic, and historical differences between the Eritrean and Oromo Ethiopian people, their common experiences of institutional racism, genocide, and humiliation have led to organized efforts to reverse the root causes of racism, economic marginalization, and health inequality. Among the most prominent and sustainable organized efforts was the active role caregivers had as members of several Eritrean and Oromo liberation fronts (ELF, EPLF, and OLF). Although the most evident goal of the EPLF was to completely destabilize and annihilate the Ethiopian imperial government and consequent communist military regime, they were also keen on developing health delivery systems (Hjalmarsson, 2019, 146). In this context, health delivery systems included the expansion of healthcare infrastructure, training public health workers, and mobilizing foreign investment funds to cater to millions of Eritreans who suffered from decades of war and extermination campaigns. (Hjalmarsson 2019, 146). A few years after the conclusion of the war in 1991, approximately 12,400 Eritreans migrated and dispersed to multiple nations throughout the Western world (Eritrean Immigration Statistics, 1960-2020).

Chronic Disease Prevention and Management

In addition of applying and accepting Western biomedicine, Diasporic Eritrean immigrant communities have also long practiced and embraced alternative health strategies, such as medicinal plants and folk/spiritual remedies to combat all forms of chronic diseases. Eritrean scientists have documented herbal medicinal properties that can potentially prevent or even cure chronic illness and diseases that range from abdominal pain to chronic cancer and heart disease (Yemane and Medhanie 2017, 2). In Hayward, the Good Shephard Lutheran Church, which hosts Eritrean and Oromo congregations, plans to promote and develop community health programs that range from health literacy books to community health engagement and outreach. Health literacy/educational books will utilize peer-reviewed information that encompasses traditional

and biomedical practices to prevent chronic diseases. (Eritrean Civic Cultural Community Center 2018).

The challenges of culturally sustaining self-care as a medical belief system in a culturally biased Western healthcare system are also similarly expressed among East African immigrants such as Oromo Ethiopians. For centuries, Oromo Ethiopians have faced brutal campaigns and policies implemented by monarchies that not only suppressed the ability for social and economic mobility, but also with regards to progress in public health and wellness. Oromo community members at the Good Shephard Church have explained how former Ethiopian regimes intentionally refrained from developing healthcare infrastructure and facilities in the Oromia regime.

The Anthropology of Caregiving Practices and Strategies among Eritreans and Ethiopian Oromos

From multiple waves of European colonization to the modern development of American military and communication bases, as well as hospitals in Asmara, Eritrea, Eritreans have long been exposed to Western norms and values, which also includes the perceptions and beliefs of public health. According to social scientists Vernon Palmer and Mohammad Matter, the development of Eritrea's infrastructure by the Italian colonialists had a profound influence among the urban and rural population (Palmer and Mattar 2016, 55). Although Eritreans were subjected to humiliation and degradation by the hands of the Italians, particularly during the fascist Mussolini era, some believed that European/American models of urban development and investments were responsible for global political stability, local economic prosperity, and remarkable advances in medicine (Palmer and Mattar 2016, 56). Therefore, some Eritreans at

home and abroad believe they've benefited from a mixture of traditional Eritrean ideals and modern American principles and values.

Similarly, Ethiopian Oromos also accepted certain Western ideologies of caregiving that revolved around increasing the life expectancies and survival rates of Oromo people, particularly women, infants, and adolescents. Dr. Gibson and Lawson, applied medical anthropologists with extensive fieldwork experience in Ethiopia, state that the skyrocketing rates of maternal and child mortality is among the most devastating health-related issues impacting Oromo communities in the country (Gibson and Lawson 2014, 62). Data from the Ethiopian Demographic and Health Surveys of 2000-2005 showed that 1 out of 10 newborns did not survive infancy and that nearly 1 out of 6 infants did not survive to their 5th birthday (Susuman 2012, 9). Given that the Oromo population is by far the largest ethnic group in Ethiopia, as well as the most widely dispersed group in the nation, these health statistics have directly affected the demographic group. However, Western capital investment in the creation, development, and expansion of hospitals and clinics in the countryside has vastly improved and decreased childhood and maternal mortality over time. Therefore, some American health practices and strategies have been incorporated with Ethiopian caregiving practices.

The social acceptance of the following American principles and health models have been widely accepted by Eritrean and Ethiopian caregivers: financial investments in healthcare expenditures, manufacturing and distribution of pharmaceutical medications, and the diversity of healthcare practitioners that range from optometrists to caregivers and doctors. From a medical anthropological standpoint, these principles and models of integrating traditional medicinal practice with biomedical systems vary on the following indicators: geographic regions (rural vs urban), cultural lifestyles, religious/spiritual values, and kinship structures (Habtom 2015, 87).

Many Eritrean and Ethiopian caregivers grew up in remote towns and villages that either had limited hospital/clinics or none at all; some even resorted to traveling to the nearest town in the area to get access to a practitioner. As they settled in towns and cities throughout the United States and Europe many witnessed what was once considered a miracle or dream: accessing more than one hospital and doctor/nurse in their new home.

However, despite being able to access some adequate healthcare facilities in an American or European city, most Eritreans and Ethiopians have been concentrated in low income housing projects and neighborhoods designed for recent immigrants, migrants, and working-class American families (Scott and Getahun 2017, 44). This concentration of living in public housing areas are due to the reality that when Eritreans and Ethiopians migrated to the United States, most came with nothing but the clothes on their backs and suitcases; These individuals and families had to start from scratch in the areas of employment, housing, education, etc. For this reason, Eritrean and Ethiopian immigrants and migrants struggled to gain social and political representation, as well as financial stability to gain intergenerational wealth and an overall good future for their children/loved ones. Also, many of these immigrants depended on collectivism and unity (via collaboration) to survive in the Diaspora. During my collaborative group meetings, some of the participants expressed how a solid support system literally saved them from a deterioration of their physical, emotional, and mental well-being.

Impact of Caregivers Migrating from Nation of Origin to United States

As reiterated, from 1961-1991, a brutal, reactionary 30-year war was waged between the state of Ethiopia and Eritrean secessionists who retaliated against the annexation of the former Italian colony (Eritrea) to Ethiopia, by Emperor Haile Selassie. As the war intensified under the Ethiopian military dictatorship of Mengistu Haile Mariam, scores of Eritreans, including

caregivers, fled their land by literally walking to Sudan and flying to countries ranging from Egypt and Greece to the United States. By the late 1970s to early 1980s, over 10,000 Eritrean migrants had already dispersed from their ancestral homeland, many of whom settled in the United States (Pew Research 2019). For the first time in their history, Eritreans were part of the Diaspora. Upon the arrival to their new “home,” many Eritreans were in destitute conditions due to the extensive psychological trauma, social suffering, and widespread violence experienced in their homeland.

As a result of such devastation, some Eritrean migrants, specifically those raised in impoverished parts of Eritrea, rely on the knowledge and resources of Eritrean professionals to improve their standard of living in the United States. A collectivist and pro-humanitarian mindset carried through the practices and legacies of their ancestors developed into a modern cultural framework to address the health problems of Eritrean immigrants and migrants across the United States. An Oromo nurse who I interviewed explained a scenario of the Oromo community in the Bay area pooling their resources and professional skills to pay for the costly health services of a middle-aged Oromo male diagnosed with stage 4 colon cancer. Although he would eventually succumb to an incurable stage of colon cancer, that didn't prevent his community from doing all they could in their power to treat him.

On the other hand, Ethiopians were a part of the Diaspora long before Eritreans; U.S. Census records from Ellis Island provide data of Ethiopians settling in the United States as early as 1909 (Sherman 1909). Although Ethiopian Oromos continued to face various forms of discrimination in Ethiopia throughout the 20th century, many Ethiopian professionals took advantage of the strong historical and political relationship between Ethiopia and the United States to leave the country. These advantages included the participation of foreign exchange

student programs and university scholarships to Ethiopian students, many of whom included midwives, doctors, and nurses (Baylor 2011, 659). After completing their studies in universities throughout the United States and Europe, some Ethiopian professionals, including health practitioners, gathered their financial assets and networking skills to move back to Ethiopia, whereas others remained in the Diaspora. Therefore, the impact of migrating from Ethiopia to the United States was significant to the field of caregiving and the general welfare of Ethiopian Oromo immigrants (the majority of whom were forced migrants as a result of the war).

Collaboration and cooperation are recognized as medical anthropological skills that collect and analyze relevant ethnographic data in a cross-cultural context. In this case, these skillsets are imperative in the field of community caregiving. Kleinman and Wilkinson argue that social and educational activities can foster an environment where trust, solidarity, and mutual respect are focal points in local communities that have conflicting and complex belief systems and practices (Kleinman and Wilkinson 2016, 169). Based on their ethnographic findings, community-based activities paved the way for multicultural societies to build rapport with public health workers, community leaders, and female caregivers that care for their loved ones within their communities (Kleinman and Wilkinson 2016, 117). Once notions of community space and self-care developed as a hallmark of public health, medical anthropological interventions are more likely to be resilient and persistent in an environment dominated by Western biomedical corporations. Furthermore, ethnographic research can serve as a way to generate valuable knowledge meant to improve the experiences of cross-cultural care and chronic-related diseases across multiethnic communities with differing perspectives on human suffering and well-being (Kleinman and Wilkinson 2016, 184). Overall, such a comparative analysis and medical

anthropological approach was applied to communities of color, including Eritrean and Ethiopian immigrant groups in the East Bay, California through my research project.

Definition and Interpretation of Caregiving between Eritreans and Oromos

The definition and interpretation of Eritrean and Ethiopian Oromo caregiving ideologies are similar to most cultures across the non-Western world where the health of groups of people are prioritized over the welfare of an individual. Among Eritrean and Oromo caregivers, young people and especially women, are expected to fulfill caregiving duties (Deressa 2003, 19). Food preparation and distribution, cleaning, administering medicine, and midwifery education are among the most fundamental requirements of young Eritreans and female caregivers to carry out in and outside Eritrea. Eritrean health practitioners have come from all social and economic backgrounds, although the majority of them are women from rural villages in Eritrea that historically lacked adequate healthcare services. Consequently, Eritrean men and women have brought their proficient knowledge with regards to caregiving to the Diaspora, resulting in a sustainable cycle of promoting good health and wellness.

Ethiopian caregivers who have immigrated to the U.S. identify the lack of caregiving literacy, as well as economic and gender equality, as the defining factor behind the social burden of caregiving (Bourdillon 2014, 1977). The “Young Lives” study, conducted by Bourdillon, examines how the social upbringing and traditional norms of Ethiopian female caregivers have been challenged and transformed over time and across national borders (Bourdillon 2014, 1977). Since childhood, Ethiopian women are raised and taught to be caregivers for their family members and residents within the community. While Ethiopian women are expected to fulfill their obligations of being full-time caregivers, Ethiopian men are socially responsible to financially provide for their loved ones (Bourdillon 2014, 1978). These traditional values were

challenged once Ethiopian men and women migrated to nations such as the United States, where the cost of living, as well as language and educational barriers forced both gender groups to seek job and education opportunities. Therefore, Ethiopian caregivers in cities across the East Bay have had to quickly adjust to multi-tasking endeavors of juggling full-time caregiving, employment, and for some, higher education.

The Eritrean and Oromo Lutheran Church in Hayward, California identifies community education and collectivism as fundamental strategies to prevent, manage and treat social, economic, and health-related issues. However, many Ethiopian caregivers are still concerned that local Ethiopian communities continue to abide by traditional and conservative gender norms and values of caregiving, while they're simultaneously left to monitor their own chronic health issues (Mitike 2006). Because chronic diseases such as heart disease and cancer are public health crisis' in Ethiopian communities throughout the East Bay (and other parts of the Diaspora), Ethiopian female caregivers advocate for men and women alike to break stereotypical attitudes with regards to caregiving. Examples include the advocacy of male caregiving, as well as gender equality, which many believe can help mitigate the distribution and exacerbation of chronic diseases. Due to these internal cultural barriers and external factors of chronic disease prevention and management, it's important to evaluate the ways in which medical anthropologists have collected and made sense of relevant ethnographic data to address underlying gaps in health inequalities.

Cultural Norms and Values with Regards to Caregiving

The norms and values of Eritrean caregivers, as well as doctors/nurses, academics, and community organizers, revolve around the following themes to help improve the health of Eritrean immigrants: gender equality, compassion, kinship, and the cultural acceptance of diverse

tribal ideologies. As a young and sovereign nation of over ten ethnic/tribal groups with over seven languages spoken, many caregivers have continued to adopt to the practices and political models of the Eritrean liberation fronts. One of the fundamental ideals of those particular movements are to celebrate the diversity of Eritreans that come from all walks of life; that regardless of one's creed, place of birth, and belief system, every Eritrean in need of help must be treated with dignity and respect. Like many global immigrant groups/populations, these professionals come from diverse social and economic backgrounds. Some of these professionals were poor, EPLF independence war veterans who developed health systems (underground hospitals/clinics, whereas others came from elitist families who were privileged enough to fund their education and send them abroad (Sabo and Kibirige 1989, 677). Despite one's personal upbringing, professional experience, and tribal background, these norms and values continue to resonate in the work ethic of Eritrean caregivers. The combination of embracing the diversity of Eritrean tribal groups and the extensive knowledge and skills of caregiving among health practitioners, had a tremendously positive effect on the Eritrean American community (Sabo and Kibirige 1989, 684).

Caregiving Practices and Strategies: Collectivism and Ethics

Eritrean caregivers, particularly women, have long believed that the practice of collectivism is not just responsible for the well-being of a specific group of people, but the survival and resilience of Eritrea as a nation. To put this into perspective, many Eritreans strongly believe the will and self-determination of the Eritrean people, as a collective, contributed to the defeat a very well-armed Ethiopian military in 1991 (Almedom 2006, 130). Despite facing such extraordinary odds, the people of Eritrea prevailed due to the consistent and back breaking commitment of Eritrean soldiers, including health practitioners, to achieve

independence. Eritrean caregivers had a key role of helping to achieve independence; in the battlefields, Eritrean caregivers had to attend to thousands of wounded and ill Eritrean soldiers. The skillset to quickly assess, evaluate, and treat chronic illnesses and diseases, as well as life-threatening combat wounds among Eritrean soldiers, was a decisive factor in their recovery and eventual victory against Ethiopian military troops.

Ethiopian Oromo caregivers, experiencing their own internal battles with the same regimes Eritrean successionists fought for generations, have similarly intertwined collectivism and ethics in the Diaspora as a direct result of the war. However, contrasting the experiences and realities of Eritrean caregivers, Ethiopian Oromos were and still remain to be the largest ethnic/linguistic group in the Horn of Africa. With over 40 million Oromos scattered throughout Ethiopia and neighboring countries, the vast population of caregivers and potential caregivers have been used as a strategy to succeed in the implementation of public health campaigns and programs. For example, the estimated 40,000 Oromo Ethiopians that reside in the state of Minnesota alone has accumulated their financial resources to build and renovate large community centers, churches/mosques, and political organizations (Tigue 2016). In return, these community centers, mosques, and organizations have thousands of congregations/members who are also caregivers, doctors, and engineers. The Eritrean community picnic I attended in Fremont, California was an instance where a congregation of professionals who brought their children and other loved ones to participate in engaging activities.

An Analysis of Caregiving, Public Health, and Health Gaps among Eritrean and Ethiopian Healthcare Practitioners

Eritrean and Ethiopian health practitioners have analyzed how caregiving practices and strategies can address concerns with public health systems and health gaps in their respective

countries and the Diaspora. In the previous sections, medical anthropological literature and data indicates how a mixed model of Western biomedicine and Eritrean and Ethiopian traditional caregiving has been portrayed as beneficial to the lives of vulnerable men, women, and children. The improvement in healthcare infrastructure in once abandoned, isolated regions of Eritrea and Ethiopia and the development of public health regimens to train future healthcare practitioners are some of several examples of significant strides in the fight against chronic diseases/illnesses. However, problematic gaps in U.S. public health systems continue to impact Eritreans and Ethiopian diasporic populations. The lack of culturally sensitivity programs, holistic approaches to healthcare, insurance affordability, and a diverse representation of practitioners are among the most critical health gaps that have affected immigrants, such as Eritreans and Ethiopians in the Diaspora (Loue and Sajatovic 2011, 136).

Culturally sensitive programs that focus on the attributes, norms, and values of healthcare patients have the potential to bridge the communication gap between healthcare practitioners and their subjects. Because some immigrants/migrants to the United States have not been exposed to, or haven't accepted biomedical healthcare institutions and programs, some health practitioners have complicated relationships with immigrant populations (Hahn and Gaines 1985, 36). For example, Fadiman documented the case of the Hmong child, Lia, who had been diagnosed with epilepsy. Her parents practiced shamanic healing, which rejected a potentially lifesaving surgical procedure. (Fadiman 1997, 29). Just as in the medical case of the Hmong child, some Eritreans and Ethiopian immigrants have been unable to successfully communicate their overall concerns and questions to their doctors and nurses. The inability for some health practitioners to attempt to understand the cultural perspectives of their patients remain to be a roadblock in the evolution of Western public health systems. This was expressed by Fadiman who described the important role

anthropologists had as cultural liaisons between the Hmong family and the hospital that treated Lia. Fadiman stressed the danger of American medical doctors forcing patients of different cultural backgrounds to comply with health-based regimens and protocols that go against one's traditional medical or holistic beliefs. (Fadiman 1997, 51).

Eritrean and Ethiopian practitioners, many of whom come from destitute, isolated and impoverished areas of their respective nations, have promoted holistic approaches to public health/medicine. Because many countryside residents of Eritrea and Ethiopia have long been neglected access to nearby hospitals/clinics, some have solely relied on alternative/traditional medicinal plants and herbs to address their health issues. Examples of ethnobotanical medicinal plants that many Eritreans and Ethiopians continue to use for symptoms of chronic illnesses /diseases are herbs, seeds, and tree species (Aberra 2014, 40). As such, the sudden exposure to biomedical surgical instruments, medications, and protocols half a world away has been a culture shock to some Eritreans and Ethiopians who grew up in rural parts of their nations. To make matters more complicated, even when biomedical institutions are suddenly accepted by rural Eritreans and Ethiopians, the lack of ethnic/cultural representation among healthcare practitioners are problematic to these two demographic groups.

The lack of diversity or cultural representation in the biomedical field is not only responsible for communication gaps between practitioners and patients, but the ability to make significant progress in the healthcare field (National Academics of Sciences 2018, 126). Eritrean and Ethiopian immigrant populations have long been served by their own people, and the forced migration out of their countries to the U.S. have resulted in a dramatic shift in the way they interact with non-Eritreans and Ethiopians. Despite the fact that urban Eritrean and Ethiopians were willing and comfortable enough to discuss their health issues with American practitioners,

many rural folks had difficulty adjusting to their new reality in the states. Therefore, after migrating to the United States, some Eritreans and Ethiopian Oromos hesitated to visit a local hospital or clinic if any health problems occurred. To make matters more complicated, Eritrean and Ethiopian Oromos faced socioeconomic barriers concerning access to feasible healthcare insurance in the United States.

Healthcare insurance in the United States has not just been a major social, economic, and political crisis among Eritreans and Ethiopians, but a policy that transcends across every demographic group in the nation. Whether a resident is a working-class Eritrean or Ethiopian, or White American business owner, the issue of gaining affordable healthcare insurance that addresses one's particular chronic illness/disease is among the most contested issues within the United States. Chronic diseases such as cancer, heart disease, and dialysis for kidney failure have cost patients and their families subordinate sums of money that range from thousands to hundreds of thousands of dollars. Even if a patient had "decent healthcare insurance" to manage or treat a chronic disease, most healthcare insurance companies don't fully cover lifesaving treatment plans such as heart, kidney, and liver transplants. Therefore, patients have died from chronic illness and diseases simply due to the lack of affordable health insurance (Park 2009).

The historic breakthrough of "Affordable Care Act" aka "Obama Care" in 2010 have had a positive impact in Eritrean and Ethiopian diasporic communities seeking quality healthcare insurance. For the first time in U.S. history, Americans with pre-existing conditions could not be turned away by American healthcare companies and doctors (Pant 2017, 42). This greatly affected the lives of impoverished and working-class immigrants in the United States, many of whom include Eritreans and Ethiopians. Although several policies of Obamacare continue to be flawed (premium costs, ability to choose any healthcare provider, etc.), some people have been

able to live longer as a result of the management and treatment of their pre-existing health conditions. Thus, certain policies of Obamacare, particularly the requirement of treating patients with pre-existing health conditions, may possibly be beneficial to immigrant populations such as Eritreans and Ethiopians.

Summary of Background Literature

The practices and strategies of Eritrean and Ethiopian caregiving have resulted in significant praise among the Eritrean diasporic population. After generations of living in war-torn regions with no apparent hope for peace and prosperity, many Eritreans continue to embrace and apply traditional forms of caregiving. This is mainly due to the perception of caregiving practices as the heartbeat of Eritrean national and cultural identity, as well as the moral fabric of Eritrean society. In other words, caregiving is just as significant as the values of religion /spirituality, family, and economic reciprocity. After 40 years of settling in the United States, Eritrean and Ethiopian Oromo immigrants have learned to co-exist with American norms and values in order to achieve the reasons why they immigrated to the Western world in the first place: economic/political stability, healthiness, and opportunities of social mobility.

Thus, the literature in medical plurality strongly supports the argument that one's upbringing, place of origin, social status, and belief systems is significantly tied to their standard of living, quality of care, and wellness. In one of the most diverse nations in the world, Black people of different age, nationality, and ethnic backgrounds are continuously struggling to get their voices heard due to hegemonic factors that either reject or are reluctant to advance their diverse health-based needs, concerns, and strategies across the U.S. (Bailey 2002, 37). Part of this struggle is attributed to the fact that, while African immigrants have common strategies and agendas to improve their health conditions, they also have distinct belief systems to counter

negative experiences with chronic diseases and caregiving. For example, based on the above literature, Eritrean and Ethiopian immigrants identified hegemonic policies, ideals, and systems as the epicenter of their social burdens and experiences with illnesses and diseases. However, their perspectives on how to deal with the effects of socioeconomic inequality, caregiving, and lack of access to healthcare services is varied due to inherited cultural beliefs and habits. Overall, it's important that medical anthropologists focus on sustainable, multicultural health models, such as cross-cultural care, in order to successfully narrow the wide gaps between ethnic groups and medical institutions, as well as fulfill their health-oriented expectations.

Overview of Literature: Personal Influence, Approach, Shaping of Research Questions, And Community Deliverable

The peer-reviewed literature was approached from a cross-cultural anthropological perspective, as the overall intention of my graduate project was to cover the health problems and public health systems in these particular communities in a transparent and authentic manner. The more I thoroughly read and collected literature from the above books, articles, and statistical data sources, the more I realized how medical anthropology was significant to the advancement of healthcare, caregiving practices and strategies, etc. Although a lot of Western studies and journals on public health continue to be dominated by biomedical perspectives, medical anthropological scholars have contributed extensive knowledge which aim to improve the health and well-being of vulnerable communities. Therefore, reviewing literature on the social origins of the distribution of chronic illnesses and diseases among marginalized ethnic societies, motivated me to approach my project on the Eritrean and Ethiopian Oromo diasporic communities in a similar way. To elaborate, one of the main goals of this project is to contribute

to a body of medical anthropological knowledge that will ultimately benefit these particular individuals, their loved ones, and communities.

My approach on studying, analyzing and evaluating the caregiving practices and strategies, as well as the prevention, management and treatment of chronic illnesses/diseases of these ethnic groups were shaped by the moral/ethical guidelines of medical anthropology.

According to the code of ethics of the AAA, anthropological practitioners should respect the human rights and privacy of research subjects on the part of the researcher; in the field of anthropology, the infliction of intentional harm and wrongdoing is not only frowned upon, but a reason to blacklist a member of the AAA who does commit such an act (Code of Ethics 1998). I made every attempt to contact my professional practice with this pro-humanitarian mindset. Prior to beginning this health project, I had to think of what the purpose and agenda would ultimately be, so that the findings of my research would become sustainable.

I approached my research questions on the premise of how this project could raise awareness on the importance of caregiving and coping practices to treat chronic disease prevention, management, and treatment. That said, I didn't want for this to be a graduate project where I could contribute to original research and submit it for the basic purpose of graduating with a master's degree. I was adamant on ensuring that my project would serve these communities in a way that would bring joy and comfort to a topic/conversation that can be emotionally draining and personal; and for that to occur, my research questions would have to reflect on the subjects of medical systems, coping mechanisms with regards to wellness, and caregiving. Rather than applying a one-sided perspective and analysis on a disciplinary field as complex as public health (biomedical or traditional), a holistic approach is one of the best strategies to make advancements in the health and wellness of human beings. Also, this approach

influenced my community deliverable, which was further explored during my semi-structured interviews and focus group sessions.

The community deliverable of my project was influenced by a mixture of several factors: the establishment of an existing strong relationship between myself and the Eritrean community, the curiosity of cultural similarities and differences of neighboring ethnic communities (Ethiopian Oromos), and the stigma of revealing personal health issues. In order to address the social stigma of disclosing chronic illnesses/diseases in traditional Eritrean and Ethiopian societies, I had to first gain the trust and respect of the latter community group. Once I gained their trust, intimate details and personal stories that were discussed during my participant-observation research, semi-structured interviews, and focus group sessions allowed me to pinpoint a catalogue of community-based deliverables. These deliverables ranged from health literacy projects to empowerment programs, such as a potential “Health Awareness” day, or month.

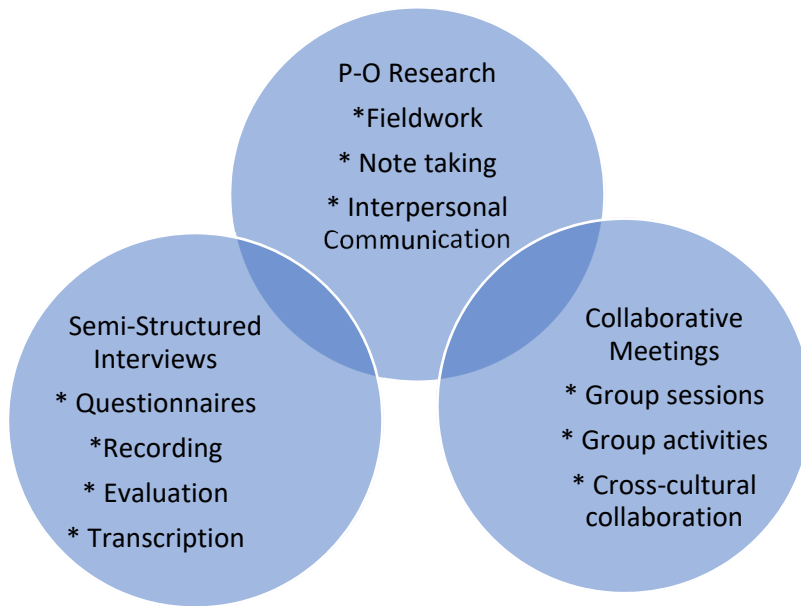
CHAPTER 3

METHODOLOGIES

I designed my methodologies to collect data on my research questions in order to facilitate community evaluation and encourage community engagement. Because the center of the research is on my project, the below methodologies will reflect on how my overall research served Eritrean and Ethiopian Oromo communities in the East Bay. The heart of my work occurred after the conclusion of my qualitative research, when community engagement between these two demographic groups were productive and successful. The combination of my participant-observation research, semi-structured interviews, and collaborative group meetings helped serve that engagement, as I focused and applied on an anthropological approach to better understand their community health-based needs, wants, and goals. Examples of such approaches included abiding by moral/ethical guidelines that respected the privacy and belief systems of the participants, cross-cultural communication/competence, and cultural awareness on caregiving practices and strategies that seek to mitigate chronic diseases and illnesses.

To answer my three research questions, I described variations in medical beliefs and practices, using carefully worded semi-structured interview questions and participant observation research to enhance comparability. I needed to identify the overarching strategies people use in managing chronic illnesses; information best captured through semi-structured interviews. Finally, I documented how people in these communities seek and receive care. I captured this information through in-depth interviews, group sessions and participant observation. In the following sections I elaborated on the data sets I captured with each technique, and my strategies for sampling within the two communities. I also illustrate components of data gathering and dissemination via a Venn Diagram.

Venn Diagram illustrating components of Data gathering and dissemination



Sampling:

The Eritrean and Ethiopian communities are only two among many African immigrant communities in the Bay Area, and they provided distinct perspectives that illustrate diversity. Because caregivers are primarily female, and the family is often the beneficiary to caregiving, primarily sampled women in these communities, but also allowed for variation between families due to life situations. My introduction to this community was facilitated by my father, a longtime church member and musician at the Good Shepard Lutheran Church in Hayward. My own participation in these networks helped build rapport; and working in these community centers also provided access to sites for participant-observation, another opportunity to meet and recruit potential interviewees and participants for my semi-structured interviews.

My sampling strategy overall was purposive, targeted to the specific immigrant communities in the East Bay, and caregivers within these communities. Therefore, purposive sampling, based on the past history of chronic disease, caretaking and health seeking behaviors,

prioritizes the comfort and personal welfare of Eritrean and Ethiopian participants involved in my research. These participants were recruited through cluster sampling (by traveling to where people cluster around community spaces) at the Eritrean Civic Cultural Community Center, and Eritrean and Ethiopian Oromo Church; both of which are located in the East Bay, California. I applied this specific form of sampling as a way of gaining trust, rapport, and healthy dialogue among individuals that coped with extremely sensitive and personal illnesses (Boyle and Schmierbach 2002, 199). While I used cluster sampling to structure my initial introductions to this community, my participant-observations was geared toward those individuals who are managing chronic disease or caring for those who are ill. However, that practice was situated in a broader sample to understand the nature of social relations in the community. As I observed and participated in the activities of these centers and recruit initial participants for interviews. Once I recruited interested interview participants, I expanded on my potential research pool by asking participants to refer me to other potentially interested parties.

Sampling was divided among the following three categories: caregivers, adults with chronic diseases, and community leaders/organizers. In each category, 8 participants were chosen for interviews and community gathering sessions, totaling to 16 interviewees. I interviewed 8 Eritreans and 8 Ethiopians. Although these two communities clearly have distinct belief systems, they also have cultural beliefs and practices that overlap due to geographic proximity. Recruitments was based on reaching a diverse range of Eritrean and Ethiopian participants that considered the following: gender, language proficiency, age, socioeconomic status and neighborhoods within the general East Bay area.

Format for Semi-Structured Interviews

My questions are centered on topics that range from personal backgrounds and experiences to caregiving strategies and practices, as well as culturally sensitive questions that would allow the opportunity for interviewees to open up and be comfortable. As a young interviewer interviewing older people, I felt the need to be extra cautious with my approach, and the format of my questions due to the overall sensitivity of discussing chronic diseases and health-related issues. It is important to note of the rarity in both Eritrean and Ethiopian Oromo culture for a young man to not just discuss public health issues with an older individual, but to interview them about highly intimate details about illnesses and diseases. Therefore, the format of my questions center on opening the interview dialogue with easy-going questions (place of birth, family background, etc.) and depending on the success of the interview, the escalation of harder, more personal questions was asked. Fortunately, each of the 16 interviewees were comfortable to the point that information on their life and health history weren't left out, and that most of their answers were detailed and concise; critical details on one's health history and coping mechanisms of a chronic illness/disease were some examples of intimate questions asked during the interviews.

Participant Observation

Participant observation requires a thorough documentation of interactions between unfamiliar and acquainted individuals clustered in a particular social environment (DeWalt 2011, 220). My observational research included actively participating in Eritrean and Ethiopian church gatherings, community meetings, as well as documenting critical details of each interaction and occasion. I attended the following two important cultural events held by each immigrant group over the course of six months (June- December 2019): the annual Eritrean Festival in Oakland,

California (August 10th), and Ethiopian Oromo Thanksgiving Potluck in Hayward (November 23rd). I also attended weekly Eritrean and Oromo church services and picnics throughout the Bay Area which was extended as an invitation from my Ethiopian and Eritrean peers and acquaintances. Observational notetaking and field notes of these relevant events were crucial to my participant research (Goldman 2013, 2). From casual conversations with individuals at an Eritrean and Ethiopian fundraising event to documenting cross-cultural interactions among clustered groups and acquaintances, my role was to be actively involved in discussions with a wide range of individuals. Overall, my exposure and professional experiences of participant-observational research and ethical principles better prepared my participant observations and semi-structured interviews.

Weekly Church Gatherings

On a Sunday in August 2019, I decided to introduce myself to the Ethiopian Oromo Lutheran Church in Hayward, California. A few minutes prior to that week's sermon, I met the head pastor of the church and a few members of their congregation. After introducing myself, I informed the pastor that my father is a choir musician at the Eritrean Lutheran Church (which is the same location of the Oromo church), and the gentleman was delighted to meet me since he met my father in a few church gathering occasions. This would be a pivotal point in quickly gaining some trust and support from members of the Oromo church, once I explained to them about the goals and intentions of my graduate research project.

In the middle of the sermon, the pastor asked me to come forward and explain my research project to the congregation. As I nervously walked down the aisle of the church, the pastor embraced me and I went ahead to confidently discuss my graduate project. The reaction of the congregation was extremely warm and welcoming, which would be one of many signs that

Ethiopian Oromos would happily participate in my semi-structured interviews and group sessions. After the conclusion of the sermon, the pastor and his wife and children invited me to have tea and pastries in the premises of the church. Some members of the congregation also joined me for a lengthy conversation on what led me to choose Ethiopian Oromos as a demographic group with regards to my anthropological project.

Several weeks later, I returned to the church in Hayward for another sermon. After the end of the service, a member of the church, an Ethiopian Oromo community leader and scholar, approached the congregation to help with fundraising efforts to transport medical equipment to Ethiopia. He explained that health facilities in the Oromia region of Ethiopia are quickly deteriorating due to the growing civil unrest and violence that has plagued the country for decades. As a result, tens of thousands, if not millions of Oromos and other ethnic populations have succumbed to treatable chronic diseases, such as diabetes, cardiovascular disease, and even early-stage cancer. The goal of the fundraising campaign was to raise more than \$80,000 nationwide to export new medical/surgical instruments and equipment, such as infusion pumps, syringes, cardiac pacemakers, and even simple devices like thermometers. The discussion of his fundraising public health campaign was perfect timing to mention about the importance of community health advocacy in my graduate project. I elaborated on how such advocacy can raise awareness on the importance of cross-cultural caregiving practices.

When caregiving was brought up, some church members were curious as to what I meant by the term; I defined caregiving as an individual that takes on the role and responsibility to care for someone with an illness or disease. I also mentioned that a caregiver can either be a parent or professional health practitioner; that a caregiver doesn't have to be paid or certified to be one. After my explanation, many of the church members seemed intrigued, yet confused on how a

young, male and American-born researcher could possibly be interested in caregiving, especially because it is a female-dominated field. Overall, this specific conversation became an opportunity to establish myself as an anthropological researcher who is genuinely interested in the well-being of the Oromo people, and not just someone that will exploit their stories, ideas, and belief systems for his own research purposes.

Subsequent weekly meetings at the church quickly built up even more trust and rapport, which eventually helped me find Eritrean and Ethiopian Oromo interviewees for my semi-structured interviews. However, there were some challenges with my initial approach to find volunteers to discuss their health issues, specifically those with chronic illnesses/diseases. When I first informed the pastor of the church and other members of the church that I would need to interview 8-10 participants, some reactions were enthusiastic and warm, whereas others were skeptical and awkward. Even when I reassured that all of the information recorded, collected, and transcribed from the interviews would be confidential and anonymous, some were hesitant to go ahead and agree to be interviewed. However, I remained respectful and understanding, since I was culturally aware of how rare it is for a young, American-born researcher to ask intimate questions and details regarding health issues among older Eritreans and Ethiopians.

The church members that were enthusiastic and curious to know more about the process of my semi-structured interviews ended up either being interviewees or connected me with people who I would eventually interview. Luckily, the church had many people who fulfilled the criteria of my semi-structured interviews, which was to interview community leaders, health practitioners, and individuals with chronic illnesses/diseases. By late October 2019, four Ethiopian Oromos and Eritreans volunteered to be interviewees, with two of them being pastors of the church. As I attended more church sessions, prominent community leaders and

practitioners (mainly female nurses) would approach and commend me for my research efforts, which were great opportunities to ask for interviews. Lastly, male and female Eritrean and Oromo caregivers expressed their excitement of participating in my semi-structured interviews and stressed to not worry about asking sensitive and personal questions with regards to aspects of caregiving. We also discussed the idea that just because I can make a decent living as a healthcare qualitative researcher in the United States, does not mean I can't simultaneously "give back" to vulnerable populations and communities in and outside Eritrea and Ethiopia.

Eritrean Festival

The annual Eritrean Festival was held from August 9th-12th, 2019 in the Santa Clara County Fairgrounds in San Jose, California. Outdoor vendor booths, fashion shows, educational programs, and children playground areas were among the main attractions of the festival. On August 10th, I participated in a conversation with three Eritrean and African American anthropologists (one of whom was a medical anthropologist in a PHD program) on the development of future educational programs for Eritrean diasporic communities. These educational programs revolved around the implementation of applied anthropological theories and methods regarding health literacy and community health programs.

The main topic of our hour-long conversation was on the importance of having more Black/African anthropologists tell the stories and cultural experiences of other Black/African research subjects. With that being said, they stated their opinion that I being a Black applied anthropologist contributed to the openness and transparency of the Eritrean and Oromo participants involved in my project. We also discussed how a long history of mistrust and skepticism among Black demographic groups have caused some members of those communities to refrain from participating in ethnographic projects led by non-Black anthropologists. I left the

discussion forum realizing that maintaining trust and transparency among my research subjects is essential for any future community health project to be sustainable. As I elaborated on how this graduate project was about improving community health and caregiving practices and strategies, they were keen on following up with another community-gathering session. After the conclusion of our conversation, we exchanged contact information and went about to participate on the rest of the cultural festivities.

We also discussed on how cultural experiences of coping with and caring for chronic illnesses, as well as receiving care among Eritrean and Ethiopian Oromo communities can be explained and interpreted by a research participant in several different ways. To elaborate, participants of this discussion forum expressed that the more a participant or interviewee is comfortable around an interviewer, the more likely he/she discloses concrete details about their personal experiences without having to feel pressured. On the other hand, if an interviewee is not completely comfortable during the moment of an interview, the interviewer will most likely not obtain significant details about the topic at hand. I kept the above in mind with each of my future interviews, as I aimed to gain as much information on one's unique experience with caregiving practices and strategies as possible.

Oromo Thanksgiving Potluck

The Oromo Thanksgiving Potluck was an annual event that occurred the Sunday before Thanksgiving, on November 24th, 2019. The potluck was a community dinner hosted by the Good Shephard Lutheran Church in Hayward, California by Pastor Temesgen at the conclusion of the day's sermon. Prior and during the potluck, I engaged in conversations with members of the congregation who had work-related experience in caregiving and/or public health as health practitioners. The conversations were mainly on the significance of cultural festivities and

ceremonies, such as Thanksgiving potluck in the Oromo community. For instance, one person highlighted how an Oromo version of “America’s Thanksgiving” is celebrated yearly every September, bringing tens of thousands, if not millions of Oromos together at a pilgrimage site located in the region of Oromia. Oromo Thanksgiving, known as Irreechaa, is the most important holiday in Oromia (ethnic region in Ethiopia) who commemorate the contributions and lifestyles of their ancestors (Cox 2016, 120). A community leader mentioned that Irreechaa is a yearly reminder that Oromo Ethiopians can achieve unity, regardless of the social hardship and turmoil they’ve faced over the past centuries.

Once the table was prepared with food and beverages, I introduced myself to members of the church I hadn’t met in previous weekly gatherings by the pastor. Some of the members I met were also nurses, which helped to get more interviewees for my semi-structured interviews. They were all extremely receptive of the purpose of my graduate project, informing me that they hadn’t met a young researcher interested in caregiving practices and strategies. After a brief conversation with members of the church, over 20 individuals gathered around the table to prepare to feast on over ten varieties of food that ranged from turkey and mashed potatoes to ethnic Oromo food.

As men, women, and children sat around the table, the pastor gave a brief speech in both English and Oromo on the subject of “giving thanks and being thankful” for those with good health, a wonderful and supporting family, and a roof over their heads. Later on, during the feast, the pastor translated what he said in Oromia; he mentioned the long history of human suffering and agony among the Oromo people in Ethiopia and how many Oromos have gone through hellacious journeys to finally arrive in countries such as the United States. Fortunately, most Oromos from this particular church have successfully graduated from college, established

careers, and decent-paying jobs that provide for their families at home and abroad. Many felt the opportunity to escape from many of their grievances in Ethiopia was enough reason to be thankful on this particular day. Unfortunately, millions of their countrymen and women in the Oromia region of Ethiopia remain trapped in a country that has faced numerous ethnic conflicts, Disfranchisement/dislocation, and governmental theft of natural resources.

The Oromo Thanksgiving Potluck continued for 4 hours, ending at around 11 p.m. in the hallway of the church. After several courses of meals, desserts, and great conversations, most of the church members were ready to go home, while some remained to help me find more interviewees at the church. Their level of generosity and kindness allowed me to find more semi-structured participants, as well as network with other church members I conversed with earlier. We then exchanged numbers and social media information, before I left the church and went on my way home. Overall, the potluck was a family-like affair that introduced me to the beautiful and rich cultural customs of the Oromo people, and left me with the impression of wanting to participate in many more Oromo festivities in the future.

Community Picnic- Inside Approach

An Eritrean engineer who I ran into at a church community picnic in Fremont, California encouraged me to utilize my skillset and knowledge on caregiving and chronic diseases/illnesses for the betterment of my community (Eritrean), as I have the advantage of growing up in an economically developed nation like the United States. He also mentioned that the tremendous lack of healthcare technology and services in African nations, as well as low earning wages, led to the migration of many African health practitioners to Western countries such as the United States. As a result, a large vacuum of healthcare workers remains to be the reality in countries such as Zimbabwe, Eritrea and Ethiopia; this is a reality that affects the livelihoods of countless

Africans with life threatening health conditions. Our conversation then transitioned to how young Eritreans, Ethiopians, and other minorities, including myself, can help mitigate these issues by heavily investing in the future of our ancestral homeland. We also discussed the idea that just because I can make a decent living as a healthcare qualitative researcher in the United States, does not mean I can't simultaneously "give back" to vulnerable populations and communities in Eritrea.

Semi-Structured Interviews

My semi-structured and in-depth interviews elicited and documented information about family composition, including family members not residing in the East Bay, the range of dietary options available and used, and their cultural beliefs about the chronic illnesses experienced. In addition, I asked about specific stories of caregiving, and the experience of chronic illnesses, as a way to understand coping strategies. I asked participants to discuss their sociocentric networks of care. These networks are areas that can provide a detailed, cross-cultural perspective on medical plurality, and how medical anthropologists have implemented programs that were effective to their target populations. These questionnaires enhanced comparability, while interviews give context and provide the stories that humanize these interlocutors. (Baer and Weller 1989, 102).

An Eritrean female caregiver and nurse with over 30 years of public health experience stated the following on humanizing interlocutors of access to healthcare services when I interviewed her: "In America, it's different. In our country (Eritrea), you don't have to pay anything. You simply go to the hospital and you get treated." This was a reference to a life-threatening scenario when the interviewee's sister became dehydrated in one of the most humid cities in the Horn of Africa (Massawa, Eritrea) and almost lost her life. When she was rushed to the hospital, she received immediate treatment and eventually recovered; when the interviewee

asked the nurses how much the treatment cost, the latter replied by saying “Nothing.” This is a completely different reality in the United States with a privatized healthcare system where millions of citizens have been in debt paying for healthcare costs (Rosenthal 2018, 58).

Semi-structured interviews consisted of recording, transcribing and evaluating conversations from each of the 16 interviewees; these transcripts were verbatim. However, prior to these interviews, I briefly discussed the moral and ethical obligations of participant-observation research, although I would reiterate such remarks in my research introduction. This way, I helped build a positive and stress-free atmosphere prior to the interviewees answering questions that can potentially be overwhelming and emotional. The evaluation of these questions also developed descriptive background questions such as where in the household one cares for someone with a chronic illness and what caregiving items and products are applied to cope with that illness. Those descriptive questions that pertain to caregiving practices then led to asking each participant if they would give me a tour of their homes (one of several places where I conducted my semi-structured interviews), and if they would map out where they store medical supplies and provide care (sketches/drawings).

These interviews were conducted in participant’s homes, as well as private rooms located within community centers and faith-based churches to affirm that ethical dilemmas will not occur while audio recordings are in session. However, there were challenges in some interviews regarding interruptions from passersby. The interviews also linked with participant observations, particularly the annual Eritrean festival in August and the Oromo Thanksgiving Potluck in November. Semi-structured and in-depth interview methods were geared toward eliciting personal illness narratives that critically detailed the medical beliefs, practices, challenges and coping mechanisms of caregiving. Interviews also included perspectives of Eritrean and

Ethiopian female caregivers that experience the social burden and economic challenges of simultaneously taking care of their loved ones while managing their own health issues.

Collaborative Meetings/ Group Sessions and Feedback

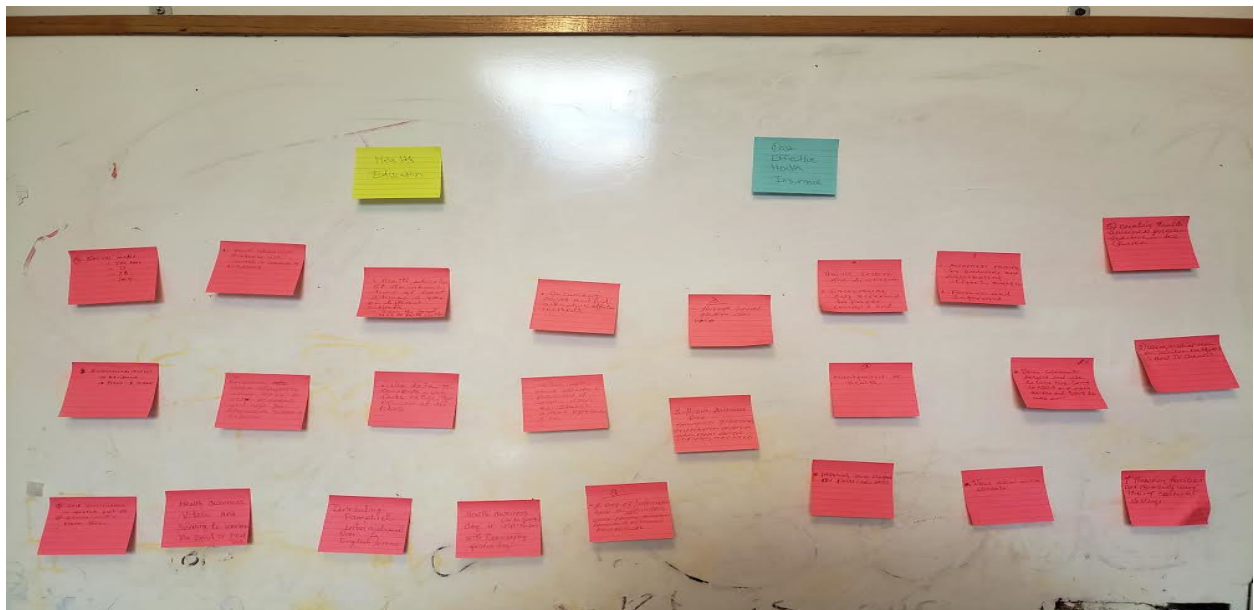
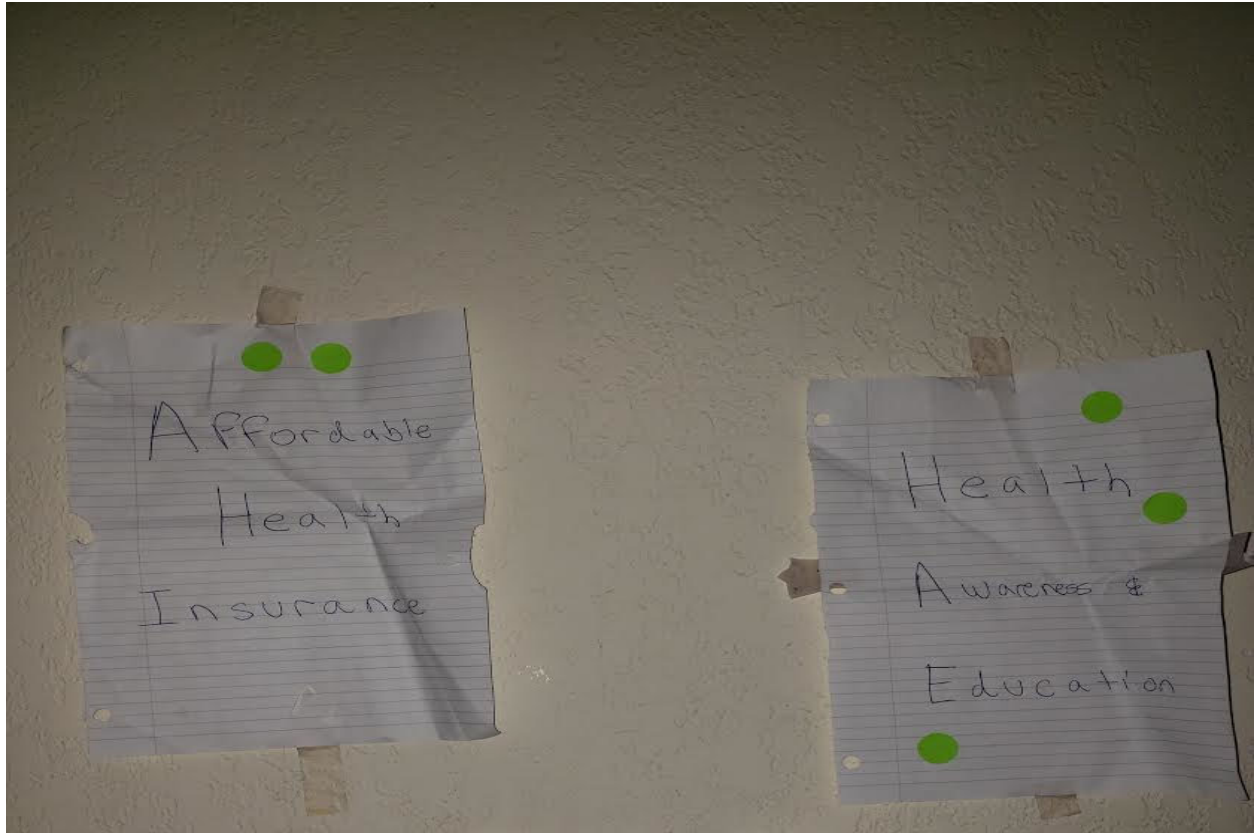
Two group sessions were split among the 16 interviewees and were conducted the week following the conclusion of my semi-structured interviews. The purpose of these group sessions were to cover the following categories: project deliverables, common and differing findings among my 16 interviews, and critical thinking activities. The purpose of the critical thinking activities was to engage the participants, as well as provide opinions on potential project deliverables that would positively impact Eritrean and Oromo diasporic communities. The way the first activity worked was that each participant would move around the room and place two color coded (green) sticky tabs on 2 pieces of paper that represented two, of what the participants personally believed, were the most prioritized health issues/concerns in their community. There was a total of five pieces of paper placed on the board in the room (each piece of paper representing a health theme). Five of the most common health concerns I found from transcribing the 16 interviews were: Health Awareness/Education, Exercise/Diet Regimens, Cross-Cultural Communication, Cost-Effective Health Insurance, and Community Involvement/Networking.

The first group session occurred in the afternoon of Sunday December 1th, 2019 at a private room within the Shephard of the Hills Lutheran Church in Hayward, California. The private room had a conference-style table with more than 12 chairs and a chalkboard. At approximately 1:15 p.m., eight Eritrean and Ethiopian participants gathered and got acquainted in the room, a few of them introducing each other for the first time. Once everyone was settled, I began the group session with a brief introduction and later explained the purpose of the session,

as well as the activity. Afterwards, the participants enthusiastically placed their color-coded sticky tabs on their two pieces of paper. The two health issues/themes that were voted on the most were 1) Health Awareness/ Education and 2) Exercise and Diet. These themes were further explored with a follow up activity that emphasized on what project deliverables would best address the two specific themes. So, I had each participant write down 3-5 project deliverables for each theme on dark green and blue-colored sticky tabs, which were later placed on the board.

The following are some project deliverables that were written and discussed on how to develop health literacy and community health campaigns in the Eritrean and Oromo church: teleconferences, social media outreach (including YouTube videos), translation books with regards to health literacy and education (from Tigrinya to English and vice versa), and a “Health Awareness Day” where health practitioners and researchers, including myself, organize a health conscious event that targets Eritreans and Ethiopian Oromos of all age groups. After roughly 25 minutes of discussing project deliverables, the group session concluded with a committed and optimistic group of people that were looking forward to my graduate project coming to fruition.

Collaborative Group Meeting Topics and Project Deliverables Discussed



The second collaborative meeting occurred the following Sunday on December 8th, 2019 in the same room where the first group session was held in the Good Shephard Lutheran Church. The group session began at approximately 4:30 pm, following the conclusion of the Ethiopian Oromo sermon. 8 Ethiopian Oromos and Eritreans gathered in the conference-style room to participate in the same format regarding discussion and activity sessions from the previous group session. However, unlike the previous session, the two most popular health issues/themes that arose from the activity were: 1) Cost-effective health insurance and 2) Health literacy/education. These community leaders, health practitioners, and those suffering from chronic diseases all elaborated on how community activism is synonymous to the improvement of health services, as well as the mitigation of chronic illnesses/diseases.

Afterwards, the “project deliverable activity” resulted in an intimate conversation and discussion about these following areas: social and politically conscious activism, social media outreach, health awareness, etc. Some of the following project deliverables were pinpointed and evaluated throughout the conversation: fundraising campaigns regarding the development of community health services, health practitioners collaborating with community organizers, and utilizing social media to create groups and promote ideas that address health disparities. Thus, patterns of project deliverables were found in both group sessions, which will make a future collaborative project more likely to occur in the Eritrean and Ethiopian Oromo communities.

An Oromo participant, a male nurse in a hospital located in Fremont, commented on the following regarding the need for more cross-cultural dialogue: “This is about sacrifice. Someone must be willing to sacrifice their time, effort and energy to teach others how to treat and manage chronic illnesses and diseases, mentally, physically, and economically. That person must be ready and willing to do it.” Prior to the above statement, an Oromo participant expressed: “We

all (Eritreans and Oromos) need to identify health issues. Whether that's through counseling, or whatever it may be...alternative methods that we can mutually share. Then we can have the problem corrected. Within the modern system (biomedicine), they're two or three different ways where you can correct a health problem." In conclusion, both group sessions/collaborative meetings ended with tremendous success, and many members in these particular communities have been motivated to participate in more community-oriented events and collaborative programs/projects. Overall, these data collection strategies and methods helped develop a roadmap to my data analysis.

Data Analysis

Once I elicited illness narratives from each Eritrean and Ethiopian participant that represents their respective immigrant group, I documented on commonalities and differences between and within each demographic group; I noted overall patterns of success, contention and interactions with healthcare practices and services. My intention was to provide a critical perspective of their needs, concerns, strategies, gender conflicts, and how bridging the cultural gap between these communities can improve their social conditions and personal experiences of health inequalities. I was able to identify the cultural differences and meanings of each immigrant population. Identifying cultural differences of the two immigration populations were the following: Eritrean immigrants relied on Eritreans from all linguistic, ethnic, regional backgrounds for a social safety net and support system, whereas Oromo immigrants solely relied on Ethiopians with an Oromo background. An example of identifying cultural meanings is how these immigration groups emphasized the need to incorporate traditional/ancestral ideals to modern day life. Such examples were crucial to my framework of post-research community gathering sessions. Overall, the goal of my data analysis was to relate the data variables and

methods to my original research questions. Therefore, I looked for patterns and distinctions in my qualitative data to generate results regarding critical details of my data variables and analysis.

The focal point of my data analysis is in the following categories that link back to larger ideas of data variables/techniques of transcribed semi-structured interviews and participant observation research. These categories are descriptive statistics of the region and of the participants in my project, ethnographic research (semi-structured interviews) and observational field notes. The transcribing of thematic coding, textual data from observational field notes, and information gathered from ethnographic research identified culturally- shaped explanatory models of chronic illnesses in these particular immigrant populations. Therefore, explanatory and complementary models of these notions yielded a comparative analysis of Eritrean and Ethiopian Oromo cross-cultural perspectives of medical belief systems and caregiving practices (Bollig and Finke 2014, 39).

Thematic Coding

Code Name	Description
Individualism	Taking care of oneself is a common cultural practice in the Western World
Family	Family-oriented ness is typical of Eritrean and Ethiopian social structures
Community Collectivism	Community is expected and obligated to take special care of a community member with a chronic illness/disease
Politics in Healthcare	Profit and cultural differences are identified as social burdens in caregiving of patient
Health Insurance	Requirement of health insurance to seek care in the U.S. is portrayed by Eritrean and Ethiopian immigrants as a problematic practice
Collaboration	The need for cross-cultural collaboration strongly resonates among Eritrean and Ethiopian interviewees
Chronic Illnesses/Diseases	The distribution of chronic illnesses and diseases is an ongoing concern among Eritreans and Ethiopians who feel that diseases are disproportionately impacting their communities more now than ever before.
Immigration/Migration	A physically and mentally exhausting journey was expressed by interviewees who immigrated to the United States in search for a better and potentially prosperous life.
Culture Shock	Once arriving to the United States, immigrants faced a complete culture shock upon witnessing overall American lifestyle.
Cultural Assimilation	Immigrants faced difficulty/hardship adapting to the United States
Cultural Acculturation	Immigrants were adamant on retaining their rich cultural norms and values while residing in the United States

Disease Management	Management of illness symptoms is key to survival; important to listen to general advice of healthcare practitioners (regardless of ethnic/cultural background).
Disease Prevention	Prevention of Chronic Illnesses and Diseases should be taught in academic settings and other fields
Biomedicine	Interviewees believe biomedicine has saved the lives of countless people from around the world, including themselves; however, there continues to be many flaws in the biomedical field
Alternative Medicine	Alternative medicine is important to prevent and manage many chronic illnesses, as they are natural, organic, and not prone to major side effects
Language	Language barriers upon arriving and even after years of residing in the United States, remains to be a major challenge of immigrants
Caregivers	Caregivers, such as midwives, herb/plant specialists, and spouses are the backbone to the health and well-being of Eritrean and Ethiopians.
Healthcare practitioners	Doctors, nurses, etc. should be praised, but also questioned with their line of work, as many interviewees brought up the concern of negligence and malpractice among such practitioners.
Hospitals/Clinics	The abundance and proximity of hospitals and clinics has been very beneficial/helpful to interviewees that grew up in remote villages and towns
Social/Cultural Spaces	Just as hospitals and clinics are used as locations for modern biomedicine, social/cultural spaces should be widely accepted as sites for caregiving practices and strategies. Examples of which are households, community centers, and even churches.

Based on the qualitative data I gathered from the participants of my 16 semi-structured interviews, a pattern of the following problems and concerns was pointed out: lack of access to quality and affordable health insurance, communication gaps due to language barriers, and lack of health educational programs in respective communities. Interestingly enough, both Eritrean and Ethiopian Oromo cultural perspectives/opinions on why and how these problems continue to occur in their communities were explained and elaborated in similar ways. For example, both communities strongly elaborated that the forced migration of their people to the Diaspora, such as the United States, was a traumatizing event that continues to affect the livelihoods of Eritreans/Oromo Ethiopians. I noticed when I asked many of the interviewees on their personal experiences of migrating to the United States, their body language, facial expressions, and explanations were hesitant and at times, emotional.

Dissemination: Post-Research Interactions and Community Gathering Sessions

A critical part of medical anthropological work is to facilitate community gathering sessions across immigrant populations with different and unique perspectives regarding public health. The study of Arthur Kleinman's "Illness narrative model" expands on the experiences of individuals in their respective communities, so that cultural patterns can be assessed and revealed in multiethnic communities (Kleinman and Benson 2006, 293). Although this particular model primarily centers on the complicated relationship between biomedical institutions and patients, it also emphasizes on how effective communication and cultural competence can improve community health issues (Kleinman and Benson 2006, 294). One particular question from Kleinman's eight questions that I used to facilitate a conversation is: "What do you think has caused the problem?" This question pinpointed what the interviewee identified as the social origins of their chronic illnesses and pointed to underlying issues of marginalization (Kleinman and Das 1997, 210). After the conclusion of my group sessions, I organized an open space to facilitate a conversation that connects Eritreans and Ethiopians in a way that they can see their commonalities and engage in potential collaborations that will be of benefit to all.

I then sent out invitations to community gathering sessions oriented towards individuals that range from community leaders, community organizers and caregivers. As a result, a diverse set of ideas, philosophies, and cultural backgrounds can bring forth a productive and healthy discussion regarding the nuances of caregiving and chronic diseases. This session will evaluate ideas and strategies of community-based intervention programs; examples include health literacy workshops, volunteer work, and surveys. Such programs can appeal to not just African immigrants living in communities throughout the Bay Area, but people outside the community that may be interested in working with this demographic. I facilitated the discussion of topics

that range from health-based strategies to cross-cultural concepts. The community session will also discuss alternative interventions, such as group activities and projects, that can improve public outreach and self-awareness. I also created a communication guide, so that representatives of a particular community do not feel isolated and disrespected while discussing about certain topics that may be perceived by some as culturally sensitive. Members of the community gathering session will be advised that their needs may be challenged by the needs of other African immigrant communities throughout the East Bay. The creation of the guide and the facilitation of intracultural and intercultural community discussions constitutes the deliverables in this project.

Future Collaborative, Community-Oriented Events Projects

The success of my two group sessions also led to a brief conversation about collaborative events with the Eritrean and Oromo Shephard of the Hills Church in Hayward, California. Community leaders, who both participated in the group sessions, have expressed their interests with utilizing my graduate project as a blueprint to develop multiple community collaborative events. Some explained how cost-effective services and resources, such as modern technology, can be fundamental for more Eritreans and Ethiopian Oromos to participate in conversations about community health and wellness. They've also explained how these open conversations can potentially break the social stigma of gender politics, and stereotypes of Eritreans and Ethiopians being reclusive and reserved with regards to discussing about chronic illnesses/diseases. As of February 2020, I am planning to arrange a specific date where community leaders and members can meet and discuss about community events other than the "Health Awareness Day" that is in the works for later this May.

Conclusion of Participant-Observation Interviews, Semi Structured Interviews, and Collaborative Group Meetings

After 6 months of participant-observation research, semi-structured interviews, and collaborative group meetings, I learned the following valuable experiences and lessons: to consistently be open-minded to ideas and opinions you don't necessarily agree with, allow participants to speak as long as possible without interrupting them, and being as professional and ethical as possible regarding the questions being asked. From a cultural perspective, I also kept in mind that as a young researcher interviewing and discussing sensitive questions to older individuals, being extremely cautious and respectful would be critical in getting the results I needed to have in order to complete my research. Fortunately, all of the participant-observation research participants approached the purpose of my graduate project with open arms and assisted me with any questions and concerns I had to make sure this project would be completed in a timely and accurate manner. However, that's not to say that obstacles and challenges of accessing participants didn't occur throughout this phenomenal journey.

The ability to access participants, most of whom were busy juggling full-time work and raising families, was one of several challenges I faced while conducting participant-observation research. Some of these participants, particularly single and widowed women, had to interrupt several conversations due to multi-tasking many responsibilities. This included answering phone calls in the middle of a conversation, chasing after their children, and leaving cultural events early. Despite all this, I remained patient and understanding, which inevitably worked in my favor as the participants eventually welcomed me to their homes after expressing their appreciation and gratitude of my overall professionalism. In conclusion, participant-observation

research has been one of the most rewarding experiences in my professional career and life, and I look forward to conducting many more in the nearby future.

CHAPTER 4

COMMUNITY PERSPECTIVES ON COMMUNITY HEALTH AND CAREGIVING

Eritrean and Ethiopian Oromo community perspectives on promoting community health practices and strategies are based on ideals that target active community involvement/participation, economic reciprocity, and humanitarianism. Based on the collection, transcription, and evaluation of the data collected from my qualitative research, both Eritreans and Ethiopians emphasized on how their people have a social and moral responsibility and duty to promote community health and wellness. For example, some participants of my collaborative group meetings stressed on the importance for community involvement in the diaspora, and not just “showing up” on an occasional cultural festival or church gathering. They mutually agreed that those suffering from chronic illnesses and diseases need a stronger and reliant support system in the community. Overall, the majority of these interviewees and participants highlighted that community leaders and members have just as much of a moral responsibility to promote public health as healthcare practitioners.

The roles and responsibilities that Eritrean and Ethiopian Oromo participants say members of their respective communities should focus on with regards to promoting community health and caregiving are the following: active participation in forums, meetings, and cultural events, informing the community on how to access local and convenient hospitals/clinics, and connecting individuals with chronic diseases/illnesses to health practitioners. Because of the few annual cultural events that occur in the United States, some of the participants stated that more people should participate in these festivities. In this case, more Eritreans and Ethiopians will have gathered multiple professional sources of public health-related information, which could potentially improve a loved one’s problem with chronic disease management and treatment.

These avenues/sources of public health information can be collected from booths, which are typically set up and scattered in Eritrean and Ethiopian soccer tournaments, festivals, etc. Because nearly every booth is dedicated to selling cultural merchandises, some community members have expressed the need for several booths to be dedicated to healthcare campaigns in future cultural events. Also, such booths can be utilized for economic purposes, in which allocated funds can be redistributed to low-income, marginalized Eritrean and Ethiopian communities.

For decades, economic reciprocity has been a fundamental outlet in the improvement of the health and wellness of members Eritreans and Ethiopians in the U.S. For instance, in many Eritrean households and businesses, a portion of one's annual income is distributed to other Eritreans living in dire circumstances; this typically includes recent immigrants/migrants, Eritreans with chronic illnesses/diseases, and people who've lost loved ones. In return, once the latter is able to financially recover; they're expected to compensate their lenders by either paying back what they owe, supporting their business by purchasing products, or fulfilling other personal favors.

The Eritrean pastor of Good Shephard of the Hills Church and community leader stated the followed regarding the aspects of reciprocity when he first migrated to the Bay Area: "I was able to find a church in a community of God where I would be able to be blessed, and then grow my faith in others. I was able to find people with the same worldview, social economy, background, upbringing, etc." In return, he eventually grew to be one of the most beloved pastors in the history of the Eritrean Lutheran community throughout the diaspora. Due to his phenomenal leadership, he single-handedly tripled the membership of participants in the Good Shephard Lutheran church in Hayward, California. Economic reciprocity is among the major

cornerstones of a thriving Eritrean and Oromo society, specifically abiding by principles of humanitarianism. Thus, the redistribution of individual and family wealth is a humanitarian practice that can address concerns pertaining to the management and treatment of chronic diseases/illnesses in Eritrean and Oromo societies.

Humanitarianism is an ancient philosophical belief system that continues to resonate in contemporary Eritrean and Ethiopian communities. After analyzing each semi-structured interview I conducted, all 16 participants underlined the significance of sympathy, generosity, and respect for people who suffer from a health issue. Also, some of the health practitioners I interviewed passionately stated their moral and ethical obligations to care for their patients, as if they were their own child/family member. An Eritrean female nurse with more than 10 years of experience in the Bay Area quoted the following during my interview: “A human being is a human being, and I see and treat them as such. Here in America, we have a long history of problems between African Americans, Caucasian folks, etc. and those problems are also seen in healthcare. Therefore, sometimes treatment plans differentiate between African Americans and Caucasian. But I don’t see it that way. I provide care the exact same way for an African American, Caucasian, etc.”

An Oromo male nurse I interviewed stated that: “I think the best strategy a health practitioner could implement in the workplace is showing their patient love and care. You know, mentally a lot of them (patients) are out of it. A lot of them! Some feel like life isn’t meaningful anymore following a diagnosis. So, to me, showing my patients consistent love and care is the most powerful medicine. It’s one of the most rewarding things someone like me, a nurse, can give to another human being in need. The caregiving belief that every human life matters regardless of race, age, sex, and political beliefs is an alternative health practice and philosophy

that remains to be a proud and celebratory cultural trait in Eritrean and Ethiopian Oromo societies. As expressed, the cultural promotion of these pro-humanitarian ideologies and concepts is utilized as a social mechanism to mitigate chronic illnesses/diseases via the following community meetings and collaborative events.

Social Spaces and Alternative Medicine

The interviewees were extremely warm, welcoming and receptive to the questionnaires, which led to detailed accounts of their personal experiences regarding the distribution and management of chronic illnesses/diseases. Based on the answers of the 16 Eritrean and Ethiopian Oromo participants, practically all explained how fundamental social and cultural spaces are to the management and treatment of chronic diseases. The interviewees who are currently suffering from a chronic illness/disease expressed how the love and support of their loved ones were crucial to their survival and well-being. For example, a spouse, mother, or daughter that constantly monitors and evaluates the health conditions of their loved one symbolizes the motivation and will on the latter to fight a life-threatening disease like cancer, heart disease, and diabetes. Thus, all of my interviewees strongly perceived cultural practices of genuinely caring for a loved as a significant strategy to improve the prognosis of those with chronic illnesses and diseases.

On the other hand, my interviewees had mixed opinions and perspectives regarding the role of alternative medicine in the prevention, management, and treatment of chronic illnesses /diseases. When I asked questions pertaining to traditional/alternative medicine, older (over 40 years old), male Ethiopian Oromo interviewees emphasized on a holistic approach to battle chronic diseases, whereas younger (<40 years old), male Eritrean and Oromo interviewees highlighted that biomedicine was much more effective to treat most chronic diseases than

traditional medicine. Although the latter group briefly mentioned the significance of traditional plants and herbs to treat non-chronic diseases, most of their statements reflected on a more biomedical approach to solve dire health issues.

Female Eritrean and Ethiopian Oromo participants, regardless of age and background, stated that a mix of cultural competence, caregiving, and biomedical practices were essential to improvements in the overall health and well-being of an individual. Most women, mainly health practitioners, expressed that one must know when it's appropriate to apply a traditional medicinal plant; that utilizing an alternative health strategy for medicinal purposes depends on the type of health problem the patient has. For example, an Ethiopian Oromo registered nurse stated the following with regards to alternative medicine: "Dietary and nutritional ingredients are very important to treat certain health issues. I treated a UTI (urinary tract infection) with natural cranberry juice (no sugar) and Vitamin C. I refused antibiotics, because I know my body, I know what works for me and what doesn't. I know what's appropriate for me and what isn't." As a result, when and how one decides to apply traditional healing and medicinal methods to manage and treat chronic diseases varied among my participants.

Also, older, male Eritreans and Ethiopians were more hesitant to visit or follow up with their doctors following a health scare or illness, as opposed to the women I interviewed. Male interviewees who were reluctant to visit their doctor explained to me that it would be mentally and emotionally draining to find out bad news about their health, which in their opinion results in an even poorer prognosis of a chronic health problem. Young Eritrean and Ethiopian men, and women of all age groups were more precautionary and proactive regarding follow ups with their physicians, as well as abiding by specific health regimens. Some participants of the latter group

also mentioned their frustration of informing older, male family members to not be negligent and careless with handling incurable diseases like chronic asthma, cancer, and type 1 and 2 diabetes.

Interestingly, Eritrean and Ethiopian women were more vocal about questioning the methods of some doctors they visited, as opposed to the men. An Eritrean woman with arthritis informed me that “I couldn’t agree with this one doctor on a medication for my arthritis. When my doctor told me to take the medication...I can’t remember the name of it. I didn’t want to take it, because my blood sugar was very high at the time. I remember telling the doctor that I’ve had problems with other medications as well, because I was not healing on “time.” Well, I decided to try it anyway and I eventually found out from another doctor that the medication prescribed from the first doctor induced diabetes.”

An Eritrean nurse diagnosed with anemia stated: “When I was diagnosed with anemia, they told me the source of my problem, which was an iron deficiency. Eventually, my iron levels got higher and improved, and I felt more energetic.” However, there were instances in which the nurse believed patients shouldn’t just consume any particular substance or medication given to them, just because their doctor is a “professional.” “What’s also important is for the doctors to listen to their patients. It’s very important to listen to their patients! Medical advice is useful, but it’s also important to do your own research as well. Don’t get me wrong, Western medicine is good. If you break your leg, you need surgery. But, maybe if you have some other illness, it’s not always the case that you need to go to the doctor. It’s also good for you to make your own decision.”

There were also different opinions regarding whether or not Eritreans and Ethiopian Oromos are doing enough to promote healthcare in their local communities. Eritrean and Ethiopian Oromo community leaders, health practitioners, and church members currently living

with a chronic disease had a wide range of opinions regarding health advocacy. Mostly younger Eritreans and Ethiopian men and women believed that their communities weren't doing nearly enough to promote healthcare due to mismanagement of priorities, such as focusing on resources to cover political affairs on a daily basis. Others, mainly older, male Eritreans and Ethiopians stated their local communities were doing all in their power to promote community engagement and health advocacy.

The definition and interpretation of caregiving also varied among the 16 participants. Most participants defined caregiving as one's personal involvement in constantly caring and supervising ill individuals, whereas a few defined the term as the overall care and support of patients who suffer from a health problem. To elaborate, the significance of being personally involved in the care of an ill person is interpreted by some Eritreans and Ethiopians as the only definition of "true caregiving". However, others defined it as either the personal or institutionalized care of someone with a health problem. Interestingly enough, defining how a health-based institution or practitioner should prevent, manage and treat a disease also varied among the participants. Some interviewees believed that solely applying biomedicine is enough to improve the prognosis of a disease; others believed that a holistic approach in assessing and evaluating a chronic health problem would be most beneficial. Despite having similar cultural backgrounds, traditional upbringings and kinship structures, Eritrean and Oromo interviewees also had unique and differing perspectives on public health topics. These topics included how to implement an effective chronic disease treatment plan, manage a life-threatening disease, and develop sustainable community health and wellness programs.

A prominent Oromo community leader, activist, and scholar who I interviewed stated the following regarding how to prioritize sustainable community health programs. “Our society (Oromos) views children as our best investment. When they get older, these are the kids that will care for us during our retirement and when, or if, we shall have health needs. Before we even talk about the effects of biomedicine or traditional medicine or caregiving, this sort of investment should be the first priority to deal with any chronic illness or disease in the Eritrean or Oromo community.” According to the individual, intergenerational cycles of Oromo family/community investment in the youth is a strategic and transparent tool to mitigate chronic diseases and other health problems in their society. In fact, such strong kinship structures have been the epicenter of the Oromo’s social and cultural identity. Organic and authentic outlooks on caregiving, and chronic disease prevention, management, and treatment provide researchers with a plethora of resources regarding the development of cultural competence in healthcare.

Despite contradictory ideological views, the need to develop, improve and innovate community health regimens in Eritrean and Oromo societies was profoundly expressed and shared among all 16 participants when asked about their personal health-oriented goals. They expressed and elaborated that community health services are important to help mitigate chronic illnesses and diseases that impact their families and societies. Many of the interviewees also mentioned how specific chronic diseases, such as cancer, heart diseases, and diabetes, impact their financial, psychological and emotional well-being. Thus, Eritrean and Oromo Ethiopian diasporic communities have stressed the need to develop collaborative relationships with health practitioners, those with chronic illnesses/diseases, and community leaders/organizers.

A recent Oromo immigrant with a history of chronic asthma told me the following during an interview: “I have this Indian doctor; she is a very nice doctor and also approachable. She’s very humble and compassionate. I also challenge her as well (on her health methods), and I appreciate that she allowed me to do that.” The fact that the interviewee had a healthcare practitioner who was respectful to his cultural norms and values, and patient due to his accent and limited English was an indication that a healthy, cooperative relationship was helpful to manage and treat his asthma. The interviewee further expressed that although he personally didn’t experience a racist or prejudiced health practitioner, some practitioners aren’t genuinely interested in treating or curing an illness or disease. For example, he elaborated on how some American doctors prioritize prescribing medication as a first-line treatment plan to manage a chronic disease, rather than treatment plans with minimal or no harmful side effects.

Similarly, an Eritrean immigrant with a history of high blood pressure and heart problems expressed his concern on how public health issues are confronted in the United States: “The life standards of people back home and here are different. There’s a lot of stress in the United States. Back home, culturally speaking, people don’t hesitate to help each other out. If someone is physically or mentally weak today, someone will be available to take care of them and vice versa. Here, some people would like to help you, but in America, it’s all about the individual.” These concerns call for a comprehensive approach that analyzes how collectivism can be intertwined with collaborative community health projects that focus on providing and receiving care.

Collaborating for Wellness

The conclusion of my collaborative group meetings resulted in an optimistic atmosphere to develop future collaborative community activities and events among the Eritrean and

Ethiopian Oromo church gatherers, and overall communities. One particular reason why there is such optimism is due to the similar cultural and linguistic backgrounds of these demographic groups. Although the official language of the Eritrean people is Tigrinya and the language of the Oromo people is Oromia, they're able to fluently communicate with each other through another language, Amharic. Both older generation Eritreans and Ethiopian Oromos speak fluent Amharic due to centuries of cultural hegemonic policies enacted by the Communist regime and former monarchies. As a result of this fluency, many of their ideas, concerns, and questions on how to improve chronic health issues in their respective societies were interpreted in a transparent manner. As a result, community health programs that focus on linguistic and cultural similarities rather than differences are a critical step to advance common goals and agendas regarding caregiving and healthcare.

An example of the above statement was a passionate remark made by an Ethiopian Oromo female registered nurse: "There (Oromia), there's a lot of obstacles with accessing healthcare. And here, language barriers are a major issue in the healthcare system. Not only language barriers, but even one's level of understanding. Once, a healthcare practitioner asked my mom who was diagnosed with stage 4 pancreatic cancer and didn't speak much English if she could rate her pain assessment from 1-10. Do you think she'll understand that?" From her point of view, relying on a social network of family members and individuals who speak the same language as the patient is just as critical to improve their dire health situation, as it is to abide by a doctor's treatment plan.

Despite strong critiques and criticism on American models of medicine, they were equally as many critiques on Eritrean and Oromo health-based practices and models. In both of my collaborative group sessions, Eritrean and Oromo participants mutually expressed and agreed

that solving dire health problems are more complex than meets the eye. Rather than solely pointing the finger at a particular health institution or system, some of their statements were self-reflections regarding how their own communities need to do a better job with communicating their needs and problems. An Eritrean participant stated: “We don’t seek any help until we get really sick. That’s what I see in the Eritrean and Ethiopian communities. They’ll be like “I was fine and doing alright until just last week.” They’ll ignore symptoms of a disease rather than simply finding out what it is. We need a lot education and awareness to our health.”

An Oromo participant stated: “Sometimes, we (Oromos) don’t pay attention to nutrition. We don’t pay attention to nutritious facts. The only thing we know about is to go to the hospital once we have “something”, an illness or whatever. But in terms of preventing that actual something, we don’t do enough as we should. We should be more aware on nutritious ingredients and the value of nutrition.”

A participant (who wishes to be anonymous) of my second collaborative group meeting, an experienced registered nurse, stated the following regarding the desperate need to improve healthcare: “I will share a personal experience that occurred a few years ago. I had a thyroid problem, a burning sensation in my throat when I coughed. I went to my doctor at Kaiser to discuss this issue and he informed me that he could order an MRI to see what the problem is. He told me the MRI would cost \$500. Then I thought (while laughing), “Maybe it will just go away.” Even if you have the awareness to prevent or manage a disease, if they’re issues with healthcare insurance affordability, it’s (progress in health services) still a problem.” Despite the fact that this individual had convenient access to doctors, hospitals, and health technological services (MRI) in the United States, the inability to afford a simply, yet costly procedure became a hinderance to her physical well-being. Other participants of this collaborative group meeting

elaborated on cultural issues and barriers that Eritreans and Ethiopian Oromos should fix within their own communities to make progress in prevention, managing and treating an illness or disease.

An Oromo community leader, scholar, and doctor eloquently expressed the following: “Some cultural issues hinder us from not learning about how to control our health. That is very important to take in for all of us. Cultural awareness is important for prevention, yes, but we need to know what is causing the health issues we have in the first place. In my opinion, they are 1) environmental 2) food-based, 3) water that we drink and 4) biological sources of chronic diseases. Now, allow me to break this down. With regards to food, if we know what we put in our mouth, we can help prevent some health issues. For example, if I consistently drink alcohol, then I should expect the consequences because I know what I’m putting in my body. Therefore, prevention is very important if we know all of these things. Now, let’s move on to hereditary factors of chronic illnesses and diseases. In many of our cases, both Eritreans and Ethiopian Oromos, we don’t know what our parents, grandparents, etc. died from. We don’t know if they died from cancer, or any other disease (due to the tremendous lack of health documentation and adequate public health resources and facilities). Everything boils down to the correlation between DNA/hereditary traits and the distribution of chronic diseases. What frustrated me is despite all this, we don’t share or care to learn such valuable information in our communities, because of old cultural issues. “Oh, I don’t want to worry the family or oh, I don’t want anyone to discuss about such a depressing thing.” This is a problem, period.”

Gathering for Care

Community picnics and potlucks are common community activities organized by the Eritrean and Ethiopian Oromo Lutheran church communities. These picnics and potlucks are

typically held in local parks throughout the Bay Area, several times a year; athletic activities, BBQ/food, and music/dance are among the highlights of the day. Because of the large and diverse number of participants in these community programs (parents, children, elders), future picnics/potlucks can include activities centered toward social networking, caregiving, and important tips from community health practitioners on chronic disease management and treatment. For example, an ice breaker game, or a “Taboo”-like educational game can be a fun-filled and informed activity for everyone involved. Some Eritreans have expressed to me that the more engaged and satisfied participants are throughout such games/activities, the more likely such valuable information will be mentally retained.

An Eritrean engineer who I conversated with at a community picnic stated the following: “You know, these community functions are full of children...small kids. And I feel that it’s important to have these kids be just as part of these sort of community events, as the adults. So, children's games and programs are also important. If these community events only involve adults, then how does anyone honestly think that the future will look bright for us, when our children are the future?” Thus, implementing fun-filled games and activities on health education and awareness that is inclusive can possibly be beneficial to the Eritrean and Oromo community.

Creating Health Awareness

A “Health Awareness” Day is another idea of an innovative community activity/event that participants mentioned during the two collaborative group sessions. The general idea is to have a particular day (end of May 2020) where Eritrean and Ethiopian Oromo children and adults would gather at church to get acquainted, learn about one another’s belief systems, and listen to guest speakers on health education. In the collaborative meeting, one suggestion was to create an event where a panel of volunteer guest speakers speak to an audience about health care

information and services. These guest speakers would encompass a diverse group of health practitioners that range from midwives/caregivers to registered nurses and doctors. Some of the topics that would be discussed by the panel are the following: cultural conceptions of chronic illnesses/diseases, biomedical perspectives on clinical treatment programs for chronic diseases, diet/exercise regimens, and the politicization of medicine and access to healthcare. The latter topic has been expressed by some of the interviewees as the most fundamental public health crisis among Eritrean and Ethiopian Oromo households, given how politics is already the most defining and central activity in these ethnic communities.

During the group session on December 1st, 2019, one of the Eritrean nurses who I interviewed stated the following regarding how she believes a “Health Awareness Day” program should be enacted: “There should be a specific theme for each health awareness event. For example, one month will be about diabetes and the next month will be about high blood pressure. The event can be divided among separate groups. One group would be responsible for open dialogue, the other for research and data gathering, so on and so forth.” Such perspectives and insights indicates that collaborative meetings/group sessions can be valuable to researchers who seek innovative approaches to improve and expand on community health and wellness resources.

The Need to Break Linguistic Barriers with Regards to Health Literacy

Eritrean and Ethiopian Oromo community leaders and health practitioners from the church informed me of their desire to implement health literacy and awareness programs by the end of 2020. In the Good Shephard Lutheran Church in Hayward, California, both pastors expressed the need for health literacy information to be first written in Oromia and Tigrinya. They expressed this concern because most of the church members’ first language isn’t English, and much of the information regarding caregiving and chronic disease treatment and

management can easily be misinterpreted and misunderstood. Although many members of the church and general community can speak and understand English, some are unable to understand the complex jargons and terminologies of the language. Also, the concern that some Eritrean Tigrinya and Oromo speakers may not know technical medical terms will be addressed by collaborating with linguistic experts in both languages. A collaborative project with researchers, community leaders, and linguistic experts can potentially address the problems of writing and translating health literacy material.

After the end of a collaborative group session, the head pastor of the Eritrean church mentioned an Eritrean linguistic scholar and community activist that I would be able to connect with, in order to develop an effective health literacy program. The pastor also expressed that although a translation book on health literacy would be a time-consuming project, such a task can be doable and feasible if those involved are committed. Also, a culturally sensitive approach, such as a health-specific dictionary from Tigrinya and Oromia to English could make the project much more inclusive and durable. This approach was also reiterated in both of the collaborative group meetings I conducted following the conclusion of my participant-observation research and semi-structured interviews.

Cultural Sensitivity- A Sustainable Community Health Approach

Culturally sensitive health programs are fundamental to the success of a sustainable public health campaign and project. A holistic concept on topics such as caregiving and biomedicine is not only beneficial to the overall health of immigrant populations, but vulnerable and marginalized societies throughout the world. Applied medical anthropology is an example of a disciplinary field that focuses on how culturally sensitive programs can drastically improve the living standards and well-being of humans across the world. The ethnographic findings of

“Chronic Disease Self-Management and Health Literacy in Vietnamese, African American, White, and Latino Ethnic Groups” by Dr. Susan Shaw indicated an urgent need for health literacy researchers to work more closely with patients, in order to possibly eliminate cultural bias and ethnocentrism in the public health field (Shaw 2012, 67).

Anthropological researchers who are respectful and mindful to the cultural constraints of their research subjects can be a helpful strategy to develop successful and sustainable collaborative community health projects. An Oromo community leader with a family history of several underlying health conditions informed me that: “The cultural issue in our communities is that they don't want to share about the health situation of their children. Whether it's Eritreans or Oromos, they don't want to expose the health issues of their children. Why do I say this? Because kids are affected by anxiety.” He further explained, off the record, that if researchers truly care about the health and well-being of individual/groups of immigrant backgrounds, one would need to do their homework on how to culturally approach a specific topic or conversation at hand. Thus, the capability of not pressing an interviewee on culturally sensitive matters that may deeply upset or disturb him/her, is a skillset that a public health researcher can practice and master over a period of time.

Cultural Tolerance

Although Eritrean and Ethiopian Oromo populations have similar kinship structures, philosophical ideologies, and other cultural values, they also have norms and values that are distinct and unique. For that reason, some of my interviewees have urged that mutual respect and cultural tolerance is ideal for any health literacy and awareness campaign/project to be sustainable.

The head pastor of the Oromo Lutheran Church stated during an interview that “We should do more regarding health awareness and how we communicate with one another regarding raising that awareness. Health empowerment and self-empowerment based on education and knowledge can be achieved if it is done as one community. You know, as a unified community, we can achieve a lot as we have much in common regarding caregiving principles, such as how we prioritize the well-being of our immediate family members here and back home.”

After finding out about being prediabetic, an Eritrean nurse told me: “After finding out I had prediabetes after my pregnancy, I had to take my medication as prescribed, exercise more...I blame myself sometimes for that. I also have to eat right. I’m trying to maintain all these regimens and do the right thing. Even nurses such as myself need to practice what we preach. As hard as it is, we have to apply our knowledge and skills in the real work to our personal lives.”

Based on the pastor’s remarks, a common agenda on how to develop a community health program and project can be brought to fruition based on unifying principles, as well as how one tolerates and communicates with someone of a different cultural background. According to the pastor, constantly pinpointing one’s cultural and ideological differences is a recipe for disastrous, and even deadly consequences, as we’re talking about chronic illnesses and diseases. Lastly, the development of culturally sensitive programs on health education and awareness is an anthropologically- based approach that many members of Eritrean and Oromo diasporic communities look forward to witnessing.

Participant Observation Findings to Information Exchanges

My participation observation findings were based on three major cultural events/sites: church gatherings at the Good Shephard Lutheran Church in Hayward, California, the annual

Eritrean festival in San Jose, California, and Community Dinners/Potlucks. The church is home to both Eritrean and Ethiopian Oromo communities and was the starting point of my participant-observation research due to my familiarity of the congregations. Through my familiarity and close relationships with members of the church, I was able to connect with more family members; some of whom would agree to be participants of my semi-structured interviews and group sessions. Outside of the church, the Eritrean festival in San Jose was a location to conduct participant-observation research, as the occasion was the first time in decades that hosted Eritreans from all over the United States (there is typically around 2-3 Eritrean festivals in the nation yearly). After the festivities concluded, my professional networking circle expanded tremendously, and included Eritrean anthropologists, doctors, engineers, tech workers, etc.

Networking with Eritrean and non-Eritrean anthropologists at the festival allowed me to listen and comprehend to multiple perspectives on ethnographic research, professional careers in anthropology, and health issues prominent among the Eritrean diasporic communities. One of the anthropologists, a medical anthropologist Ph.D. student named Dina Gustavo, had a very interesting and through analysis on how the United States can learn from healthcare systems from other nations. As a frequent traveler due to her own research, she explained how public healthcare systems in Cuba have significantly improved the life expectancies and overall health of Cubans. Despite the lack of sustainable health infrastructure and advances in medical technology due to disastrous economic policies, Cuban doctors, nurses, and health researchers remain to be internationally renowned for their medical advancements and humanitarian health practices (Kirk 2009, 275). She also brought up this example to illustrate the point that a marginalized community doesn't necessarily have to be economically or financially wealthy to succeed in public health programs and projects. Before our conversation ended, she informed me

of her participation in the upcoming annual Medical Anthropology Conference in Havana, Cuba, which is scheduled to be held on March 9th-12th at the University of Havana.

Community Journeys

On a Saturday afternoon in November 2019, the Eritrean Lutheran Church organized a community picnic in Fremont, California. The picnic hosted members of the church, as well as family and friends from other communities. Pastors, community organizers, elderly men/women, and children were all active participants of the event. When I arrived at the picnic, folks were busy interacting and enjoying each other's company; most of them were communicating in Tigrinya. As food and drinks were passed around, I caught up with an Ethiopian-born, Eritrean engineer named Henok, who I hadn't seen in a while; this individual is also, a member of the Eritrean church. We discussed about my graduate project, as well as his personal experiences and journey living in Ethiopia, Zimbabwe, and eventually the United States.

Henok discussed about his experience migrating from Ethiopia to Harare, Zimbabwe as a university student in the 1990s, and how his observations and overall living standards influenced his personal beliefs regarding healthcare, education, and the economy. For instance, he mentioned how Zimbabwe was a nation of a very young, educated and literate population, but lacked adequate health infrastructure and facilities. He expressed how Zimbabwean health practitioners had a reputation in the continent of being among the best in the Africa, but due to economic shortages and other governmental policies, migrated to more prosperous nations. As a result, millions of Zimbabweans and other Africans were and continue to suffer and die from many treatable illnesses, especially waterborne illnesses such as cholera.

The engineer's personal journey with experiencing public health infrastructure, technology, and services in over three countries (Ethiopia, Eritrea, Zimbabwe and the United

States) shaped his mindset with regards to advocating progressive community health programs /projects. The dire scenarios in which countless Africans are left to suffer and die, as a result of poor and inadequate healthcare facilities and the vacuum of trained healthcare workers remain to be a daily reality. His testimony on public health systems serves as a reminder that global medical researchers, world and community leaders have a long way to go to improve life expectancies, living standards, and wellness for the most vulnerable members of a society. Also, Henok's testimony on the global need for improvement in community health and wellness resonated in the ideals and opinions of some participants in my collaborative group discussions.

Overall, the above testimonies on cultural observations of health awareness, community-based wellness, and perceptions of healthcare technology, management, and services stressed a holistic approach on community health is desperately needed. I noticed every participant involved in my qualitative-based research advocated an integrated approach to better understand the intricacies of public health. At the end of the day, whether a conversation was on caregiving or biomedical models of health, these 16 participants agreed that a one-sided viewpoint on public health can't possibly solve any health-based concerns and problems.

CHAPTER 5

CONCLUSION OF ANTHROPOLOGICAL DATA AND INSIGHT ON CAREGIVING AND CHRONIC DISEASES

The nature of this project was to study and analyze the relationship between caregiving practices/strategies and mitigating factors of chronic diseases by utilizing medical anthropological methods in order to facilitate a community conversation on steps to take to improve community wellness. The research was done as part of an empowerment process that brought the community together to exchange ideas and decide on the steps members would like to take next. From participant-observation research to semi-structured interviews and collaborative meetings, the scope of this project was extremely wide, complex, and unique. Based on my sixteen interviews, two collaborative meetings, and several community-oriented events, I learned just how passionate and optimistic participants from Eritrean and Oromo communities were about their involvement in this project. I came into Good Shephard of the Lutheran church believing the majority of the congregation members would be participants in this project; however, what I did not anticipate was the level of community support and love I received from the church members. These communities exceeded my expectations in terms of how much they were willing to go out of their way to help me complete this project, as well as the impressive level of knowledge some participants already obtained on the significance of anthropology in the field of medicine and public health.

Eritrean and Ethiopian Oromo participants, particularly health practitioners and community leaders/organizers, were keen on developing sustainable health programs and projects after the completion of my research. They informed me that they want to avoid a scenario of a researcher barging into their communities to exploit one's health-based needs,

concerns, and desires in order to fulfill their self-centered agenda. They also made it clear that simply writing a graduate research paper on project deliverables and goals was not going to cut it; the researcher (me, in this case) must be willing to make long-term investments in the community, even after a paper or project is completed. Therefore, I had and continue to have the moral responsibility of ensuring that these communities will be served in an authentic, honest and transparent manner. After completing my qualitative anthropological research, I was asked by community organizers to also collaborate with Eritrean and Ethiopian professionals and researchers in other interdisciplinary fields, which is what I'm currently doing.

Community Needs on Future Collaborative Health Education Programs

Community-based collaborative projects, abiding by moral/ethical guidelines, strong communication skills, and concrete knowledge on medical anthropological theories and methods are fundamentals of anthropology in public health. First and foremost, how an anthropologist condones his/her behavior and attitude on a public health project will reflect on the success or failure of that project. Also, the level of success regarding an anthropologist's research publications, papers, etc. on a demographic group will partially be dependent on the depth of knowledge about the cultural norms and values of that group. Once the foundation of cultural awareness and strong moral and ethical values are established and practiced among an anthropologist, collaborative community health projects can be more efficient and transparent. An example of the above statement is the Eritrean and Oromo communities desire to include culturally sensitive and tolerant topics in future health literacy education programs; this was expressed by health practitioners in my collaborative group meetings.

Community collaborative projects, in the field of public health, is a difficult task that not only requires extensive knowledge and skills on a particular subject matter, but extreme

discipline, tolerance, and determination. It is one skill to study and comprehend the socio-economic, cultural, and health issues of a demographic group, but it is entirely another for a researcher to learn and have solid behavioral skills to successfully sustain a community health program or project. According to anthropologists Elliott and Thomas, community collaborative projects also require expertise in community engagement and cooperation, as well as social activism (Elliott and Thomas 2017, 2). Therefore, a holistic anthropological approach, such as collaborative ethnography is needed to analyze the public health needs, wants, concerns and goals of a community. Collaborative ethnography is an innovative anthropological approach that has shown to be effective in community-based collaborative projects. My collaborative group meetings were an opportunity to discuss ideals of collaborative ethnography, such as involving consultants from professions that are both relevant and non-relevant to public health.

Collaborative ethnography is defined as sharing the collection of data material between ethnographers, consultants, and other stakeholders involved in a project (Lassiter 2005, 15). This approach has been emphasized by some applied anthropologists as a productive strategy to collaborate in every stage of the project's process, with the aim of minimizing or eliminating problems that may potentially harm a demographic group (Lassiter 2005, 17). Such problems include misinformation campaigns, inadvertently exposing personal and confidential details from interviewees and disrespecting one's livelihood and cultural norms/values. Thus, mutual cooperation and respect are imperative with the formation of a strong, healthy partnership on a health-oriented ethnographic project that seeks to develop and expand health services and resources. The above statement was similarly communicated by my interviewees when questions were asked pertaining to drastic changes needed in health care facilities.

The aim of collaborative partnerships in the context of this anthropological project are to establish a mutual goal based on sustainable ways a racial/ethnic group can improve the health outcomes of their people (Roussos and Fawcett 2000, 369). Self-reliance and self-sufficiency are social practices that ensures that communities, specifically members of stigmatized and vulnerable societies can depend on themselves rather than foreign institutions. My project on Eritrean and Ethiopian Oromo immigrants is a case of immigrant populations that seek to rely among themselves, as well as individuals or communities of whom they trust to mitigate the deteriorating health conditions of their people. Due to a lengthy history of the U.S. government exploiting minority groups through racially motivated policies, some Eritreans and Ethiopians realize that only with community collaborative strategies can they truly make significant progress with their health and well-being. Overall, collaborative partnerships via collaborative ethnography, or other community-based concepts and approaches is a powerful social weapon among disenfranchised groups. The successful collaboration between Eritrean and Ethiopian Oromo research participants brought about conversations on how to constantly improve and expand on public health projects.

The Eritrean and Ethiopian Oromo participants in this project have utilized the fundamentals of collaborative partnerships to create sustainable solutions for one's dire health circumstances. These collaborative partnerships came to fruition during the two group sessions that were conducted at the Good Shephard Lutheran Church in Hayward, California. By the time these hourly group sessions ended, 16 of the Eritrean and Ethiopian Oromo participants successfully collaborated with one another by exchanging valuable project deliverables regarding public health strategies and practices. Teleconferences, social media outreach, linguistic programs, and power point presentations were some of such ideas discussed, eventually leading

to participants networking with other members in the group meeting. Also, the exchange of laughs, productive conversations, and an overall positive and healthy social atmosphere partially contributed to the success of my graduate project, as it made the objectives of cross-cultural community collaborations much easier.

In conclusion, applying community-based collaboration practices to study and analyze chronic illnesses/diseases of a demographic group are an innovative tool that has transformed anthropology. Despite the methodological challenges of collaborating with several population groups who have different social, cultural, linguistic backgrounds and ideologies, community collaboration can still be effective and transparent. The ability to allow each participant to be an inclusive member of a public health community-based project is one of the most rewarding attributes for an anthropologist with genuine intentions to look out for the well-being of one's research subjects. Therefore, practicing inclusion and diversity can potentially be a valuable anthropological tool in a health-based community project or activity. The testimonies of nearly every interviewee from my semi-structured interviews reflects on how instrumental inclusivity is to the social and cultural identities of the Eritrean and Oromo people.

Research Study Limitations

Interviewing more than 16 research participants, as well as applying a mixed method approach of qualitative methods were research study limitations that occurred throughout this project. Because of limited health statistical data on Eritrean and Ethiopian Oromo caregiving practices, as well as Eritrean/Ethiopian immigrants suffering from chronic illnesses/diseases in the Bay Area, I had to solely rely on qualitative methods. The fact that few studies had been done on Eritrean and Ethiopian Oromo caregiving, as well as the prevalence of chronic diseases among these demographic groups limited the scope of my overall research project. My original

goal of interviewing 20 Eritrean and Ethiopian participants was an extremely difficult task given how long it even took me to gather and interview 16 interviewees. My target of interviewing 10 Eritreans and 10 Ethiopians by a particular deadline failed when some folks began to have second doubts and even a culture shock due to being approached by a young, inexperienced male interviewer. To some members of these communities, a male researcher still in his 20's asking extremely personal, health-based questions about life or death situations, politics, and one's life history was culturally unacceptable and even awkward. However, as an anthropologist, I completely understood and respected their hesitation to be interviewed, and proceeded to just interview the 16 people that agreed to be part of this project. Despite these obstacles, the research limitations of interviewing 20+ people allowed me to spend much more quality time on and off the record with each of the 16 interviewees, to which they were grateful and optimistic about the overall purpose of my project.

Reflections and Experience- Need for Health Awareness and Literacy

My reflections and experience of this community health project is based on personal gratitude, professionalism, and acquiring knowledge on public health problems and policies. First and foremost, I am eternally grateful to have had the opportunity to interview people from within and outside my community in a field that I'm extremely passionate about (medical anthropology). Secondly, I am humbled to be the cultural liaison between Eritrean and Ethiopian Oromo communities in the East Bay, California. It should be noted that these phenomenal people have trusted me to collect and transcribe data pertaining to personal information they never had to disclose to begin with. The more interviews I conducted, the more I noticed how each interviewee was willing to go out of their way, particularly with their own limited free time, to

invite me into their homes and gladly answer my questions. Also, the hospitality of each interviewee offering me lunch/dinner and drinks was a gesture that I will forever be grateful for.

Next Steps and Future Projects

The next step for my future anthropological projects is to eventually become part of larger-scale collaboration community health projects, which will include stakeholders of diverse interdisciplinary fields. This particular project provided me with the opportunity to sit, discuss, and interview Eritreans and Ethiopians who come from all walks of life: engineers, doctors, nurses, caregivers, and university professors. The abundance of unique perspectives on caregiving and the distribution, management, and treatment chronic diseases compelled me to transition this journey into a long-term professional career in community health. Based on the feedback from the people I've conversated with, such a career would have a positive or "revolutionary" impact, as few professionals have ever documented caregiving practices on chronic health issues in these communities. For this reason, I look forward to meeting this linguistic scholar and other peers in July of 2020, which is when the annual Eritrean Lutheran Church conference will be held in Los Angeles, California. Meanwhile, the literature and methods of these health literacy books, pamphlets, and brochures will be based on a holistic approach that informs the reader on biomedical and alternative medical perspectives of chronic illnesses/diseases.

Future Projects

The translation of health literacy books from English to Tigrinya (Eritrea's official language) and Oromia (language of the Oromo people) is a future project that I am currently working with the Good Shephard church. Following the conclusion of one of my group sessions, both pastors of the Eritrean and Oromo congregation noted that it would be a good idea if the

church collaborated with linguistic experts to do the translation. As expressed in previous chapters, medical jargons and terminologies in public health literature has led to some immigrants, whose second language in English, misinterpreting healthcare information. For that reason, translation books on health literacy and community healthcare is much needed in immigrant populations throughout the Diaspora. Also, translations of health-related material can be distributed to Eritreans and Ethiopians who don't speak English whatsoever, which will be ultimately beneficial to all members of these respective communities.

Future community activities and events, such as a “Health Awareness Day or Month”, are future projects I am currently working in collaboration with the Eritrean and Ethiopian Oromo community. However, the theme of this activity/event will focus on caregiving due to minimal studies that have covered this public health topic. During my group sessions, health practitioners urged that caregiving practices regarding childcare and maternal health should be prioritized in future health programs. We also discussed that young children and teenagers, will be just as active and vocal during these community events, as the adults. That way, the former will potentially be encouraged and motivated to be participants in future community collaboration events, rather than feel obligated or pressured to be involved by their elders. Finally, this “Health Awareness Day/Month” public campaign project could pave the way for future community collaboration programs among Eritreans and Ethiopians outside the church.

The need for health awareness and literacy in the world is dependent on both small and large-scale collaboration efforts to combat life threatening viruses, illnesses, and diseases. As the world is currently experiencing the global pandemic of COVID-19, global collaboration efforts to mitigate this public health crisis are pivotal to not only mitigate this public health crisis but prevent worst-case scenarios where millions of people around the world would die. Therefore, a

post-COVID evaluation and update for the Eritrean and Ethiopian Oromo community is a potential public health project I am interested in developing in the future. The way I would implement a post-COVID evaluation is by having follow-up collaborative meetings with the 16 people I interviewed via Zoom conference calls, or similar apps where one can have productive, lengthy conversations with multiple individuals at the same time. These virtual group meetings will discuss on subjects pertaining to how Eritrean and Oromo participants, especially those with underlying health conditions, are coping with the “shelter in place” order. Future meetings will also cover on health-based strategies, practices and regimens that my participants are applying to prevent exposure to the coronavirus.

In conclusion, the extensive health-based experiences, knowledge, and skills gained from this graduate project are transparent and tenable resources that can be utilized in future community health projects. Furthermore, applying medical anthropological/public health literature and methodologies (participant-observation, semi-structured interviews, and collaborative group meetings) in real-world settings has successfully compelled and garnered Eritreans and Ethiopian Oromos involved in my project be participants in cross-cultural anthropological studies that I will conduct over an extended period of time. Although I was prepared to address issues of confidentiality, there were clear signs of interviewees who were extremely uncomfortable and anxious with revealing their personal health history, experiences, and beliefs. Therefore, I applied a cautious and culturally sensitive approach to the format of interview questionnaires that helped me gain trust and rapport among the participants of my qualitative research. Ethnographic fieldwork, extensive note taking, and solid interpersonal communication were aspects of participation-observation and collaborative research that contributed to the collection of detailed and accurate material/information. Lastly, the qualitative

data collected from the Eritrean and Ethiopian Oromo communities in the East Bay has led to an increased awareness on the need for sustainable community health and caregiving system throughout the United States.

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Appendix:

Mental Notes to Professionally Document Field Notes Following Participation Observation:

Behavioral Traits

- 1) Eye Contact
- 2) Inviting body language (make sure the individual is comfortable when conversing)
- 3) Avoid texting or answering phone calls in the middle of conversation
- 4) Listen more than talking
- 5) Observe tone and mannerisms (hand gestures) while having a conversation

Environmental Traits

- 1) Inspect area to make sure interruptions of conversations are limited
- 2) Try to avoid loud areas with regards to participation observation
- 3) Look for areas with tables, benches or chairs, so conversation with individual(s) can last longer
- 4) Describe environment (site) in detail

Types of Questions

- 1) Warm-up questions/statements (Meaning, don't directly ask intimate or personal questions).
- 2) Once participant has opened up and is comfortable, ask questions about subject at hand (ex: healthcare, cultural perspectives on medicine, etc.)
- 3) Ask questions that will engage participant to make detailed statements about said subject (Avoid simplistic, vague questions that typically end up with a one-line response)

Interview Guideline

Intro: Good morning (Name of Person), my name is Phil Berhane, a graduate student studying applied anthropology at San Jose State University. Firstly, I want to thank you for your participation and cooperation with regards to my graduate project; I'm aware this can be an extremely sensitive and personal topic, especially with sharing your journey, experiences, and

overall lifestyle as a result of your chronic illness, caregiving beliefs, and practices. Therefore, your identity will be anonymous, and all of the data being recorded and transcribed in this interview will remain confidential and secured within the Department of Anthropology at San Jose State University. Here is a copy of a consent form you signed as a participant of my semi-structured interview.

The purpose of my research project is to analyze and better understand the impact of chronic diseases and caregiving practices in the Eritrean and Ethiopian communities, particularly in the Easy Bay, California. My aim is also to analyze the health-related needs, concerns, strategies, and practices of individuals in these particular communities, and how that can lead to a bridge of cross-cultural and community collaboration. I strongly believe that your input can directly contribute to the betterment of public health in your respective community, because the collection of data material from all of my interviewees will eventually lead to an open-ended, community gathering session. Finally, the conclusion of my research will hopefully garner more individuals in these communities to collaborate in the future, so future generations can take their health and well-being in their own hands.

So, let's start with the first question...

Q1: Please tell us a little more about yourself (your background, hobbies, interests, what you do for a living, etc.?)

Q2: How long have you lived in the Easy Bay California?

Q3: How many people live in your household? What are their relationships to you?

Q4: Who is in your family, and where do they live?

Q 5 4: tell me about your experience immigrating to the city?

Probe tell me about your experience leaving Eritrea and Ethiopia?

What did you go next?

When you came to the East Bay (Oakland, Hayward, etc.) what did you do?

Q6: What are the major similarities between your lifestyle, particularly when it comes to your health and well-being, back in your country of origin vs the Easy Bay, California?

Q7: What are the major differences between the way you pursue your health and well-being back in your country of origin and here in the Bay Area, California?

Q7: When do you seek care from health practitioners in the Bay Area?

Probe: tell me about a time when you decided to seek out a practitioner. What happened?

Probe: tell me about a time when you decided not to seek out a practitioner. What did you do?

Q8: what kind of advice to practitioners give you when you make those visits?

Probe: what parts of the advice do you find useful? Why? (Or “tell me more”)

Probe: what parts of the advice do find easy to follow? Why? (Or “tell me more”)

Probe: what parts of the advice do you find less useful? Why? (Or “tell me more”)

Probe: What parts of the advice do you find harder to follow? Why? (Or “tell me more”)

Q9: how do you decide which particular health practitioners you want to visit for physical checkups, illness symptoms etc.,

Probe: what role does race play in your decision? Why? (Or “tell me more”)

Probe: what role does culture of origin play in your decision? Why? (Or “tell me more”)

Probe: what role does language play in your decision? Why? (Or “tell me more”)

Probe: what role does how close and convenient the practitioner is play in your decision? Why? (Or “tell me more”)

Q10: What disease or diseases are you currently diagnosed with?

Q11: When were you diagnosed with this specific disease?

Q12: How has this disease impacted you and your family?

Probe: How do you manage your illness on a daily basis?

Probe: How do you manage your illness on a weekly basis?

Probe: How do you manage your illness over the course of a year? What times of the most challenging and why?

Q13: What are your strategies/methods and practices to improve your health conditions?

Q14: How has this disease impacted your job, income, and benefits?

Q15: Who is the caregiver in your household?

Probe: Tell me about a time that your caregivers had to give you care. What happened?

Q16: what kind of things does your caregiver provide you with the help you need to manage your illness on a daily basis?

Probe: how many hours do you think your caregiver provide you care?

Probe: what kind of obstacles you have in getting care from your caregiver?

Q17 Since your diagnosis, how often do you have to meet with your caregiver/doctor?

Q18: tell me of a time when you had to give care?

Probe: what happened? Tell me who you cared for?

Probe: what did you do?

Probe: were there any obstacles you experienced in providing care?

Q19: Let's talk about money. How much do you think it costs you to manage your disease?

Probe: Where does that money go?

Probe: What is the most expensive service you have in managing your disease?

Probe: What is the least expensive service you have in managing your disease?

Probe: What economic change would make the biggest difference in your life?

Q20: What are the top three health services (chemotherapy, anti-retroviral therapy, etc.) you would like to see become more cost-effective and affordable cost-effectiveness within your community?

Q 21: Tell me of a time you think your cultural/ethnic background mattered when you were trying to seek care for your chronic disease. Probe: from your cultural perspective what causes your disease?

Probe: from your cultural perspective, what is the best way to treat your disease?

Probe: how did you learn about (Ethiopian and Eritrean) health and treatment practices

Q 22: Do you apply any alternative medical practices (non-biomedical or "Western") to manage and improve your chronic disease? If so, what are they?

Probe: tell me the time you sought alternative medical practices?

Probe: how did you find out about those practices? What happened?

Q23? Do you combine alternative or traditional medicines with biomedical/" Western" treatments? If so, tell me about this.

Probe: tell me of a time you used both kinds of healthcare. What did you do?

Probe: Why did you choose to use traditional medicine?

Probe: why did you choose to use biomedicine?

Probe: knowing what you know now, would you have done it any differently? Why?

Q24: What do you think biomedical care has to offer? Probe: what are the obstacles you see in using biomedical care?

Q25: What do you think traditional care has to offer?

Probe: what are the obstacles you see in using traditional care?

Q26: what do you think your community members and leaders do now to promote healthcare? What do you think they can do more when it comes to health issues that directly impact your communities and neighborhoods?

Q27: Are you actively involved with community-affiliated events and programs?

Probe: which programs? Tell me of a time you became involved with the community event.

Probe: what would need to change for you to become more involved?

Q28: Lastly, what is your vision of a productive, healthier, and thriving (Eritrean/Ethiopian) community in the Bay Area?; please provide details of what you believe people affiliated with your community, including yourself, should do to decrease the gap of health-related problems.

Conclusion: That concludes our interview. I want to once again thank you for your patience, cooperation, and generosity of providing such personal and sensitive information to help me complete my graduate research. I highly appreciate it. I will also reiterate that all of the information recorded and transcribed will strictly be applied for research purposes, and that once my project is published, your identity will remain anonymous. I will touch base with you once I successfully collect and transcribe all of my interview data, so that I can pick a particular day and time that is most convenient for all my interviewees to meet for a post-community gathering session. Best of luck to you and I sincerely hope your health and well-being improves. You are more than welcome to reach out to me at any time.

Take care and enjoy the rest of your day.

Collaborative Group Discussions/Meetings

INTRO:

Welcome and Thank you everyone for joining me in this focus group and workshop session. I know it wasn't easy or convenient to get you all in one place at one particular time, so your presence and participation is very much appreciated. I interviewed each of you to not just fulfill requirements to complete my graduate project, but I genuinely wanted to understand how Eritrean and Ethiopian (Oromo) community leaders/members, healthcare practitioners, and those with chronic illnesses and symptoms perceive, interpret, and evaluate chronic illnesses and diseases. Each of your interviews were extremely insightful and informative, and I have personally learned a lot from you all. With that being said, I want to now elaborate your unique insight, knowledge, and experience by completing the following activity. Also, it's important to reiterate that you all are anonymous, so your names will not be revealed throughout this focus group session.

After spending hours evaluating and transcribing your semi-structured interviews, I found both common and different cultural perspectives on analyzing chronic illnesses and diseases. Here are 5 of the most common, critical, and concerning themes I found from your interviews. Health Awareness and Education, Documentation of local plants, herbs, and other alternative sources, Cross-Cultural Communication, Cost-Effective Health Insurance, and Community Involvement/ Networking. Although all of these themes are very important and fundamental to the improvement of health conditions and outcomes in the Eritrean and Ethiopian community, you can only choose 2 of these sheets listed on here. When I tell you to begin, I want you all to take these green color codes and place them on 2, of what you personally believe, are the most

important or prioritized topics that should be immediately addressed in your respective communities. Once you all are done, we will address what we can do to implement this idea as a health service and overall, as a project deliverable. We will address this by brainstorming each of your valuable opinions, and then we'll go from there....

Please be free to speak out and be as comfortable as you possibly can! This is meant to be both a fun-filled activity and informed, educational one where we can express our needs, wants, and concerns however we want. At the end of the day, I'm here as an observer, and an admirer of your amazing and unique visions to improve health issues and outcomes

(BEGIN WITH COLOR CODE ACTIVITY)

Now, I want to ask each of you, why did you specifically choose these 2 themes? What stands out to you about them?

(WAIT FOR EACH PERSON TO ANSWER)

Ok, now I want to ask you all to brainstorm 3-5 ideas on how this can be implemented as a health-related service for the church and the community in general.

(WAIT FOR EACH PERSON TO WRITE IDEAS ON STICKY TABS)

Place all sticky tabs on board to discuss their relevance and importance to community health and chronic disease management, treatment, and prevention

CONCLUSION