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Ethiopian Language Policy and Health Promotion in Oromia

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In the time of HIV/AIDS, epidemics for which we have no vaccination or cure, public health is bound entirely to depend on the traditional health education strategies to stop or contain this disease. This reality demands that we travel extra miles and thoroughly employ every health promotion tool at our disposal. The Ottawa Charter for health promotion stressed the need for public policy to create supportive social conditions for health. This necessitates a commitment to enduring social conditions for health and raises topics that have been neglected by the traditional public health scholars. A close examination of the colonial language policy of Ethiopia reveals that language is not value free and is intermingled with power and has significant public health impacts. In this paper, I critically examine Ethiopian language policy within the framework of health promotion and demonstrate the ways in which such policy creates a barrier for the Oromo people in making life choices. Additionally it hinders them from ensuring the conditions in which they can be healthy. This paper addresses a gap in the research literature on the impacts of colonial language policies on health promotion.

Key words: public health, Ethiopia, health policy, health education, Oromia, colonial language policies

Introduction

The impact of the Ethiopian language policy on health promotion in Oromia can best be examined if we define the terms

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“health promotion” and “health.” According to the World Health Organization (WHO) Health Promotion Glossary (1998), health promotion is the process of enabling people to take greater control of their health and improve it. Health promotion is intended to strengthen the skills and capabilities of individuals to take action and build the capacity of groups or communities to act collectively to exert control over the determinants of health and achieve positive change (Ottawa Charter, 1986). This means health promotion is not something that is done to people; it is done by, with and for people either as individuals or as groups. Indeed, health promotion represents a comprehensive social and political process, and knowledge of community members is essential to achieve the desired health goals.

According to the WHO “health is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity” (Bull World Health Organ, 2002). The Ottawa Charter for Health Promotion (see Ottawa Charter, 1986) declared: “The fundamental conditions for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity” (Terris, 1994). It is also known that health determinant conditions include socio-economic status, income, education level, environmental conditions and biological factors (Ballantyne, 1999). In fact contemporary health promotion is working with a concept that portrays health as a part of everyday living and one of the essential dimensions adding to the quality of our lives. Health is thus envisaged as a resource, which gives people the ability to manage and even to change their surroundings. This view of health recognizes freedom of choice and emphasizes the role of individuals and communities in defining what health means to them. No matter how health is defined or measured, the Ethiopian language policy has significant effects on the freedom of choice in life.

Language makes events and ideas meaningful and often defines our reality. According to Dei and Asghazadeh (2003) language plays a crucial role in the maintenance of individual and collective ways of living as well as in the development and maintenance of individual’s and group’s identity and their aspirations. Languages provide meanings, relations and

interrelations and it also foster self-reflection of the past and critical thought into the learning process. Language plays a guiding role in the maintenance or alteration of the community's social fabric.

Language is potentially converging with the intellectual resources of centuries human endeavor and thus, it plays significant role in community stability and social transformation. When it comes to information human beings never depended on his/her own experience alone. Due to the limitations of his/her own experiences and knowledge, instead of having to discover what others have already discovered, instead of spending time and resources to make trials they can go on from where their ancestors left.

The primary objective of this paper is to raise awareness about the impact of Ethiopian language policy on health promotion in Oromia and explain the mechanism by which it affects the health determinant factors. This paper explores a range of topics that are linked to the Ethiopian language policy: (a) the exclusion of Oromos from formal schooling; (b) deaths resulting from the misdiagnoses of diseases; (c) Oromo avoidance of modern health care; and (d) the wider consequences of the language policy such as the loss of property, shelter and social status.

Social Construction of the Ethiopian Empire

Ethiopia is a multi-national empire formed at the beginning of the last century when Abyssinia clustered big and small nations in the North Eastern Africa (Holcomb & Ibsa, 1990). The formation of the empire, the maintenance of the border, and power relations were not achieved by peaceful means (Holcomb & Ibsa, 1990; and Bulcha, 2002; Jalata, 2005). Since its formation, Abyssinia dominates the political life in Ethiopia. The impact of Ethiopian language policy on health promotion cannot be analyzed without reference to power relations and the social construction of the Ethiopian Empire. In the Ethiopian case, it is important to critically look at the social structure of the Empire in terms of language and education policy, because these socially constructed conditions limit the capacity of individuals and groups to make choices in life.

Oromos are indigenous African people who constitute a significant portion of the population in the Horn of Africa. Oromo constitute about 39 million of the 73 million inhabitants in Ethiopia and they are also found in neighboring countries such as Kenya, Somalia and Uganda. The Oromo language (Afaan Oromo) is categorized as a Cushatic language, similar to that of the ancient Nubians, and it shares a common vocabulary and grammar with Afar, Sidama, Somali and other Cushatic languages. Afaan Oromo has the second most speakers among African indigenous language, next to Hausa (Bulcha, 1994).

However, the Oromo people are being denied the right to develop their own literature (Bulcha, 1997). This affects the rights of Oromo people to enjoy the highest attainable standard of physical and mental health set forth by WHO constitution (see, Bull of World Health Organ, 2002) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) (See, ICESCR).

Until recently the Ethiopian government was not willing to recognize the socio-cultural diversity of the people in the empire. From the perspective of public health, culturally diverse societies have distinct social and health problems and each of them requires a specific strategy to address their problems. The denial of cultural diversity is a denial of opportunities in addressing these social problems.

The population of Ethiopia is about 73 million (WHO, 2004) and it is one of the poorest countries in the world. In Ethiopia, twenty six percent of the population gets less than \$1 a day. The Ethiopian government spends as much as 50% of its GDP on its military while they allocate only 6% to health care. Ethiopian life expectancy is one of the lowest in the world--even lower than neighboring countries such as Kenya and Sudan (see the World Bank Group). The life expectancy at birth is 47 years for men and 49 years for women. The maternal mortality ratio ranges from 560 to 850 per 100,000 live births. Infant mortality is 114 per 1000 children born. Only 24% of the populations have access to sanitized water (WHO, Statistics, 2004). Though there are no data available along ethnic lines, it seems logical to assume that the disadvantaged groups like the Oromo people have significantly poorer health and a higher

prevalence of disability (Dugassa, 2003). Thus, from a health promotion perspective it is critical to examine conditions that increase the risks and vulnerability of people and how these risks and vulnerabilities can be reduced and/or avoided. This goes beyond a simple biomedical concept of health and takes into account politics and social justice.

Ethiopia is one of the countries in the world most severely hit by HIV/AIDS. The incidence of HIV/AIDS (ICG, 2001) and malaria (Babaniyi, 2005) has been increasing steadily. Political instability, lower socio-economic conditions, widespread human rights violations and famine accelerate the transmission of HIV/AIDS. Currently over 2.2 million people live with HIV/AIDS (UNICEF, 2005).

In absence of vaccination and treatment against HIV/AIDS, raising awareness about AIDS is the only means of prevention. Data collected by the Ethiopian Statistics Authority make it clear that the number of Oromo, Afar and Somali women who have heard of the existence of HIV/AIDS lags behind women in the Amahara and Tigray regions. Not only that, among those women who have heard of the existence of the disease, many are reluctant to believe the information (see, Ethiopia Demographic and Health Survey (2000)). This reflects the Ethiopian language policy and power relations. One of the major reasons for differences in knowing about the disease is lack of access to the Amharic language that dominates the media. The other explanation for the discrepancy is that the state-controlled media and public health institutions are seen as state agents and viewed as police and security forces which have no respect for the peoples' rights and dignity.

The recent WHO (2005) report revealed that in Ethiopia the coverage of DPT3 immunization rate varies between regional states. The Tigray region, the home of Ethiopia's dominant political party, DPT3 immunization coverage is over 80%, while it is less than 5% in the Somali and Afar regions.

Currently, the Ethiopian adult literacy level is 47% for men and 31% for women. In the year 2000, 72 percent of children still had no access to formal education (ENA, 2000). Accessibility to education is not equally distributed. The Ethiopian official language policy is one of the tools used to discriminate against non-Amharic students.

Emmanuel Abrah (1995), an Oromo man who served as a Director General in the Ministry of Education from 1944 to 1947, was at one point accused of educating only the "Galla." Galla is a derogatory term for Oromo. Without Abraham's knowledge, King Haile Selassie directed the headmaster of a school that had the largest number of students to make a list of the pupils in various ethnic groups; and he found, out of a total of 991 pupils, that 701 or about 71 percent of them were Amahara nationals and the rest came from the various ethnic groups. Then the Emperor commanded Abraham to get a list of all the pupils in the Addis Ababa schools by ethnic groups and Abraham came up with an exact figure in a few days. Accordingly, it is known that in April 1947, 4,795 students attended schools in Addis Ababa. Of those, 3,055 or about 64 percent were Amharas and the remaining 1,740 were from the other ethnic groups. Of these, only 583 or about 12 percent were Oromo nationals (Abrah, 1995). The allegation against Abrah was fallacious. Arguably, the motive of the allegation was two fold: first, the Abyssinian elite wanted Abraham out from the position he holds, since, he is an Oromo in an Abyssinian dominated circle; second, they did not approve even a handful Oromo students attending school.

Twenty years after Emmanuel's Abrah data were collected, Hultin (2003) recorded that from 1967 to 1969, of the students who reached grade 12 and sat for the final exam, 60 percent were Amharic speakers. In 1970 there were 4500 students in Haile Selassie University and only 10 percent of the students were Oromo nationals (Balsvik, 1985). It is very clear that there is overt and covert discrimination against the Oromo people. However, only recently, the Ethiopian education system acknowledged that one of the major contributing factors for the high illiteracy level is its language policy (WIC, 2002)

Ethiopian language policy has its basis in conquest, military and political subjugation, and economic exploitation as well as socio-economic exclusion (Holcomb and Ibsa, 1990, Bulcha, 2002; Jalata, 2005). The contemporary status of English, French, Portuguese and Russian indicates how successfully and ruthlessly the principle of language imposition was applied (Phillipson, 1999). Colonizers claimed their colonial motives as "a civilizing mission." Correspondingly, they claimed that

language is neutral and thus, imposing the colonial language on the colonized would have no social, political and/or health consequences. However, a close examination of the contemporary Ethiopian language policy reveals that language is not value free and it is intermingled with power (Wright, 2001); hence, implicated to the social well being of people.

Colonialism and Language Policy

Colonizers explain their colonial agenda as a 'civilizing' mission; but for the colonized people, colonialism is a 'disease'. Colonialism affects the socio-economic status, knowledge construction and way of life of the colonized people (Watts, 1997). The problem of colonialism goes beyond the exploitation of human and natural resources (Said, 1994). Colonialists used language for social regulation, imposing their moral, cultural and hierarchical social norms on the colonized peoples. Soon after Oromia fell under Abyssinia, Abyssinia slowly imposed its language and culture upon the Oromo people. Though the Amharic language has fewer native speakers than the Oromo language in Ethiopia, it is the working and official language. Knowledge of the Amharic language is used to screen individuals and groups from accessing education, information, and well-paying professional jobs (Dugassa, 2005). This creates an enormous socio-economic barrier for the Oromo people.

Language is one of the most complex tools that the colonizers use for control, exploitation and suppression. Amharic is the official language in the Ethiopian empire (Bulcha, 1997) and it is required for employment and promotion in the public services and other well paying jobs. Success of students is measured on their knowledge of Amharic. For over a century, the Oromos have been forced to communicate with Amharic-speaking lawyers, teachers, judges, police, doctors, security guards and others. Very often the Oromos have to pay for translators.

This language policy denies the Oromo people the right to have access to information and to develop their own literature, so they have been excluded from literature, art, science, and music. Oromos have no choice but to purchase Abyssinian books, magazines and newspapers and even listen

to Abyssinian music, thus creating jobs and business opportunities for the Abyssinians.

According to Hassen (1993), Hodson, (1927) during the nineteenth century, Afaan Oromo was the major language of trade, the main lingua franca in the Horn of Africa. It was the language of government, business and education within the Oromo states. After Oromia was colonized, slowly the Oromo language was legally banned (Bulcha, 1997). After a long struggle, in 1991 the Oromo people achieved a partial victory for the use of Afaan Oromo in the work place and as a language of instruction in school. However, in several parts of Oromia, Afaan Oromo is still not used in workplaces or schools. For example, in the province of Wallo, in the district of Wonbera, in the cities of Dire-Dawa and Harar, as well as Finfine (Addis Ababa) this right is still denied. In addition, the current government of the Tigray People's Liberation Front (TPLF) is planning to deny language rights in several cities and towns in Oromia.

Similar language policies have been used under several colonial rules. For example, the famous Macaulay Minute on Indian education argued that the intent of colonial education was to create a class of Indians who were so in name but otherwise English in everything else through linguistic engineering. This was clearly a theory that had emerged from practice. Indian bodies with English minds are expected to see the world in the same way as their white engineers. The re-formed Indians would become efficient and trusted interpreters between the colonizers and the millions whom they ruled (Ascroft et al, 1995). The French elaborated this into a system they called "assimilation," in which some Africans could become French citizens through the same process of linguistic and cultural engineering. The French created a vast army of Macaulay-type interpreters to help them homogenize French subjects. The Portuguese in Angola, the Belgians in Republic of Congo and the Abyssinians in Oromia used the same approach.

Language transcends the reality of everyday life for the given community (Berger & Luckman, 1967). Students learn based on their former experiences. As such, language affects the learning process of children through construction of meaning. If the subject they are about to learn is not comparable to what they know, they do not learn, as they should (Bishop, 1998).

For that reason Ethiopian language policy implicated to educational underachievement. For example, for the Oromo people black and blackness represents purity and holiness; however, for most of European and Amharic languages black represents crime, sorrow and evil (Dugassa, 2006). Oromo children who have been denied the rights to learn in their native language are forced to integrate into their thinking the dominant concepts and symbols, which I call "imperialism of mind".

Language and Health Promotion

In health promotion and medicine the language barrier has significant effects. Doctors diagnose the patient's health problems based on her or his narrative. If doctors cannot communicate with patients they are not likely to make proper diagnoses. If they cannot make proper diagnoses there will not be appropriate medical prescriptions and no patient education about their health. In fact, a communication barrier between patient and doctor can be fatal.

When a patient does not fluently communicate with her or his health care provider, several adverse effects can happen. A patient may not comprehend the education the health professional provides, often resulting in poor patient satisfaction and poor compliance to health advice. Health education that is intended for the maintenance of good health and preventive measures can be totally ineffective if there is a language barrier. According to Timmins (2002) and Flores et al (1998) poor patient outcomes attributed to language barriers between patients and providers include: (1) increased use of diagnostic tests, (2) increased use of emergency services and decreased use of primary care services, (3) poor or no patient follow up and (4) misdiagnosis, negative outcomes and malpractice. According to David and Rhee (1998) language barriers affect patients' compliance with medication and their satisfaction to the service.

There are several solid pieces of evidence that show a language barrier could adversely affect quality of care. Liao and McIlwane (1995) reported that the health needs of Chinese populations in Glasgow are not fulfilled. This report suggests that the main barriers to the effective use of health services

and gaining benefits from health promotion and health education programs are language difficulties. A similar situation was also reported among the Spanish, speaking population in New York State (David and Rhee (1998).

According to the reports made by Committee on Perception and Communication (See, National Cancer Institute, 1989), health communication is used as a tool to let the public know about the health threats and influence to individual and community decisions to enhance the individual's and the public's health. The report also suggests that effective communication helps community leaders and policy makers become allies with health professionals to influence change in existing socio-economic and health policies. This also includes increasing awareness of health issues among community members by insisting on changes in attitudes and beliefs, and obtaining group or institutional support for desirable health goals. Very often, effective communication leads to a structural change in the community, which encourages health behavior changes. In turn, this can influence individual behavior by affecting norms and values and attitudes and opinions by creating better physical, economic and cultural environments. Effective communication can be achieved if, and only if, the communication is done in the language the community fluently speaks.

Several studies have examined the healing rituals used by religious institutions (Freedman, et al. 2002). Their findings showed that healing depended on a meaningful and convincing discourse that transformed the patient. This transformation did not necessarily remove the symptoms; it did change the meaning a patient attached to the illness or changed a patient's life style (Gesler, 1997). Verbal language allows the patients to bind themselves to the past and to the future and help them develop positive abstract concepts (Emmert & Donaghy, 1981). By connecting ourselves to the past and the future we learn from the mistakes, accomplishments and the wisdom of our ancestors and also transmit these and, our current experience to the incoming generation. This means that through language we learn from the knowledge produced in the past and teach the future generation and so bind our selves to the past and present.

The Ethiopian language policy is contrary to the principles

of health promotion. For example, according to Alma-Ata declaration (1978) the attainment of the highest possible level of health (social wellbeing) should be the most important social goal. The realization of this goal requires not only the actions of health sector but also the participation of several social and economic sectors. The Sundsvall statement (1991) on health promotion emphasized the need of assembling the physical, the social, the economic and the political environment in supporting health rather than damaging to it. Access to information is essential to achieving effective participation and empowerment of people (See, Jakara Declaration, 1997).

Let me share my personal observations. One day I was sitting in a small teashop not far from a hospital in Finfine (Addis Ababa) and I saw an old brave man carrying a woman crossing the road toward the teashop. He put the woman very close to the entrance door and came into the teashop and bought bread and tea for himself and for the woman who was sick and not able to walk. A few minutes later he came back to the teashop and asked the cashier to read the prescriptions, which he had gotten from a doctor in the hospital. The shopkeeper could not communicate with this Oromo man. When I spoke to him in Afaan Oromo, he was relieved and shared with me his concerns. He showed me two prescription drugs, which he had put in separate pockets hoping to identify them later. One of the drugs was for his wife and the other was for himself. Since he could not read, he wanted to know which drug was for whom and how and when they had to take these drugs.

It is obvious that this man and woman did not understand the Amaharic language. There was no way for them to communicate competently with the Amaharic speaking doctors, nurses and pharmacists in the hospital. There is no mandate for health professionals to provide translators for their patients. If that is the case, how could the doctor make proper diagnoses of diseases in this man and woman? How could they educate the couple about their health problems? If I had not been in that teashop to help him to understand the instructions of the doctor, he may have taken the medication that was supposed to be for his wife and vice versa. One can imagine the tragedies that might result from such communication problems.

The second case is about HIV/AIDS. In 1996 a friend introduced me by telephone to his friend from Finfine. A year later, I learned that this person had died. To express my condolence I called his wife. In our conversation she told me that she was also sick. I asked her what was happening, hoping to know whether or not she was aware of the AIDS/HIV epidemic. I asked her whether or not she watched television and listened to the radio. She said, "I do not understand Amaharic. The Afaan Oromo program soon after it has started you will find it is finished." During the television show in Afaan Oromo she said, "they talk about their propaganda, who is going to listen to their lies? In our coffee gathering I heard about a baleful shadow that is going around." I asked her what the baneful shadow was. She answered, "it is the shadow of evil, that is flying around. If that shadow passed on your clothes that you put to dry in the sun you will catch the disease. The person who is caught by the disease would die a year later and there is no medication for the disease "Waaqni haan akkas namaa habaasu". (Let God forbid such tragedy)". She passed away a year later.

I raise these issues not as separate accidental cases, but as realities that the Oromo people have been facing throughout the country for over a century. How many such cases are known? How many people die from such a preventable tragedy and how many more are going to die from them in the near future? The man and woman I mentioned above are not in a foreign country, they were born there, their ancestors lived there and their children are going to be there. Why are these people treated inhumanely? Why are their lives considered less important than others?

The most basic component of an effective form of communication is to establish trust. In education we know that students' learning processes are influenced by not only where and when the subject is presented but also who presents the subject. Credibility in health promotion is as important as it is in teaching and learning. According to Hilliard (2000) full communication involves earning and sustaining trust, listening actively, mastering timing, conveying a sense of sincere caring, formulating ideas clearly and succinctly, and transmitting sympathy or empathy as needed. Before reasoned

actions take place, the public should have evidence, which has to be provided to them from reliable sources in oral, written or visual forms, or they have to see it themselves. Generally, the public trusts information that is coming from an institution that they trust, that belongs to them, where they can be involved in collecting the data and in educational planning as well as in implementation. In Ethiopia, public health education has failed (Ethiopia Ministry of Health, 2002). Lack of trust in the information provided by government agencies is one of the contributing factors for the failure (Dugassa, 2005).

Knowledge of a society is embedded in language. Reliability of health information depends on how and who has provided them. For example, the Oromo people consider their language as a their treasure. These treasures are the collected wisdom of ages; the knowledge that has been established over a long period of time, which guides and monitors the Oromo peoples' very lives today and in the future. The Ethiopian language policy, which is practically designed to dismantle and disrupt these treasures, significantly affects the information delivery system. Packaging information in Afaan Oromo is the perfect delivery mechanism for informing the Oromo people about health risks.

The Ethiopian government that has imposed this language policy and discriminatory practices in all social structures of the Empire State has created two categories of people. On one hand there is the Ethiopian government and its agencies, including public health agencies and on the other hand the general Oromo public. The government agencies represent the interests of the institution to which they belong. They are therefore, not in a position to address the true needs of the Oromo people; in response, the public has lost trust in these agencies. Such a long-term colonial power relationship between Abyssinia and Oromia has created a condition in which the general public does not trust the public health agencies and the government media. As a result, in Ethiopia, public health education is considered state propaganda (Dugassa, 2003). That is one of the reasons that Ethiopian public health education has failed to stop or contain the HIV/AIDS epidemic (Ethiopia Ministry of Health, 2002). To bring health behavioral changes, the credibility of public health agencies must be established. Credibility

can be established and public skepticism, or indifference, to information about health risks will be addressed if the public health agencies are seen to belong to the people.

The Ethiopian government language policy slowly expropriated the socio-economic, cultural and political power. Slikkerveer, (1990) made an intensive survey in the town of Babile in Eastern Oromia. According to the report, the Oromos and Somali people use traditional medicine more than the Amaharas. Most of the government employees are Amahara nationals. The economic status of Amahara is much better than the others.

Information is knowledge and knowledge is power (Foucault, 2001). Information access determines one's social status during the information age. From a health promotion perspective, providing information empowers the public. Hence, language is used as a tool to empower the public so that the public acts upon the advice to achieve the desired health goals. Knowledge about disease-causing agents or conditions and their means of transmission or control, is a powerful tool to combat epidemics. For example, in Canada, in health professionals' qualifications, the ability to communicate with patients is considered the second most important skill for health professionals (The Royal College, 1996). This document suggests that communication between practitioners and patients is essential in understanding and solving patient's health problems.

The Ethiopian language policy is one of the major obstacles in health promotion in Oromia. Such a language policy has disempowered the Oromo people and denied them access to information in science, health and farming techniques. Because they are denied the use of their language in school, they are deprived the ability to develop their own knowledge at the local level and also access to knowledge produced elsewhere. These conditions have resulted in the Oromo society continuing to lead a sluggish socio-economic-health-cultural life style for over a century. To improve the social wellbeing of the Oromo people, the rights of the people to use their language in school, court, health care and at the work place are essential.

Control of language is an instrument of power. Information and education are essential tools to effect behavioral changes and preventative actions, as well as joint problem-solving and

conflict resolution. Language proficiency skills are essential to increase public awareness of specific disease risks through organized education, information, and communication (Tinker, 1996).

The motive behind making laws and the intent of policy making in general has never been neutral. As such, the Ethiopian language policy is intended to improve the Abyssinians' quality of life at the cost of the Oromo people. The Ethiopian language policy should be seen in parallel with other colonial language policies that are intended to monopolize, control and disempower (Kasuya, 2001). From a health promotion perspective, the Ethiopian language policy should be seen as a social construct that limits the Oromo people's choices in life and in some cases condemns them to death.

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