



VOICES OF THE OROMO COMMUNITY

INTRODUCTION

Demographic changes in the Seattle area are having a profound impact on the local health care delivery system. Health care providers need to hear from ethnic communities about their experience in trying to access health care. Offering culturally appropriate care requires being open to the perceptions, realities and expectations of a community that may be different from one's own.

The Cross-Cultural Health Care Program (CCHCP) in Seattle, WA works with health care providers, interpreters and community-based organizations to address these needs. Established in 1992, the CCHCP is funded by a grant from the W.K. Kellogg Foundation. This "Voices of the Communities" profile is one of a series developed by the CCHCP. The profiles and an earlier survey of 22 underserved ethnic communities are part of the CCHCP's effort to provide a forum for underserved communities to interact with the health care community. These profiles were developed by and in consultation with members of the profiled community.

OROMO DEMOGRAPHIC AND CULTURAL BACKGROUND

Location and history

The Oromo people are the largest ethnic group in Ethiopia, representing about 30 million people out of 60 million, and are the third largest nationality in Africa. Their original home land, Oromia, included most of what is now Ethiopia and stretched into northern Kenya, where some Oromos still live. In the 20th century, Oromos have experienced political and social oppression under Ethiopia's ruling governments. For a time the Oromo language was banned and the government tried to establish the Amhara culture as the culture of all Ethiopia. The United States began accepting refugees from Ethiopia in the late 1970s, but has not granted refugee status to Ethiopians since a new Ethiopian government was established in 1991.

Language

Traditional Oromo language, Afaan Oromo (Oromiffa) is a highly developed spoken language. The written forms use the Roman alphabet. Because Amharic was Ethiopia's official language and Oromiffa was banned in the 1970s, many Oromos who had formal education or grew up in urban areas can speak and write Amharic. Oromos in rural areas continued to speak Oromiffa.

Social system and family life

Oromo economic, cultural, social and political life is organized under the Gada system. This system organizes Oromo society into groups or sets that assume different responsibilities in society every eight years. Oromos typically live in extended family households. Marriages in rural areas are usually prearranged. Women may marry at age 15. Children are considered full members of the family and the community. Adults appreciate that children keep their parents' spirit present in the community even after the parents' death. Unlike other cultural groups from

Ethiopia, Oromos allow children to eat at the same table with adults and participate in discussions of significance when they are old enough to talk and understand.

Religion

Traditional Oromo religious belief involves one God, Waaqa, who is responsible for everything that happens to human beings. As Oromos adopted Islam or Christianity, they maintained the notion of Waaqa. Oromos who are Christians are primarily Catholic or Pentecostal rather than Orthodox, since the Ethiopian Orthodox Church is associated with the dominant Amhara cultural group. Within the Oromo nation, Muslims and Christians have mingled peacefully.

THE OROMO COMMUNITY IN THE SEATTLE AREA

Population size and residence

Most of Seattle's Oromo population lives in south Seattle (Rainier Valley and Holly Park), but some families have also settled in Ballard, West Seattle, Kent, Edmonds and Bellevue. Oromo refugees began arriving in the United States in the early 1980s, with the largest numbers settling in Seattle between 1989 and 1993. There are approximately 3,000 Oromos in the Seattle area, with the number growing rapidly by new births and a few family members still immigrating from Africa.

Employment and family life

Oromo households in the Seattle area include extended families of up to eight people, nearly half being children under age 10. Most of the community members came from rural areas and have had little formal education. Those who came from urban areas are educated and had worked as health professionals, engineers, teachers and social workers. Unemployment or underemployment are leading problems for many heads of household.

Community organizations

The Oromo Community Organization in the Seattle area was established for community members to help each other build new lives in Seattle. The organization focuses on education, health, counseling and job training. The organization is especially interested in promoting education to improve the community's health and welfare, especially that of women and children. The Oromo Community Center, in the Central District (2718 S. Jackson), hosts meetings, English as a Second Language (ESL) and Oromo language classes, tutoring and social gatherings.

CONCEPTS OF HEALTH CARE AND MEDICINE

Traditional healing

Traditional Oromo healers are skilled at bone-setting and surgical procedures such as tonsillectomy. They widely practice cauterization to disinfect skin and prevent bleeding, as well as in

treatment of snake and scorpion bites. Illnesses are treated with medicines made from local plants and roots. Individuals also were accustomed to using plants for home remedies, but they are not able to find the needed plants in the Seattle area.

Hygiene is important in every Oromo family. They recognize that some diseases are contagious. Oromos use several methods of avoiding or preventing infection, including prohibiting and controlling the movements of infected persons.

Illness and misfortune are often considered to be a punishment from Waaqa for sins a person has committed. In addition, the "evil eye" is believed to be a malevolent influence from other people that can cause disease, especially in infants.

Maternal and child health

Oromo women are assisted in pregnancy and childbirth by female neighbors or female elders. When a woman is ready deliver, she might notify a female friend, but not her husband, as a man's involvement in delivery is limited. The new mother and baby stay at home for 40 days after birth, with female relatives and friends helping to care for them. The majority of women breast-feed; breast-feeding in public is acceptable. Mothers introduce other foods to the infant at six months of age but continue breast-feeding up to three years or until the woman is ready to have another child.

Circumcision

Oromos circumcise boys in early infancy or before the time of marriage. Male circumcision is considered mandatory for reasons of health, hygiene, social acceptance and religious law. Female circumcision is desirable but optional.

Medical care

In urban areas and refugee camps, where Western-style medical care is available, antibiotics are used frequently. Oromos who consult doctors usually receive a medication for every illness.

CULTURAL BARRIERS TO HEALTH CARE

Medical care and providers

Most Oromos in Seattle get care from Harborview Medical Center. Oromo refugees from urban centers in Ethiopia have some experience with Western-style medicine. However, Oromos from rural areas may have trouble understanding Western notions of the causes of disease, the means of transmission and methods of prevention. They also don't understand the practice of withholding treatment until diagnostic work is done. Because Oromos from urban areas or refugee camps are accustomed to receiving antibiotics or other medications for every illness, they feel it is a waste of time to go to a doctor if no medication is given, even for a minor illness. This is a common point of dissatisfaction with health care in Seattle.

Oromos tend to be uneasy about large blood draws because they worry they will not be able to replace the lost blood. The traditional method of replacing lost blood (drinking fresh blood from a sheep or cow) is not possible here. Taking blood from a finger for lab tests is more acceptable. Blood transfusions also generate concern and potential misunderstanding.

Gender

Oromo women are reluctant to discuss gynecological issues or childbirth, especially with male doctors or interpreters. The idea of a pelvic exam may be completely foreign and unacceptable to a woman who is not familiar with Western medicine.

Maternal and child health

Oromo women in Seattle have several concerns with childbirth: they are uncomfortable with male doctors and medical students and with the American high-tech approach to anesthesia, fetal monitoring and augmenting delivery. Many think that American doctors are too quick to perform Cesarean sections for what Oromos consider to be normal variations. For this reason, they may wait at home until well into labor in order to avoid unwanted procedures. Since men traditionally are not present at delivery, many Oromo women are reluctant to have their husbands involved.

Because of school, work and other obligations, Oromo women in the United States are not able to take the traditional 40 days of rest after childbirth. They also worry that nursing in public is inappropriate or find that work or school interrupts the feeding schedule. They have trouble maintaining breast-feeding as long as they would like. Most are unfamiliar with pumping and storing breast milk.

A shortened period of breast-feeding is contributing to high fertility rates in Seattle's Oromo community, since breast-feeding an infant up to three years was the most common form for birth control. Oromo women do not commonly practice other methods of family planning.

Circumcision

The Oromo community is very concerned that they have still not circumcised some of the boys born in refugee camps. The cost for a routine procedure with general anesthesia in the Seattle area is more than \$2,000. The Department of Social and Health Services pays for circumcision in older children only if medically indicated.

Suggestions

- Information should be provided on disease prevention.
- Health care providers should explain diagnostic tests and why treatment might not be given until test results are available.
- If no medications are given, providers should explain why.
- Providers should take blood from a finger rather than a vein for lab tests.
- Provide female doctors for women; explain pelvic exams and the medical procedures used in childbirth.



- Offer information to new mothers on pumping and storing breast milk.
- Offer information on family planning.

FOR FURTHER INFORMATION

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This is a condensed version of the profile. For the complete profile and survey report, please contact the Cross Cultural Health Care Program, (206) 860-0329 or www.xculture.org.

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