

The Significance of Collective Rights to Public Health Development: The Case of Oromia Regional State in Ethiopia

Begna Dugassa*

Oromo Studies Association, Mississauga, Canada
*Corresponding author: begna.dugassa@gmail.com

Abstract Colonialism is a violation of the collective rights of people. This violation has denied them the right to decide on their social, economic, political, cultural and environmental rights. This has hindered them from building their social, economic, political, cultural and environmental capitals and achieving the highest possible level of physical and social well-being. The essence of collective rights includes the social, economic, political, cultural and environmental rights; all of them are essential to the development of public health. First, as the violation of social rights is an attack on the social wellbeing of people, so the violation of economic rights is an attack on the economic wellbeing. Second, the violation of political rights is taking away the decision making power. The violation of cultural rights is obstructing societies from culturally reproducing themselves and developing problem-solving skills. The violation of environmental rights has caused severe degradation of the natural environment. Violations of those rights act individually and synergistically and hinder the development of public health. The efforts the Oromo people make to assert their collective rights are part-and-parcel of building their social, economic, political, cultural and environmental capacities and promoting health and preventing diseases.

Keywords: *colonialism and public health, collective rights and public health, Oromo, Ethiopia*

Cite This Article: Begna Dugassa, "Significance of Collective Rights to Public Health Development: The Case of the Oromo People in Ethiopia." *American Journal of Public Health Research*, vol. 6, no. 5 (2018): 203-214. doi: 10.12691/ajphr-6-5-1.

1. Introduction

Indigenous people around the world continue to experience poorer health than the colonial settlers [1,2]. The magnitude of health disparities between them varies across time and place. As colonial settlers started framing their social policies from human rights perspectives, the gaps in health disparities started to get narrower. The rights the colonial settlers' societies adhere are individual's rights, and it is based on the neo-liberal theory. The principle of individuals' rights does not recognize the unique social, economic needs, political, cultural structures as well as environmental realities of colonized people. It imposes neo-liberal political-economy, morality, ethics, and perspectives on the colonized people. Health and diseases are socially determined, and if the colonizers want to reclaim their dignity and decency and improve their quality of life, they need to assert their collective rights. This means the efforts the colonized people make to freely determine their social, economic, political, cultural and environmental affairs are the efforts they make to improve their health.

Public health has evolved from controlling biological contaminants and chemical pollutants to social hygiene. The development of vaccines and antibiotics for several infections made controlling many infectious diseases

possible [3]. However, several degenerative diseases and nutrient deficiency syndromes remain significant challenges. Besides that, many public interventions continue to focus on changing individual's behavior and promoting healthy lifestyles. Among the colonized and at-risk communities, unless structural determinants of vulnerability are addressed, they cannot achieve the desired goals. If the primary objective of public health is to prevent diseases and promote health, we need to identify the structural determinants of vulnerability and accordingly address them. This necessitates promoting the collective rights of people.

The status of a population health is intricately tied to social justice. For example, in the 1880s, during the formation of the present state of Ethiopia, Oromia was conquered by the Abyssinian king. Since then the Oromo people have been denied the right to decide on their social, economic, political, cultural and environmental affairs [4,5,10]. Violations of those rights have caused the socio-economic conditions of the Oromo people to deteriorate over time or stagnate. Critical historical analyses of the colonial public health system suggest that as the Indigenous peoples lost their sovereignty, colonial social policies either compromised their safety and security or failed to understand their needs [2]. The struggle of people to end colonial rule is to assert their collective rights and halt their suffering. Empirical data clearly show the denial of the collective rights of the Oromo people has exposed

them to overt and covert harms and has created pathological social conditions [6,12].

Until the 1880s, the Oromo people have been democratically ruled themselves under the Gada system. They were emancipated and freely elected their leaders every eight years. The Abyssinian king, Menelik II, saw the Oromo system of governance as an obstacle to his colonial agenda. He deliberately worked to abruptly dismantle and erode the Oromo democratic culture, the authority of the Oromo systems of governance and institutions [7,8]. Under the consecutive Ethiopian regimes, the Oromo legal, religious, political and cultural institutions were banned [4,8], land ownership was shifted from the Oromo private/collective ownership to Abyssinian individuals and institutional landlords. Only a few Oromo individuals who collaborated with the Ethiopian government and served in their military were allowed to own land [9]. This resulted in the disruption of the social foundations of the Oromo people and hindered the development of public health conditions.

The record shows- as has happened in several parts of the world- the Ethiopian colonial social policies have incapacitated the Oromo people and crippled their public health conditions. Indeed, after 10 years of Ethiopian rule, the population of the Oromo people was reduced by a half to two thirds [11]. Although killings and the slave trade have played a significant role, most of the mass deaths resulted from famine and several epidemics that sprung from the Ethiopian government's covert and overt actions [12].

We are born into the world that was made by those who lived before us. The social conditions in which we are born are beyond our individual's power to improve. For this reason, progress in a population's health does not happen because individuals wished for it. It results from a society's continuous efforts, careful thinking, and strategic planning. This necessitates providing visions, setting up institutions and developing skillful people. Building these essential conditions requires allocating human resources, providing financial support, assembling institutions, infrastructure, setting programs having in mind the impacts of the social determinants of health on a population's health. Those responsibilities are the duties of the states; because public goods are created and maintained by collective efforts [13]. In Oromia, most of the public health problems have resulted from malnutrition and infectious diseases, and they are easily preventable. The political and economic marginalization of the Oromo people has limited their choices in life. In many ways, this has shaped the quality of public health conditions in Oromia.

Human needs and human rights are interrelated. Colonial power relations that suppress the social, economic, political, cultural and environmental rights hinder the rights of people to have a decent standard of living. Developing social, economic, political, cultural and environmental capacity is essential for the improvement of public health.

1.1. Objectives

The primary objective of this paper is to explore the relationships between collective rights and the

development of public health. It is intended to describe how violations of the social, economic, political, cultural and environmental rights have gradually eroded the social conditions of the Oromo people and hindered the development of public health. The secondary objective is to convey the idea that the principles of collective rights, i.e., the right of people to self-determination should be part of health promotion and disease prevention.

1.2. Research Questions

In what ways do colonial social policies affect the public health conditions of the colonized people? When the Oromo people are, collectively dispossessed of their land, denied the necessities of life, why have the international humanitarian organizations that deliver relief foods, failed to make efforts to address the underlying causes of famine and diseases? Human beings are social beings and dispossession of lands, de-legitimizing the Oromo social, economic, political and cultural institutions of the colonized people are disruptions to their social fabric. The theoretical underpinning of public health should direct its goals and actions. If that is the case, why do public health textbooks fail to notice this and advance of the collective rights of people?

2. Methods

The conceptual framework denotes the organization of ideas. This paper is built upon the theory of collective rights and collective good. It draws lessons from the concepts of public health, collective rights, i.e., the right of people to self-determination. Racist motives and economic interests drive colonial agendas. Dialectical theory suggests that theories inform practices and practices inform theory; this means colonialism is a violation of collective rights and it is the manifestations of deep-seated epistemological racism that includes cultural and biological aspects.

This paper examines the relationships between public health conditions in Oromia and collective rights. It closely looks at the ways the violation of collective rights has hindered the realization of "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" projected in the International Covenant on Economic, Social and Cultural Rights [14]. The highest attainable standard of physical and mental health is an ideal concept, and there are no established methods to quantify it. Health status can be indirectly measured by looking at the presence or absence of the right to self-determination, i.e., regarding the social, economic, political, cultural and environmental rights. The secondary indicators are access to clean water, sanitary living conditions, food security, and vaccination coverages for major infectious diseases, prenatal and maternal care. For this paper, data is harvested from secondary and primary sources.

In parallel with Sen's [15] theory, this paper explores whether or not epistemological racism that I have discussed elsewhere (58) instigated the violation of collective rights of Oromo people and led to the social, economic, political, cultural and environmental un-

freedom – “ill-health.” The violation of collective rights took away the means to build the social, economic, political, cultural and environmental capacity of Oromo people and conditioned them to live in poverty, disease and other kinds of un-freedom.

2.1. Terms Defined

It would be difficult to examine the relationship between collective rights and public health without discussing the concepts surrounding these issues. According to the WHO [16], public health is “the science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society.” The Institute of Medicine (IOM) [17] defines public health as a social and political concept aimed at improving health, prolonging life and improving the quality of life among whole populations through health promotion, disease prevention and other forms of health interventions. The IOM describes the function of public health as “fulfilling society's interest in assuring conditions in which people can be healthy.” The IOM states:

Public health is distinguished from health care by its focus on community-wide concerns...rather than the health interests of particular individuals.... Its' aim is to generate organized community effort to address public concerns about health by applying scientific and technological knowledge ([17], p. 140).

The IOM definition underlines the idea that public health is “what we as a society do collectively to ensure the conditions in which people can be healthy.” The New Zealand Health Strategy group [18] defined public health as the science and art of promoting health, preventing disease and prolonging life through the organized efforts of society. The Organization of Healthy America [19] defines public health as an effort organized by society to protect, promote, and restore people's health. All these definitions suggest that public health is a public good and it functions at the societal level. These definitions raise vital questions that are central to this paper. Among these vital questions are: What if people or societies are not empowered? What if they are not in a position to decide on their affairs? What if they are not entitled to get organized and make collective efforts? The second crucial question is if the collective and organized efforts of people are essential conditions needed to achieve the desirable highest attainable level of physical and mental well-being, why has public health, as a field of studies, failed to promote the collective rights of people?

The desire for a better quality of life is a universal human aspiration, and it is a leading motive for socio-political activism of Oromo people. The ongoing efforts people make to free themselves from colonialism, racist policies and inequality is part and parcel of the prevention of diseases and widening their choices in life. In other words, the struggle for social justice is part and parcel of the effort we make for better public health [20].

Public health is the practice of managing health risks and vulnerabilities. Public health gives particular attention to the social roots of diseases and focuses on the improvement of health through a wide range of

intervention measures. Those measures include health education, health promotion, and disease prevention methods. According to the WHO [16], “health promotion is the process of enabling people to control over the determinants of health and thereby improve their health.” The idea of health promotion is to enable individuals, families, and communities to improve and increase their control over the determinants of health and health conditions. Health advocacy is a combination of individual and social actions designed to gain political commitment, policy support, social acceptance and system support for a particular health goal or program. Health advocacy promotes the need to change social environments, service systems, and social norms to advance healthy goals. Health protection constitutes controlling infectious diseases, reducing exposure to environmental hazards and enforcing laws that protect public health. In the WHO [16] definition, disease prevention covers measures to prevent the occurrence of disease, such as risk reduction, but also arresting its progress and reducing its consequences. It includes the prevention and reduction of the spread of diseases and lowering the number of disabilities, injuries, illness and premature death. None of these methods, however, mention the importance of collective rights. If people are under colonial rule, how can they effectively run health promotion, advocacy, health protection and disease prevention?

2.2. A Brief History of Colonial Public Health

From the sixteenth to the nineteenth centuries, European empire builders colonized most of the tropical world. Racist ideologies and economic interests drove the colonial agenda. The self-righteous European colonizers presented their colonial agenda in a positive term “as a civilizing mission”, while the colonized people saw colonialism as de-civilizing and disease [21]. The contagious diseases that the colonizers had brought with them and the social conditions the colonial power relations had created frequently ravaged many colonized populations [22]. The European colonizers explained the massive death of indigenous people in the social Darwinian Theory- that they were dying because they were racially and culturally inferior to them [23]. Although the links between colonialism and public health problems are well known, the social processes by which colonialism retrogressively affected population health of the colonized are not well discussed.

As the prevalence of diseases of colonized regions threatened the colonizers, this necessitated the development of colonial sanitation and tropical medicine. Colonial sanitation, health care, and tropical medicine were designed to serve and protect the colonizers. The research in tropical public health was first intended to protect the health of the colonial military and administrators; later on, it was enhanced to control the major tropical diseases that were interfering with the economic development of the colonies [24].

In several parts of the world (e.g., Canada, the USA, Australia and others) under colonial rule, several indigenous peoples were exterminated. In these exterminations, famine and diseases played a significant role. Researchers in health and human rights also emphasized individual

rights [25]. Although the objective of public health is to improve the quality of life and create healthy social conditions, there is a gap in the literature between collective rights and public health. In countries like the USA, Canada, and Australia, where individual rights are respected, the life expectancy of indigenous people is lower than colonial settlers [26]. Most of the Europeans asserted their collective rights and security. However, in order to protect themselves from their consecutive states, they promote the principles that guarantee individuals' rights. When it comes to the case of colonized people they need to assert their collective rights even before their individual's rights. The significance of collective rights to the development of public health is quintessential than the individuals' rights.

The primary objectives of Ethiopian colonialism have been to exploit human and natural resources of Oromo people and assimilate them into the Abyssinian culture [27]. The consecutive Ethiopian regimes have denied the Oromo people developing their leadership, caused environmental pollution and dispossession of lands. Their policy is intended to maximize profit by exploiting the human and natural world. In doing so, they have intensively polluted spring water, ponds, and lakes on which the Oromo people are dependent. Land dispossessions have disrupted the Oromo social system, threatened the Oromo ways of life and affected their food security. For nearly 140 years over the right of Oromo people to have access to safe, clean water, adequate supplies of healthy foods, healthy work, and living conditions have been compromised.

Understanding the relationships between the collective rights of the Oromo people and their public health conditions necessitates exploring four significant areas. First, exploring the ways colonial power distributes privileges and risks. Second, how colonial power has validated their knowledge and power and invalidated the knowledge and aspirations of the Oromo people. Third, by looking at how the colonial power has denied institutional building and leadership development of Oromo people. Fourth, considering missed opportunities in comprehending the magnitude of public health problems, developing strategies and envisioning a better future in addressing just causes.

There is a tendency for human beings to focus on their family, community, and nation selectively. In Ethiopian case being an Orthodox Christian and speaking Amharic and Tigrigna language provide privileges and upward social mobility. The inclusion mostly goes along cultural and racial lines as well as social, political and economic interests. The rationales for inclusion and exclusion are racial and culturally and politically driven. Even if we achieved progress in the legal system and demanded that all human beings be treated equally, society would still be far from achieving equity in health. Belonging to a dominant socio-cultural, racial and family group allows the members to enjoy the collective good of the group. Most people not only care more about the members of their community but maintain that that view is justifiable. Colonial states established several social, cultural and political institutions and through them promoted their collective needs. In Ethiopia, the Orthodox Church is one of such examples. The institutions of colonized people are

covertly and overtly disrupted and this has hindered the means they can rebuild their common goods. Colonialism made the structure between the colonizers and colonized to be distal. The distal social structure, on the one hand, makes it difficult for the colonizers to understand the needs of the colonized people. On the other, it puts the needs of the colonized people beyond their moral inclusion of care criteria and allows unjust social conditions [1].

Racism and colonialism fueled the disenfranchising, assimilationist and genocidal ideologies [1,23]. Improvements in the underlying determinants of health and development of the public good can only be achieved if the colonized and marginalized people collectively challenge racist ideologies and policies. For example, advances in nutrition, sanitation and understanding health and diseases have led to improvements in the human condition in Europe. Such organized efforts have led to the decline of malnutrition, infection and reduced food security. Guaranteeing clean water, sanitation, food security and other public infrastructures are beyond the individual's reach. However, better public good services are achieved if individuals coordinate their human and economic resources and act collectively. This makes the collective rights of people an essential condition for the development of public health.

Historical analyses in public health suggest that the creation of high-quality public health conditions is a deliberate plan of the state and community [3,28]. Significant advances in public health have resulted from public interventions where states deliberately planned and strategically acted to solve the underlying causes of diseases, i.e., natural and social environments. Thus, improvements in public health conditions result from the continuous organized efforts of the state. Given that the principal duties and responsibilities of states are to establish the security and safety of its citizens, guaranteeing collective rights are indispensable conditions for the advancement of public health. The denial of collective rights of people is either a direct attack on the determinants of health or an obstacle to the development of safety and security or right public health conditions.

2.3. Significance of Collective Rights

Collective rights mean the freedom of people to decide on their affairs and live a meaningful life in their community and country. The two most critical collective rights recognized by the UN are the right of people to self-determination (SD) and the prohibition of genocide – a convention on genocide [29]. The preamble of the Universal Declaration of Human Rights (UDHR) [30] also states that the signatory parties recognize the inherent dignity and equality and inalienable rights of all human beings. The right to SD is a concept that includes free will, freedom of choice, independence and self-direction [31]. SD is self-sufficiency, self-management, and sovereignty on collective affairs. The principle of SD includes determining a society's social and economic policies and prioritizing the allocation of human and natural resources based on group needs.

The significance of the collective right is that all human beings live in groups sharing a common culture and

aspirations. Commitment to a shared culture involves the members' similar social, political, economic, cultural and environmental needs, which condition them to collectively make efforts to defend the foundation of their society and defy impositions of alien ideologies and policies. When people collectively work, they are more effectively defy the imposition of colonial policies, identify conditions that put them at risk and effectively find solutions to their problems. The International Covenant on Economic, Social, and Cultural Rights ICESCR (14) and the International Covenant on Civil and Political Rights ICCPR) [32] of 1966, state:

All peoples have the rights of self-determination. By virtue of that right they freely determine their *political status* and freely pursue their *economic, social and cultural* development.

All peoples may, for their own ends, freely dispose of their *natural wealth* and resources without prejudice to any obligations arising out of international economic cooperation, based upon the principle of mutual benefit, and international law. In no case may a *people be deprived* of its own means of subsistence.

In the UN human rights convention, the principle of self-determination constitutes social, economic, political and cultural rights. Although colonialism and its economic exploitation enormously affect environmental health, the charter does not include environmental rights. However, the environmental rights adopted in 1992 at the Rio convention on climate change. The rights of people to SD mean that they should be able to define their social needs including built and natural environment, social relations and develop social protection and social care [57]. To have political rights means that people need to develop their leadership to help members of the society solve outstanding social, economic problems.

The right of people to SD is seen as a process resulting in people acquiring the degree of control they desire over those aspects of life which are necessary to them [33]. SD is also viewed as a means of acquiring autonomy, independence or respect and of granting opportunities to develop and act upon plans for the future [34]. The idea of collective rights is about the liberty of people, which includes a) independence b) dependence c) interdependence. For colonized people, the right to SD is a legal means of overcoming illegal power and control. Daes Erica-Irene [35] maintains that the right to SD is "the freedom for indigenous peoples to live well, to live according to their values and beliefs."

The efforts Oromo people make to assert their collective rights means providing themselves with the possibility of choosing the most favorable social and political framework that is essential for planning their own social, economic, political, cultural and environmental policies necessary for the development of their common good. For the Oromo people, the struggle for collective rights is essential to undo unwanted external power and restore their dignity and decency as well as promote their common good, i.e., public health.

The principles of collective rights are actively promoted by those who have experienced indignity, poverty, and disease under colonial rule. For example, Article 19 of the African Charter on Human and Peoples' Rights [36], states that "all peoples shall be equal; they shall enjoy the

respect and shall have the same rights. Nothing shall justify the domination of a people by another". Article 20 of the African Charter of Rights is more specific about the collective rights of people, and it states:

All peoples shall have the unquestionable and inalienable rights to self-determination. They shall freely determine their political status and shall pursue their economic and social development according to the policy they have freely chosen.

Colonized or oppressed peoples shall have the right to free themselves from the bonds of domination by restoring to any means recognized by the international community

All peoples shall have the right to the assistance of the state parties to the present Charter in their liberation struggle against foreign domination, be it political, economic or cultural.

Although the idea of collective rights is linked to decolonization, the concept overlaps the principles of self-sufficiency, self-management, autonomy, sovereignty, independence, and liberty. From the Oromo perspective, the struggle for collective rights means demanding security and safety that can be established through self-governance, autonomous status, independent social policies, and institutions. Such rights are essential for the people to construct or reconstruct social realities and develop policies to improve/maintain the security of the members and bring about social transformation. The denial of collective rights and liberty is an obstacle to developing security, self-management, and self-sufficiency. Violation of such rights creates pathological social conditions.

If collective rights are respected, the sovereignty of people has restored it creates an enabling social environment. Collective rights are vital for societies if they are to become more independent in understanding their needs and in setting their goals and following through with action plans, and developing problem-solving skills. For example, for the Oromo people, collective rights mean having the freedom to be in charge of their own lives, choosing what form or system of governance they want to have, what form of relationships they want to establish with neighboring people and deciding how to or where to allocate their resources. It includes determining the ideology that governs them and choosing where, when, and how the members of the group obtain necessary social support for any problems they might have.

According to Espell, Hector [37] a UN special rapporteur, the actual application of the principle of the rights of people to SD is the essential basis for recognizing other human rights. The international conference on the right of people to SD made an interesting conclusion. The conclusion highlights the idea that self-determination is an ongoing process and vital to the achievement of human security and the fulfillment of human needs with a broad scope of possible outcomes and expressions. The right

to SD can guarantee cultural security, self-governance, autonomy, economic self-reliance, active participation at the international level, land rights and the ability to care for the natural environment, spiritual freedom and the various forms of entitlement that ensures the freedom of expression, and the protection of collective identity and dignity of people [38].

People need ideologies and social policies of their own to organize themselves in the face of global certainties and uncertainties. If the people are self-determined, they can protect themselves from injustices committed against them and unjust social policies that target them. They can also build the appropriate institution and prepare themselves for the unknown future. Collective rights can effectively shift the balance of power, distributive justice, social, economic progress and the distribution of the underlying social determinants of health. The primary goal of every society is to survive. According to Van Scotter and colleagues [39], if societies wish to secure their survival, they have to establish stability in a changing world and maintain peace and social justice. If societies want to secure their continuance, first, they have to reproduce biologically, culturally and socially and develop and maintain a purpose in life. Second, they must set up their own goals, aspirations, and purposes in life. Third, they should have internal social order and have ideologies that inform their relation to the external world. Finally, the group must continually work on the improvement of the physical and mental health of the community. It is the institutions of society that carry out survival tasks. As we have seen in the case of the Oromo people, if the collective rights of people are violated, and their social institutions are dismantled, the capacity of the group to understand and solve their problem deteriorates.

The concept of collective rights is also seen in parallel with the idea of freedom of choice. Having a choice is not a pure privilege- it is about safety and security. Denying people the right to decide on their affairs restricts or limits their choices in life. Limiting people's choices in life compromises their security and increases their vulnerability. Colonial power relations limit people's choices in life and their ability to enjoy and exercise their rights. According to Espiell [37], the UN Special Rapporteur, the right of people to SD is a prerequisite for the enjoyment of other human rights. If the right of people to SD is achieved, they can take necessary measures to ensure their dignity, the full enjoyment of all rights, and the political, economic, social and cultural transformation.

Experts in the field of collective rights are convinced that such a right is a precursor to the enjoyment of other rights and recommend that the right of people to SD be made a compelling law. In 1978, at the UN commission's thirty-fourth session, it was the view that the right of peoples to SD should be regarded as a compelling law [40]. According to Parker [41], the principle of SD has the status of "erga omnes," i.e., compelling law. This makes violating the collective rights of people grounds for international concern [37]. However, the right of people to SD is given to states as a duty to promote [37]. As cited by Scott [42] Dodson described the right of people to SD in the following statement.

It could be said that at the heart of all the violations of our [the colonized people] human rights has been the failure to respect our integrity, and the insistence in speaking for us, defining our needs and controlling our lives. Self-determination is the river in which all other rights swim.

The Dodson statement suggests that collective rights are the primary condition required so that all other rights are flourished and exercised. Indeed, collective rights are

proven to effectively shift the balance of power by creating conditions for distributive justice, social and economic progress; they are essential for improving the wellbeing of the entire population.

2.4. Functions of Public Health

The functions of public health are framed having in mind the public good. Public health is a very complex task and influenced by a wide range of policies across a range of sectors. Identifying public health problems requires gathering information on a specific health issue, and this requires a wide range of methods and skills. This method includes data collection and interpretation, identifying needs, setting social policies, implementing the policies and evaluating the whole process. Public health functions include technical fixes and designing social changes. Success in those actions depends in part on the availability of well-trained researchers, policymakers, organized public institutions, media, businesses, society at large, families and the voluntary and community sector. Individuals and institutional decision-making are not made in a vacuum; they are indeed, influenced by the social environments in which people live and work [25].

The absence and presence of the social, economic, political, cultural and environmental rights of people influence the functions of public health in several ways. For example, politics influence public health through recognizing the problem, the policy-making process and in the allocation of resources. Politics determines what social, economic and cultural programs are to be subsidized and commercialized. It determines which health problems require careful investigation and which require little or no attention. Politics determines whom to feed and not to feed, whom to shelter and whom not to shelter. It determines the values of individuals' work; who should live in certain neighborhoods, and who should perform what and be responsible for certain jobs [43]. It determines who should have access to higher education and research institutions, and it determines who should participate in policy-making processes [7].

The vast accumulated knowledge in public health suggests that the social determinants of health play a significant role in the health of a population [44]. Political power makes the distributions of these essential social conditions. The only way the underlying determinants of health can equitably distributed among several stakeholders is by distributing power as well. For the colonized people the distribution of justice could be achieved if they established their sovereignty or established autonomous status [1]. It is for those reasons the German scientist Virchow [45], the French scientist Villermé and the British social activist Edwin Chadwick stressed that poverty and disease could no longer treated as individual problems [24]. These founding fathers of public health clearly showed the relationship between public health and social justice and promoted not only the idea of sanitation but also social reforms. The German medical doctor Virchow's 1848 works are exemplary because it suggested that one of the primary functions of public health is to study the social conditions under which various social groups live [45]. From this knowledge, the principle of promoting health and preventing disease have included social as well as medical [3].

Virchow is one of the exemplary researchers in colonial public health. In his studies in upper Silesia- who were predominantly Polish people but ruled by the Germans- he established the relationships between colonialism and public health. Virchow promoted the idea that the oppressed and the colonized people should not have to wait for the goodwill of their guards to enjoy a decent quality of life [45]. For over a century, the work of Virchow has been used to explain the health conditions of the working class, poor and the marginalized groups in the Western world. However, there has been little literature on Virchow's idea examining the public health effects of colonialism. A century later, Mann and his colleagues [25] successfully elaborated the links between the individual human rights and health. Indeed, the former UN Secretary-General Kofi Anan asserted this overlooked issue when he stated, "It is my aspiration that health finally will be seen not as a blessing to be wished for, but as a human right to be fought for" [46].

Knowledge is socially constructed [59]. Intrinsically colonial knowledge is not synthesized to understand and address the need of the colonized people. For this reason, the relationship between collective rights and public health is under-discussed. Critical historical analyses in public health suggest that under colonial rule, the public health conditions of colonized people deteriorated. In several cases, this has resulted in the total annihilation of the colonized people. Alcabes [47] is critical of contemporary public health and of the ways the academy provides professional training to public health students. The critical point includes the idea that public health over-emphasizes individuals' health behavior rather than the need for social reform. Alcabes argues that although the denial of access to social determinants of health has resulted in increased vulnerability of people to be sick, as it is in the past, public health sciences continue victimizing the vulnerable people.

In his words, they [public health authorities] will go on blaming health problems on attitudes which are beyond the reach of reform and get away with wagging their fingers at bad behavior. Our public-health authorities try to convince us that everything will be better if only each one of us would do the right thing. It is a little like believing in angels. [47] ppB6-B9.

Environments (both built and natural) play a significant role in public health. Tackling these problems is beyond any individual's efforts, but they can be solved through collective and coordinated efforts. In many cases, collective action can have more impact than the sum of decisions taken at an individual level.

The US Institute of Health has identified ten essential public health services [17]. The first important function is the assessment. Assessment includes continuously monitoring health status and identifying community health problems and diagnosing and investigating health problems and health risks in the community. From the perspective of colonized people, the significance of assessment is it is not a neutral action. Assessing includes monitoring, investigating health problems and health risks. It is influenced by the interests and perspectives and experiences of those who make the assessment. Very often, the colonizers assess the social conditions of the colonized people having profit and control in mind. Hence, the

assessments the colonizers make usually victimize the victim. Even if the colonizers make genuine efforts to understand the needs of colonized people, they are not in a position to understand the needs of the colonized. Not only that, the colonizers are not allowing the colonized people to organize their institutions and train their professionals. This means the social problems of the colonized people cannot possibly be adequately dealt with by the colonialists.

The second important category is policy development. Policy development includes informing, educating, and empowering people about emerging or existing public health issues; mobilizing community partnerships in identifying and solving public health problems and developing policies and plans that enable individuals and communities to promote health. The desires of the colonizers are usually contrary to the colonized. The colonizers are intent on increasing profits by displacing the colonized people from their homes and polluting their environments.

Human rights are interdependent, indivisible and interrelated [48]. Violating the collective rights, i.e., the social, economic, political, cultural and environmental rights hinder the ability of people to attain the highest possible quality of health. The violation of such rights often impairs the enjoyment of other human rights, i.e., the rights to education or work, and vice versa. Human rights charters obligate states to respect (refrain from interfering with the enjoyment of the right), protect (prevent others from interfering with the enjoyment of the right and fulfill (adopt appropriate measures towards the full realization of the rights) [49].

The relationships between an individual's rights and health have been discussed [25]. The central motive for linking human rights to health is that the two interact synergistically. Promoting human rights and human dignity is seen as part of the efforts we make to improve the social wellbeing of people. Violations of human rights affect mental and physical health and increase the likelihood that the person will live in poverty, remain illiterate and be homeless. Illiteracy, poverty, and homelessness create favorable social environments for diseases. This makes regard for human rights as a prerequisite for health promotion and disease prevention. Regard for individual human rights and challenging the thinking and actions that are contrary to principles of human rights are essential to understanding social problems, setting social policies and implementing them [25]. Although the principles of collective rights have been used in effectively challenging the colonial power relations, empowering people to freely determine their (social, economic, political, cultural and environmental) affairs and create favorable social conditions for people so they can avert the underlying conditions that are limiting their choices in life, there is a remarkably limited literature on the relationships between collective rights i.e. the right of people to self-determination and public health conditions.

Let me offer specific examples. In 1973/74 in Wallo province, many people suffered from starvation and many of them tried to leave their area to search for food to the south. The Ethiopian emperor chose to stop the movement of people, justifying "they are damaging the image of the

country” [50]. In 1991, when the Tigray People Liberation Front (TPLF) took power, they dismantled the former Ethiopian army. Many of the soldiers were known to be HIV positive. To reduce the spread of the HIV, several non-governmental organizations (NGO) encouraged the TPLF government to halt their plan of dismantling the army and sending them to their villages and towns. The TPLF refused the pleas of the NGOs, thereby grossly contributing to the HIV/AIDS epidemic [51]. The motives of the colonizers were to increase profits and control; they denied people the right to develop their institutions and leadership. This means unless the collective rights are thoroughly respected, people cannot fully and freely make the assessment, participate in a decision making process and guarantee progress in public health. It is only equitable and enabling social arrangements that allow policies to be framed in marginalized perspectives.

The third category is assurance which includes enforcing laws and regulations that protect public health and ensure safety and security; linking people to the needed health services and assuring the provision of care; assuring the development of competent public health leadership and workforce and evaluating effectiveness, accessibility, and the quality of public health services. Assurance includes establishing and enforcing laws, developing leadership that evaluates and envisions a better future. The colonizers' goodwill to provide services for the colonized very often compromises their needs and aspirations. Even if they make maximum efforts to provide assurances, the services they provide would not be culturally appropriate. Under colonial rules, the colonized peoples' legal institutions are banned. In the case of the Oromo people, they are not allowed to conduct meetings, transmit information in writing, radio or electronically. Of course, they are denied the right to make laws. This makes assurance practically impossible. Let bring a specific example. Until 1992, using the Oromo language in schools, courts and all public services were outlawed. In Ethiopia, health professionals have no obligation to communicate in the language their patients understand. This made public health services culturally inappropriate. Not only that, Ethiopian language policy made diagnosing health problems and health education essentially ineffective [52]. The opportunity of diagnosing disease on the personal story of the patient is missed.

The last category is researching. Researching is serving all functions which include researching new insights and innovative solutions to existing and emerging public health problems. Again researching is not a neutral action. Data collection and interpretation is influenced by the prior knowledge, interests, and worldview of the researcher. Indeed, colonizers consolidated their power by invalidating the incredible wealth of indigenous knowledge.

Now let us take a close look at whether public health functions are affected by the presence and absence of political rights. The assessment of public health conditions, policy development, assurance and providing services require the coordination of human and economic resources, which requires a political willingness and persistent efforts. Under the successive Ethiopian regimes, the Oromo people are evicted from their lands, denied deciding on their human and natural resources, define their own needs and get organized. This implies the colonial intent to control and

exploit as an attack on the social fabric of society and the denial of access to the social determinants of health. This makes colonialism is an attack on public health and an obstacle to the development of a public health system.

Public health programs are promoted through organized government bodies encouraging individuals to make informed choices in life. The choices individuals make - for example, regarding food and nutrition - impact health, but it is impractical for every individual to know all the information necessary to improve their health. Besides, there is a limit to what personal decisions can achieve. However, public health problems can be tackled better by decisions made to change and modify the ecological (social & environmental) conditions at the societal level. Establishing a public health system, creating healthy social conditions, setting up appropriate infrastructure, allocating resources and regulating the underlying determinants of health require collective efforts. Public health conditions will be underserved without the collective actions of the members. This makes respecting the collective rights of people a precondition for them to identify their needs, coordinate their human and natural resources and solve their outstanding problems. Public health can achieve its goals if the people are self-determined, get organized, make collective efforts and contribute their part to the betterment of their society.

3. Discussions

Improved quality of life is the long-standing desire of all societies. From ancient times, all societies have worked to improve the quality of life for their members. Significant progress in the development of public health goes hand in hand with the rise of centralized government [3]. When states were formed, improving the quality of life became one of their principal duties. Progressive changes in the quality of life of people materialized when democratic governments were established. Democratic states generally plan and execute infection control, disease prevention, health education and health promotion.

A significant step in understanding the health status of a given population, and identifying the factors that improve or harm their health, is to document the presence and absence of social justice in that society. Recording these trends directly and indirectly tells whether or not social conditions favorable for health exist. Given that the major determinants of health are social rather than biological, to reveal the public health conditions in Oromia it is necessary to take critically look at the social gradients of ill health.

The third international conference on health promotion [53] identified four critical public health strategic actions. These strategies are: a) strengthen advocacy through community action; b) enable communities and individuals to take control over their health and environment through education and empowerment, c) build alliances for health and supportive environments in order to strengthen the cooperation between health and environmental campaigns and strategies; d) mediate between conflicting interests in society in order to ensure equitable access to a supportive environment for health. Strategies for public health include enabling individuals and communities, coordinating the

effort of all, building alliances and advocating equity. This means that colonial agendas are contrary to public health motives.

The qualities of public health are directly determined by the socio-economic, political, cultural and environmental conditions [54]. If colonial policies attack the social structure and conditions of the colonized, they disrupt the social order of the group. It is an act contrary to the public health agenda. Development of public health is dependent on resources; however, if the people are not entitled to their human and natural resources, they cannot allocate them where needed. Public health problems and their solutions are dynamic, and people need to make continuous and flexible efforts to solve them. Society needs to continually upgrade their knowledge and pass

their experiences on to younger generations. The younger generations need to continue addressing the challenges from the point where the older generations have left. Besides, societies need to organize their members, develop institutions and leadership that collect and interpret data, set policies and implement them [7,55]. Notably, the entitlement of society to reproduce their culture and pass on their long accumulated experiences and decide on their political rights is central to the development of public health. Furthermore, the people's right to live in a healthy social environment is crucial to the development of public health. As shown in Figure 1, the violations of collective rights are the sum of the violations of the socio-economic, political, cultural and environmental rights [6].

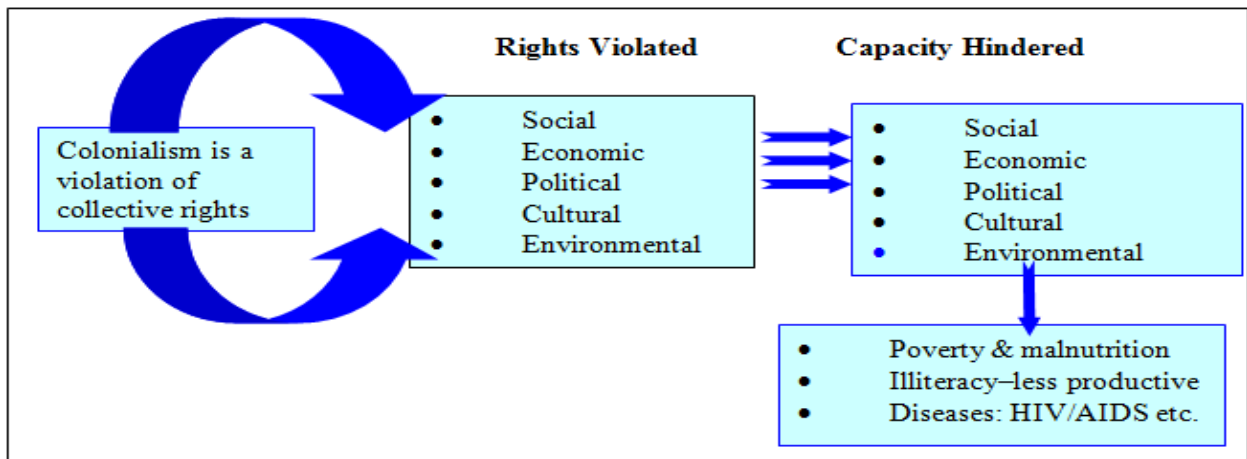


Figure 1. Violation of Collective Rights, Impaired Public Health Conditions

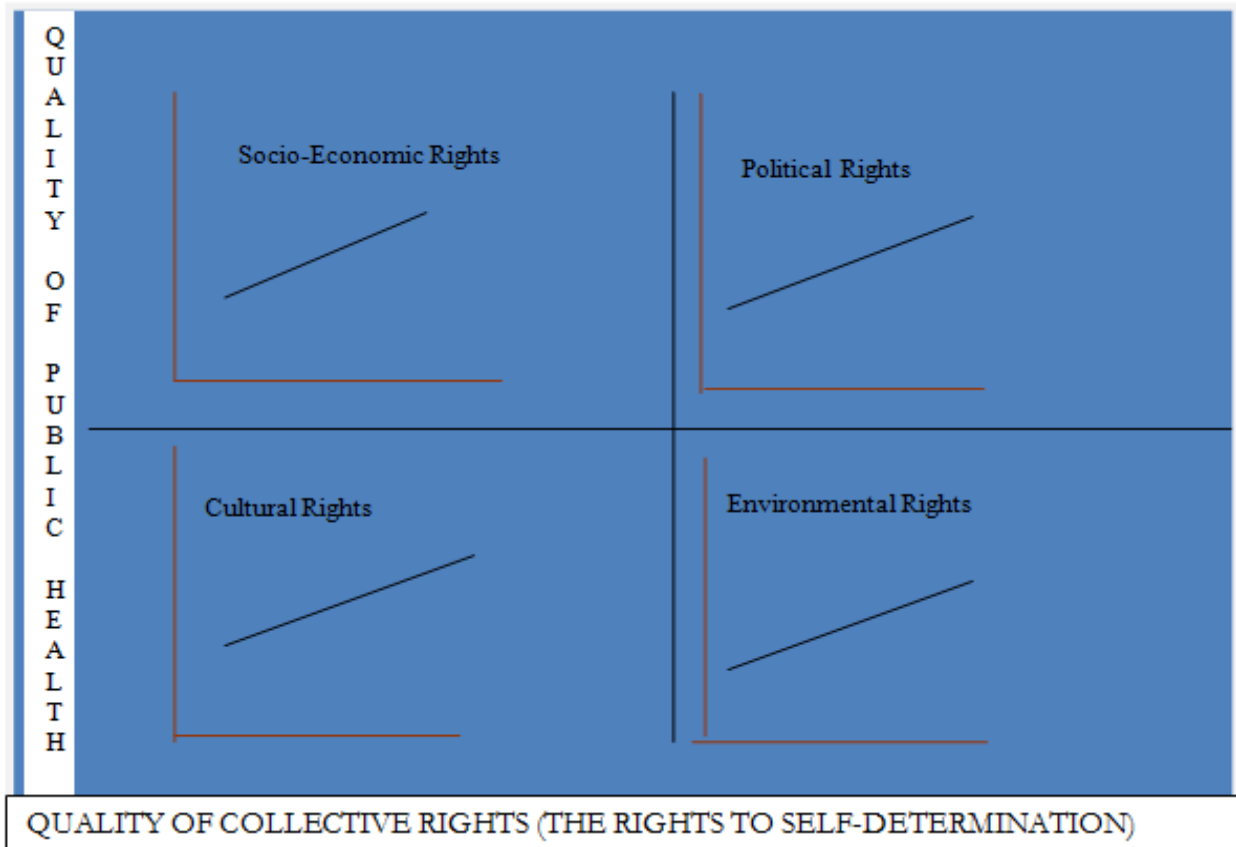


Figure 2. The Correlation between Collective Rights and Public Health

The rationales for colonialism and the denial of people to self-determination are driven by racist mindsets. Racist views are self-righteous and erroneous belief. As such, racist views inform the colonial policies and deny people access to the underlying determinants of health, diminish their ability to prevent diseases and promote health. In doing that, gradually the colonial power relations have slowly crippled the existing public health system and denied the development of a new one [56].

As clearly illustrated in Figure 2, as the rights of people to their social, economic, political, cultural and environmental are respected, they will develop their social, economic, political, cultural and environmental capacities. The development of such capacities inevitably results in improving the social conditions in which they live and work and widens their choices in life. This implies that for all societies the development of public health is dependent on the enjoyment of the highest attainable social, economic, political, cultural and environmental rights.

The enjoyment of the highest attainable level of physical and mental health is leadership and resource dependent; if the people are denied the right to decide on their affairs, freely elect their leaders, they cannot achieve the desired goal [55]. Colonialism overtly and covertly intends to neglect the needs of colonized people, cripple public health conditions and hinder the ability of the colonized people to prevent diseases and promote health. Indeed, as it has shown in Figure 2, there is a strong correlation between collective rights (socio-economic, political, cultural and environmental) and public health. Those rights influence public health development independently and as a group. In many cases, those rights work synergistically, and their sum is more than each separate rights.

4. Conclusions

This paper has brought to light eight major points. First, the quality of public health improves as societies continuously make efforts to address the social needs of its members. Making such efforts requires society to get organized, set their institutions and allocate their resources. To achieve those goals the Oromo people need to guarantee their collective rights

Second, collective rights are the rights on which other rights will grow and flourish, and it is essential to guarantee their members the rights to enjoy social protection, care, and social justice.

Third, the quality of health is dependent on the economic status of the people; to improve public health conditions in Oromia, the Oromo people need to build their economic capacity. Building economic capacity is possible if the economic rights of people are respected.

Fourth, understanding public health problems and addressing them requires identifying the social problems. This requires collecting data and interpreting them, developing policies, i.e., action plans and evaluating them and all of them are the matter of political decision-making. In improving public health conditions in Oromia, asserting political rights is quintessential.

Fifth, education is one of the social determinants of health. Identifying public health problems and developing

appropriate policies and evaluating requires skill. This necessitates developing the cultural capacity of the Oromo people. Cultural capacity can only be built if the collective rights are respected.

Sixth, for the Oromo people, a healthy natural environment is an essential component of their health. This means that in enhancing public health, the right people to manage their natural environment needs to be respected.

Seventh, colonialism is compounded by racial and cultural superiority theories and economic interest. The idea of a racial and cultural superiority theory is promoted through cultural/religious impositions. Such impositions are validating the colonizers' power and knowledge and invalidating the Oromo knowledge and authority. It is to make the Oromo people feel hopeless and worthless. Demoralization and instigating helplessness are one of the significant obstacles to promoting health and bringing about social transformation. This makes the idea of self-determination and self-management the aspirations for healing and forward-looking.

Eighth, colonial knowledge overtly and covertly neglects the fact that the social problems of the colonized people result from colonial structural deficits. Although the health statuses of the colonized people are a reflection of a wide range of non-medical conditions, the solutions the colonizers usually offer are mechanical fixes - medications. The Oromo people could better raise their health standards by investing in their limited resources and guaranteeing themselves the right to self-determination, providing themselves clean water, nutritious foods and other sanitary programs rather than merely medical care.

References

- [1] Czyzewski, Karina. (2011). Colonialism as a Broader Social Determinant of Health, *The International Indigenous Policy Journal*, Volume 2 Issue 1, Article 5, p1-14.
- [2] Crichlow, Wesley. (2002). Western Colonization as Disease: Native Adoption & Cultural Genocide. *Critical Social Work*, 2 (2), 104-126.
- [3] Rosen, George. (1993). *A History of Public Health*, The Johns Hopkins University Press, Baltimore, USA.
- [4] Holcom, B., & Ibsa, S. (1990). *The invention of Ethiopia, the making of a dependent colonial state in Northeast Africa*. Trenton, NJ: The Red Sea Press.
- [5] Jalata, Asafa. (2005). *Oromia & Ethiopia: State Formation and Ethnonational Conflict, 1868-2004*, (Lawrenceville, NJ: The Red Sea Press). (Reprinted with one revised and expanded chapter and one new chapter).
- [6] Dugassa, Begna. (2016). Free Media as the Social Determinants of Health: The Case of Oromia Regional State in Ethiopia, *Open Journal of Preventive Medicine*, 6, 65-83.
- [7] Dugassa, Begna. (2012). Denial of Leadership Development and the Underdevelopment of Public Health: The Experience of the Oromo People in Ethiopia. *Journal of Oromo Studies*, Vol. 19, No. 1 & 2, p139-174.
- [8] Hassen, M. (2000). A short history of Oromo colonial experience: Part two, colonial consideration and resistance 1935-2000. *The Journal of Oromo Studies*, 7(1&2), 109-198.
- [9] Leta, L. (1999). *The Ethiopian state at the crossroads: Decolonization and Democratization or disintegration?* Lawrenceville, NJ: Red Sea Press.
- [10] Dugassa, Begna (2014) *Human Rights and Public Health: Toward Understanding the Root Causes of Social Problems in the Oromia Regional State, in Ethiopia*, LAP LAMBERT Academic Publishing.
- [11] DeSalviac, M. (1901/2005). *An ancient great African nation. The Oromo*. Translated by K. Ayalew, Paris.

- [12] Dugassa, Begna. (2018). Colonialism and Public Health: The Case of the Rinderpest Virus in Oromia Regional State in Ethiopia, *Journal of Preventive Medicine*, Vol. 3 No.1:4 p1-14.
- [13] Siegal, Gil; Siegal, Neomi; Bonnie, Richard (2009) An Account of Collective Actions in Public Health, *American Journal of Public Health*, Vol. 99, No. 9, p1583-87.
- [14] ICESCR (1966). International Covenant on Economic, Social and Cultural Rights. <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>.
- [15] Sen, A. (1999). *Development as freedom*. New York: Anchor Books.
- [16] WHO (1998) Health Promotion Glossary <http://www.who.int/healthpromotion/about/HPR%20Glossary%201998.pdf> (Retrieved March 1, 2018).
- [17] The Institute of Medicine (1988) *The Future of Public Health*, National Academy Press, Washington, D.C. 1988.
- [18] The New Zealand Health Strategy (2000) <https://www.health.govt.nz/system/files/documents/publications/newzealandhealthstrategy.pdf>.
- [19] The Organization of Healthy America (2007) <http://healthyamericans.org/docs/>.
- [20] Krieger, Nancy and Bim Ann-Emanuelle (1998) A Vision of Social Justice as the Foundation of Public Health: Commemorating 150 Years of the Spirit of 1848, *American Journal of Public Health*, Vol. 88, No. 11, pp. 1603-1605.
- [21] Fanon, Frantz (1965) *A Dying Colonialism*, Grove Press, New York.
- [22] Wright, Ronald (1993) *Stolen Continents. The "New World" Through Indian Eyes*, Penguin Books, Toronto, Canada.
- [23] Brantlinger, Patrick (2003) *Dark Vanishings: Discourse on the Extinction of Primitive Races, 1800-1930*, Cornell University Press, Ithaca.
- [24] Watts, Sheldon (1997) *Epidemics and History. Disease, Power and Imperialism*. New Haven, Yale University Press.
- [25] Mann, J., Gruskin, S., Grodin, M., & Annas, G. (1999). *Health and human rights, a reader*. New York: Routledge.
- [26] McCaskill, Don; FitzMaurice, Kevin and Cidro (2012) Toronto Aboriginal Research Project, Final Report, Commissioned by Toronto Aboriginal Support Services Council, Toronto, Canada.
- [27] Bulcha, Mekuria (1994) The Language Policies of Ethiopian Regimes and the History of Written Afaan Oromoo: 1844-1994, *The Journal of Oromo Studies*, Vol. 1, No. 2 p91-115.
- [28] Fee, Elizabeth and Acheson, Roy (1991) *A History of Education in Public Health*, Oxford, Oxford University Press.
- [29] UN Genocide Convention (1948) Convention on the Prevention and Punishment of the Crime of Genocide. Adopted by the General Assembly of the United Nations on 9 December 1948, <https://treaties.un.org/doc/publication/unts/volume%2078/volume-78-i-1021-english.pdf> (Retrieved June 16, 2018)
- [30] Universal Declaration of Human Rights (1948) <http://www.un.org/en/universal-declaration-human-rights/> (Retried on June 16, 2018).
- [31] Bremer, Christine; Kachgal, Mera and Schoeller, Kris (2003) Self-determination: Supporting Successful Transition. *Research to Practice Brief. Improving Secondary Education and Transition Services through Research*. April, Vol. 2 Issue 1.
- [32] International Covenant on Civil and Political Rights, <https://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx> (Retrieved June 16, 2018).
- [33] Abrey B. H. & Stancliffe R. J. (2003). An ecological theory of self-determination: theoretical foundations. *Theory in Self-Determination: Foundations for Educational Practice*. In M. Wehmeyer, B. Abery, D. Mithaug & R. Stanc- life (Ed.), pp. 25-42. Charles C. Thomas Publishing, Spring- field, IL.
- [34] Freeman, Michael (1999) The Rights to Self-Determination in International Policies: Six Theories in Search of a Policy. *Review of International Studies*, Vol. 25, pp 355-370.
- [35] Daes Erica-Irene. (2002). Article 3 of the Draft United Nations Declaration on the Rights of Indigenous Peoples: Obstacles and consensus. In *Seminar Rights to Self-determination of Indigenous Peoples. Collected Papers and Proceedings*. New York, 18th May.
- [36] African Charter on Human and People's Rights, adopted 27 June 1981, entered into force 21st Oct. 1986, OAU Doc. CAB/LEG/67/3 Rev.5.
- [37] Espell, Hector (1980) The Right to Self Determination: Implementation of United Nations Resolutions Study, Special Rapporteur of the Sub Commission on Prevention of Discrimination and Protection of Minorities, (E/CN.4/Sub.2/405/Rev.1), 1980.
- [38] Barcelona, Report. (1998). The Implementation of the Right to Self-Determination as a Contribution to Conflict Prevention Report of The International Conference Of Experts Held In Barcelona From 21 To 27, Organized by the UNESCO Division of Human Rights, Democracy and Peace and the UNESCO Centre of Catalonia.
- [39] Van Scotter, Richard; Haas, John; Kraft, Richard and Schott, James. (1991). *Social Foundations of Education*. Third Edition. Prentice Hall, Englewood Cliffs, New Jersey.
- [40] The UN Commission. (1978). on Human Rights Report on the thirty-fourth Session, Economic and Social Council Official Records, Supplement #14, New York 1978.
- [41] Parker, Karen. (2000). "Understanding Self-Determination: The Basics." 1st International Conference on the Right to Self-determination, Geneva, August 2000.
- [42] Scott Craig (1996) *Indigenous Self Determination and Decolonization of the International Imagination: A Plea*. *Human Rights Quarterly*, 18, p.814 -820.
- [43] Farmer, Paul, (2003) *Pathologies of Power. Health, Human Rights, and the New War on the Poor*, University of California Press, Berkeley.
- [44] WHO Commission on the Social Determinants of Health (2008) Closing the gap in a generation Health equity through action on the social determinants of health, http://apps.who.int/iris/bitstream/handle/10665/43943/9789241563703_eng.pdf;jsessionid=31BBC6B4B0E9CDCBA104D1C349ED7056?sequence=1.
- [45] Taylor, R. and Rieger, A. 1985. 'Medicine as Social Science: Rudolph Virchow on the Typhus Epidemic in Upper Silesia'. *International Journal of Health Services*, 15(4): 547-559.
- [46] UNFPA -HUMAN RIGHTS- Quotes on Human Rights, <http://www.unfpa.org/rights/quotes.htm> (Retrieved on January 31, 2013).
- [47] Alcabes, Philip. (2007). What Ails Public Health, *The Chronicle Review*. *The Chronicle of Higher Education*, Section B. November, 9.
- [48] UN, Vienna Declaration and Programme of Action Adopted by the World Conference on Human Rights in Vienna on 25 June 1993, <http://www.ohchr.org/Documents/ProfessionalInterest/vienna.pdf> (retrieved on March 1, 2018).
- [49] United Nations High Commissioner for Human Rights and World Health Organization, The Right to Health, Fact Sheet No. 31, <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf> (Retrieved February 23, 2018).
- [50] Dugassa, Begna. (2004). Human Rights Violations and Famine in Ethiopia. *The Journal of Oromo Studies*, Vol.11, Number 1 and 2, page 47-68.
- [51] Dugassa, Begna. (2003). Powerlessness and the HIV/AIDS Epidemics in the Ethiopian Empire. *The Journal of Oromo Studies*, Vol.11, Number 1 and 2, page 31-66.
- [52] Dugassa, Begna (2006) Ethiopian Language Policy and Health Promotion. *Journal of Sociology and Social Welfare*. Vol. XXXIII, No. 4, Page 69-86.
- [53] Third International Conference on Health Promotion (1991) Sundsvall Statement on Supportive Environments for Health, Sundsvall, Sweden, <http://www.who.int/healthpromotion/conferences/previous/sundsvall/en/>
- [54] Raphael, Dennis. (2004). *Social Determinants of Health*, Canadian Perspective, Canadian Scholars Press, Toronto.
- [55] Rowitz, Louis. (2001). *Public Health Leadership. Putting Principles into Practice*. Aspen Publishers, Gaithersburg, Maryland.
- [56] Dugassa, Begna. (2008). Colonial Trauma, Community Resiliency and Community Health Development: The Case of the Oromo people in Ethiopia, *Journal of Health & Development*, Vol. 4, No. 1-4, p43-63.
- [57] Jones, Nicola and Shahrokh Thea. (2013). Social Protection Pathways: shaping social justice outcomes for the most marginalized, now and post-2015, Background Note, <http://www.gsdrc.org/document-library/social-protection-pathways-shaping-social-justice-outcomes-for-the-most-marginalised-now-and-post-2015/>

- [58] Dugassa, Begna (2015) Epistemic Freedom and Development of Better Public Health Conditions: The case of Oromia Regional State in Ethiopia, *Journal of Oromo Studies*, Vol. 22, No. 1& 2, p199-238.
- [59] Foucault, Michel. (1980) *Power/Knowledge: Selected Interviews & Other Writings 1972-1977*. Ed. Colin Gordon. New York: Pantheon Books.