

# What can we Learn from the Past Deadly Pandemics and Prepare to Curb COVID-19? The Case in Oromia Regional State in Ethiopia

Begna F. Dugassa \*

Oromo Studies Association (OSA), Mississauga, Ontario, Canada

\*Corresponding author: [Begna.Dugassa@gmail.com](mailto:Begna.Dugassa@gmail.com)

Received March 02, 2020; Revised April 10, 2020; Accepted April 19, 2020

**Abstract Background:** Although biological agents cause pandemics, they require favorable social conditions to spread and cause ill health. Revisiting past epidemics helps to enhance our understanding of the interactions between biological agents and social conditions. Looking closely at the history of epidemics in Oromia is instrumental in understanding the ways the Ethiopian socio-political policies create favorable social conditions for biological agents to spread from place to place and cause enormous suffering. **Objective:** The primary objective of this paper is to take a close look at the socio-biological conditions in which epidemics spread, identify risky and protective social conditions and learn from the mistakes of past public health interventions and to build upon their strengths. The secondary objective is understanding the complex interactions between biological agents and social conditions and developing prevention strategies to mitigate the impacts of COVID-19. **Methods:** Using historical methods, in this paper, I closely looked at different pandemics and illuminated the social processes of the resurgence and transmission of infectious diseases. **Conclusions:** This longitudinal study reveals two major findings. First, although biological agents cause all pandemics, the social conditions of people either protects or exposes them to infections and reveal social inequality. Second, understanding the biology of disease-causing agents and social conditions for transmission are not adequate to control epidemics. It requires building the social, economic, political, and cultural capitals of Oromo people. Oromo people can strengthen those capitals if their rights to self-determination are respected. If the rights of people to decide on their own social, economic, political, and cultural rights are violated, their public health preparedness is curbed and makes them more vulnerable to pandemics. The struggle of people to guarantee themselves the right to decide on their social, economic, political, and cultural affairs should be seen as the means to build these essential capitals.



Figure 1. Prison in Oromia Region –Jato, Nekemte, in Ethiopia. April 4, 2020

**Keywords:** COVID-19, history of Panedemic, Oromia, Ethiopia

**Cite This Article:** Begna F. Dugassa, “What can we Learn from the Past Deadly Pandemics and Prepare to Curb COVID-19? The Case in Oromia Regional State in Ethiopia.” *American Journal of Public Health Research*, vol. 8, no. 2 (2020): 67-76. doi: 10.12691/ajphr-8-2-5.

## 1. Introduction

COVID-19 is an unprecedented respiratory disease<sup>1</sup>. Because it is unprecedented, it necessitates unique inquiring questions and analyzing some historical parallels with other pandemics and learning from them. In public health, researching the history of epidemics is a way of learning from the past, and seeking better ways of preventing diseases, effective means of managing the new and securing the highest possible attainable health. Historical analyses have been used as an ideal instrument in understanding past events and comprehending the present realities and envisioning better prevention strategies. Although microorganisms are invisible to ordinary human eyes and they are a longstanding health problem. Sometimes human beings explained pandemics as the work of a divine and magical power. For centuries, epidemic infectious have provoked our curiosity and imagination. Although we have been familiar with the human Corona Virus for over six decades [1], COVID-19 is unprecedented. Since December 2019, it has been spreading like a forest fire all over the world, breaking families, communities, and threatening the very social fabric of all societies, and it is reinstating our deep-seated imagination.

Public health sciences have evolved through our curiosity, imagination, and the many trials and errors that have fostered the expansion of our scientific knowledge. For many years, religious and cultural beliefs influenced our understanding and “explained” the causes and effects of infectious diseases. As we learned that our prayers did not save us and found out the religious leaders whom we hoped prayed on our behalf and would rescue us were as helpless as many others, it has become clear that we did not get it right. As a result, many people started to wonder, even change their beliefs, and develop their curiosity with or without religious dogma. When we recognized the limitation of the creationist theory of understanding pandemic diseases, we were conditioned to bring together our lived experiences, connecting information, fostering scientific curiosity, and building upon our strengths.

Infectious diseases have always existed in human history, ever since hunter-gatherer days. However, the agrarian lifestyle has created communities, and that made epidemics and pandemic more prevalent. The denser the settlement of people, the added routes of connections between communities, the more likely epidemics and pandemics occurred. Most of the public health measures framed in biomedical models, and they are focused on finding curative and vaccination measures. For COVID-19,

we have no therapeutic or immunization measures. The only known preventive strategies for COVID-19 are social distancing and personal hygiene. As it has been in the past, social distancing and better personal hygiene mean having adequate housing, clean water, and food security. This means the people who are most likely vulnerable to COVID-19 are those who have been already marginalized and underprivileged.

Sociologists have long known that the social status of people either generates protective social conditions or takes away their protective factors. The social conditions of people influence the ways the hosts react and the ways infections are transmitted. In the initial stage, most of the major pandemics seem not to discriminate. However, as the social patterns of the transition of infection made clear and prevention methods are known, it has become clear that diseases are more prevalent among the poor and the marginalized groups. The world poorest tend to live in socially risky conditions, which are where the prevalence of infection is higher. In light of this, it is imperative that we critically examine the potential causes that exacerbate the spread of infectious diseases, so that public health can address the root causes of the public health problem. Carefully looking at the ways the government treats its citizens during a pandemic could be used as a litmus test. COVID-19 is unprecedented, and it is the ultimate leadership challenge.

Microorganisms frequently leverage social and ecological pathogenic conditions. The social and natural ecological imbalance creates favorable conditions for the transmission of infection and weakens the body to resist. When the pathologic social conditions make the living conditions harsher, biologically, they weakened the body and created vulnerable populations [2]. Hence, the unhealthy social condition makes the living circumstances unhygienic, overcrowded make them susceptible to microorganisms. In Ethiopia, the socio-political relations are not just unhealthy; it is pathogenic. For over a century, Oromo people have been denied the right to decide on their social, economic, political, and cultural affairs and forbidden developing their institutions, leaderships, and disempowered [3,4]. The Ethiopian government policies either aggravate or acts indifferent to the Oromo social problems [5].

Ethiopia was formed in the 1880s when the Abyssinian King Menelik II, supported by the European empire builders, invaded their neighbors [6]. Since then, the Oromo people are denied the right to decide on their social, economic, political, and cultural affairs. The social-political conditions of the Oromo people are the same as the situation of many African people under the European colonial rulers. The Ethiopian empire was built and maintained by military forces. In Oromia, human rights violations are institutionalized, and the Oromo people are denied the right to develop their institutions and address their collective problems. The widespread human rights violation in Oromia are paramount, creating favorable social conditions for known and unknown diseases to spread [7,8,9].

<sup>1</sup>Public health researchers have defined diseases if it is an epidemic or pandemic. The difference between the two terms epidemic and pandemic is how widespread the disease is across the geographical and political border. Bubonic plague, cholera, smallpox, and influenza are the most brutal diseases in human history. Several times the outbreak of these diseases simultaneously occurred across the international borders and fulfilled the criteria to be defined as a pandemic.

The Ethiopian Prime Minister Abiy Ahmed, who came to power with the popular movement, was expected to advance human rights and social justice, however, he miserably failed and followed the old path and further institutionalized human rights violations [10] (Amnesty International, 2020). While COVID-19 is ravaging the global world and all states are rushing to inform their citizens preventive strategies, the Ethiopian government denied over 25 million people landline telephone, cellphone, and internet services and kept over twenty thousand political prisoners in overcrowded prison cells [11].

This paper consists of three major parts. The first part introduces the issue and discusses the research question and the objective of the research. In the second part, I carefully look at the history of major epidemics and see the ways that political power, war, and the desire to dominate and exploit aggravate public health problems. The third part covers discussions and conclusions.

## 2. Research Questions, Objectives, and Methods

The unprecedented COVID-19 pandemic has challenged the world community in numerous ways. It shows us that political borders are irrelevant. It conditioned the global community to collaborate and have a nimble and responsive public health policy. If pathogenic social-environmental conditions in the Hubei province of China caused the birth of the COVID-19 pandemic, it is logical that the global world should work closely and prevent the social-environmental pathologic conditions everywhere. In the USA, the number of Blacks who are dying from COVID-19 is staggering. For example, in Louisiana, where the population of Blacks only constitute 32 percent, out 512 deaths recorded, seventy percent of the victim are blacks. Also, in other USA states, Blacks are hard hit by the COVID-19 [12]. The enduring systemic racial inequalities, poverty, unemployment, inadequate housing, and inequity, as well as limited access to health care services, have made African-Americans far more vulnerable to the COVID-19. The experiences of Blacks in the USA are not a unique phenomenon; it can replicate elsewhere, like in Ethiopia, where discrimination is institutionalized. In this paper, I ask and try to answer what is required to create a nimble and responsive public health policy in the Oromia region in Ethiopia and minimize the impacts of COVID-19 locally and globally.

## 3. Objectives

The primary objective of this paper is to revisit the past and trace the social conditions that have grossly contributed to epidemics, learn from it, and advance the social protection system. The secondary objective is to understand the complex interactions between biological agents and social conditions, develop public health strategic plans of health promotion, disease prevention, having in mind the “uphill public health metaphor” and advance social medicine in Oromia and prevent and mitigate the impacts of COVID-19.

## 4. Research Methods

As we ask more questions and try to answer them, we further enhance our knowledge and build on what we knew in the past. In this paper, using historical methods, I explore pandemics, illuminate the process of the resurgence and transmission of infections by carefully looking at them longitudinally. Historical methods of inquiry offer tremendous value in exploring past phenomena, explaining the process, and revealing the challenges and opportunities. Here, having in mind the “uphill public health metaphor” I apply historical methods to analyze and accurately interpret the past on contemporary scientific knowledge and advance the need to merge bio-medical sciences and sociology in better understanding pandemics.

## 5. Short Historical Facts of Epidemics

### 5.1. Bubonic Plague

The bubonic plague, also known as Black Death, is one of the diseases that provoked our curiosity and imagination. This infectious disease passes from rodents to other animals and humans through flea bites. The flea acquires the bacteria known as *Yersinia Pestis* that lives on the skin of the rodent and passes it to humans. The name of the disease comes from its symptoms of painful swelling of the lymph nodes. During the Middle Ages, bubonic plague was referred to as the Black Death, because it causes blood to accumulate and dry under the skin and blackens the skin [13]. Bubonic plague is a disease that has been going on for centuries, and the biblical descriptions of some of the disease outbreaks most likely involve this infectious disease. With the advance of antibiotics, we somewhat controlled contagious disease. The infrequent outbreaks of bubonic plague do not mean that we do not face it anymore. In North America, the last largest outbreak of bubonic plague occurred in Los Angeles in 1925 [31].

The social processes of the emergence of bubonic plague during the Middle Ages in Europe made life very interesting. The record shows the disease originated in Central Asia. When Mongolia invaded Europe, the disease arrived with the army in the ancient town of Caffa – now known as Feodosia – in Crimea – the region that Russia has recently annexed from Ukraine. The dwellers refused to surrender their town to the invading army and kept them at bay. While the Mongolian army was planning their next action to invade the town, bubonic infection emerged in their camp among their army. The Mongolian military quickly converted the unfortunate event into the opportunity and took the dead bodies and threw them in the town. Within a short time, the infection started in the town and forced the dwellers to flee. Some left the town by foot, others by boats in different directions, thereby spreading the infection all over Europe [13]. What do we learn from the case of bubonic plague? The history of the bubonic plague makes it clear that the enemy can change unfortunate infectious tragedies into opportunities.

## 5.2. Spanish Flu

One of the known pandemics more relevant to Oromia is the Spanish flu. Spanish flu is a highly infectious influenza of avian origin; it is now scientifically known as H1N1. This influenza is a viral respiratory illness that invades the body cell and makes us sick. This influenza started in Kansas, the USA, in 1917. War and diseases go hand in hand. The 1917-20 influenza pandemic occurred during the First World War. The US army sent to Europe to support the alliance forces unwittingly took with them the deadly virus and introduced it to the troops they wanted to help and the people they wanted to rescue. The European colonial forces and travelers brought with them the H1N1 virus to their colonial lands in Asia and Africa and made it one of the major pandemics. The record shows that this deadly influenza had infected over 500 million people and killed 50 million people. Although the Spanish flu influenza affected all age groups, it was more severe among the young. The record shows India lost about 6 percent of its population to influenza [14]. Malnourished individuals and communities are more vulnerable to influenza, and this made Indians more vulnerable than the British colonial forces.

In Ethiopia, the Spanish flu is known as Yehidar Beshita – the November Diseases- in Amharic. On November 20, 1918, one European diplomat stationed in Finfinne took pictures of the sick and recorded some of the public health measures taken in the city. According to this diplomat, the first public health measure was burning trash. Later on, the Orthodox clergy changed it to burning incense in St. Michael church. Although we have no conclusive evidence where influenza started in Ethiopia, the case of Finfinne is widely covered. The influenza epidemic must have been brought to Finfinne by either European diplomats or their militaries stationed in Eritrea, Djibouti, Kenya, and Sudan and then to Finfinne. One record suggests that the virus reached Ethiopia through Guelph of Eden by train [15]. During the 1918-1920s, the Ethiopian army was engaged in pacifying the land they newly conquered. As they traveled from place to place, they spread the infection to different parts of Oromia.

Oromo institutions function from the Oromo perspective; they protect the interests and aspirations of the people. For that reason, the Ethiopian government viewed Oromo institutions as obstacles to the Abyssinian colonial agenda. For those reasons, the Ethiopian army deliberately attacked the Oromo social, economic, political, and cultural institutions. For example, when the Ethiopian government attacked the Oromo Gada, Siiqee, and Qaalu institutions, they created several unhealthy social conditions and hindered their public health preparedness. The first is that- as the Oromo institutions were entirely banned, or weakened- they denied the Oromo people developing the leadership that can early detect the social problems, revitalize the society and foster resiliency.

Second, as a result, the Abyssinians either imposed their institutions or created institutional vacuums among the Oromo people and opened the door for others to come and take it over. In Oromia the Spanish flu occurred after the following events: a) the war of conquest compounded

with the recurring of rinderpest epidemic that has been going on since the 1890s; b) the mass settlement of the Abyssinian army and civilians in Oromia; c) the banning of Oromo institutions and imposing the Abyssinian ones instead; d) the imposition of heavy taxation and e) pacifying measures intended to weaken the Oromo people [6,16]. These all conditioned the Oromo people to be more vulnerable and affected Oromia more severely.

Carefully looking at the ways the Abyssinians understood the Spanish flu is vital to analyzing the impacts on the Oromo people. Clearly, the Abyssinian elites understood influenza as the work of divine power. They perceived it that it was caused by divine power, because they had sinned or that there were sinners among them. To be forgiven, some Abyssinians fasted, others offered religious objects to their churches. Because the Oromo people do not adhere to the Abyssinian belief system, the Oromo people have been blamed and accused as if they were sinners. Indeed, when they state that “sinners are among us,” they were referring to the Oromo people. The Abyssinian self-righteous racist attitudes are consistent with the views of other colonizers. Such a racist attitude further victimized the Oromo people.

The record shows that the Spanish flu covered all Oromia. During the hardships and the unknown events, Oromo people turned their faces to their institutions, such as Gada, Qaalu, and Siinqee. When their institutions were banned, instead of adopting the Abyssinian institution, they choose to adopt other foreign institutions. For example, in the Dembi-Dolo area, when the Spanish flu was raging, in resistance to the Orthodox church teaching, people went to Sudan – then ruled by the British- and brought in Presbyterian Church group (17). The oral story suggests that to cross rivers from Sudan to Oromia, people carried those missionaries on their backs. For that reason, in the Dembi-Dolo area, the protestant church is referred to as “the institution that our fathers had brought for us in their piggybacks.”

## 5.3. Rinderpest Infection

One of the epidemics that have changed the socio-political and environmental conditions of Oromia is Rinderpest, also known as cattle plague. This infection was not endogenous to Africa, and it emerged in the Horn of Africa in 1887, when the Italian army stationed in Massawa, the Eritrean seaport, brought cattle infected with the virus to feed their army. Italians are the ones who have introduced the concept of quarantine, and they have been practicing it for centuries; however, when they were dealing with the land and people they are planning to conquer, they abandoned that procedure. The army of Abyssinian King Yohanis invaded the Italian camp and unwittingly took the infected cattle to the highland regions of Eritrea [18]. Soon after, the cattle were taken to the highland regions of Eritrea, and the disease spread locally in Eritrea, Tigray, Gonder, and then reached Oromia. Before the infection reached Oromia, it had already wiped out cattle in Tigray and Amhara regions and caused famine. Indeed, as starvation incapacitated King Yohanis’ army, he confronted the Sudan forces that invaded his territory and died in the war front. Soon after, the starving

Abyssinians massively joined the Menelik II army as a means of securing themselves food security [18].

Menelik II, who took power after the death of Yohannis, used the Rinderpest as the opportunity to build his army to pacify the colonized people and further conquer other independent regions and people. Also, Menelik provided relief foods and received starving people in Finfinne to the feeding centers. The foods sent for relief, and the feeding centers were acquired from the grains the Menelik army has looted from the Oromo people. Given that many Abyssinians were saved because Menelik had fed them, so they got better opportunities, settled in Oromia, and exploited and subjugated the Oromo people, Menelik was seen as Emiye Menelik- Mother Menelik. After their settlement, destitute and starving Abyssinians soon became landlords and colonial masters [18].

The rinderpest virus impacted the socio-economic-environment of the Oromo people in several ways. First, it wiped out the cattle that usually provided them food, clothing, workforces, and fertilizer and led to starvation. Second, the Abyssinians used the epidemic as an opportunity to build up their army and consolidate their power in Oromia and allow in more settlers in Oromia. The settlement of Abyssinians in Oromia was followed by the power stratification and exploitation, i.e., unhealthy social relations between the Oromo people and the Abyssinians. Third, starvation made the Oromo people vulnerable to known and unknown infections such as smallpox, cholera, and influenza and even made them susceptible to the attack of wild animals. The record shows under the Abyssinian colonial rule, the population of Oromo has reduced by two-thirds in twenty years [19].

The impact of the rinderpest virus on the natural world of Oromia was colossal. As I have noted in my previous work, most cloven-hooved animals are susceptible to the infection. However, there are some differences in their susceptibility. European cattle, zebu cattle, water buffalo, yaks, African buffalo, giraffes, warthogs, and Tragelaphinae (spiral-horned antelope) are particularly susceptible. Wildebeest and yaks are moderately susceptible, and gazelles, sheep, and goats are only mildly so. As a result, the virus wiped out several wild animals, such as the African buffalo [18].

## 5.4. HIV/AIDS Epidemics

HIV/AIDS is one of the pandemics that has affected Oromia. This viral infectious disease was first recognized in 1981 in Los Angeles, USA. Later on, the origin of the virus was traced back to the Democratic Republic of Congo, and now it is believed that the virus had been transmitted from monkey to human being in the 1920s. The virus is transmitted when the fluid of an infected person is passed on to a healthy person. The three most known methods of transmissions are unprotected sex, blood transfusion, and sharing needles. Like many other infectious diseases, HIV/AIDS is caused by biological agents, and the initial victims of the diseases were the more affluent and traveled group. However, later on, when we understood the roots of transmission and prevention, the disease has become the problem of the poor, marginalized, and the illiterate [20].

The major social causes of HIV/AIDS epidemics have been ill-planned consecutive Ethiopian government policies. From 1976 to 1991, the Ethiopian government conscripted millions of young Oromo men to the war front. Consistent with the Abyssinian cultural practice near the military garrisons' towns and cities, they allowed commercial sex work to flourish. The war took a heavy toll, and many of the conscripted young men lost their friends to the war. Also, the social conditions of the military camps were depressing. As a means of relieving their stress, the conscript armies were allowed to go once every quarter to the nearby towns and cities and spend their time being high with alcohol and nights with commercial sex workers. At that time, HIV/AIDS was ravaging Africa and the global world [21]. Initially, at that critical moment, the Ethiopian government denied the existence of the disease in the country. Later on, the government admitted the presence of the disease; however, given that the focus of the military government was to win the war, they did not make adequate efforts to provide preventive methods to the public and their military.

In 1991 when the coalition of the Tigray Peoples Liberation Front (TPLF), Eritrean People Liberation (EPLF), and Oromo Liberation Front (OLF) won, the war abruptly ended. The TPLF dominated government followed in the footsteps of the military government and adopted policies that are contrary to principles of human rights. Instead of incorporating those militias and army soldiers in the national army, they banned over half a million of them and sent them to their villages and towns. Most of the troops were infected with HIV/AIDS, and they took the virus and spread the disease and caused the death of millions of people.

In 1991/92, diplomats and NGOs stationed in Finfinnee persuade the TPLF government not to ban the former army and militia and send them to their home villages and towns. To prove their concern and convince the TPLF government, they collected blood samples of hundreds of former militia and army and tested for HIV/AIDS. The test shows that most of them were HIV positive. Even after the evidence was produced, the TPLF refused to keep them in the army and sent over six hundred thousand troops back to their village and towns [21,22].

Why did the TPLF led government had refused to keep the Ethiopian army and militia in their military? The TPLF was angry with the Ethiopian military government and society. The TPLF policies were derived from anger, and they were not designed, having in mind the principles of human rights. Therefore, knowing the risk of banning the military and the militia and sending them to their home villages and towns constituted the deliberate spreading of HIV/AIDS.

If Ethiopian social policies had been designed from a human rights perspective, the Oromo people would have been entitled to decide on their social, economic, political, and cultural rights, and there would have been no war in the first place—because it was an unnecessary war. Even if the war had been unwittingly started, but human rights had been respected, the young men who were conscripted in the army would have been informed about the risks of HIV/AIDS, and they would have been kept in the military.

## 6. COVID-19 Pandemic

Coronaviruses are a large family of viruses. Some of these viruses infect only animals, and others can infect animals and humans. The human coronaviruses were first identified in the mid-1960s. The name coronavirus is used because the virus has crown-like spikes on its surface. COVID-19 is one of the seventh members of the coronavirus family. The seventh known virus is COVID-19, which is also known as SARS-CoV-2 [1]. Among the seven coronaviruses, four of them cause only minor respiratory symptoms. The three severe acute respiratory syndromes (SARS CoV), Middle East respiratory syndrome (MERS CoV), and SARS-CoV-2 (COVID-19) have been associated with life-threatening diseases. Coronavirus (COVID-19) is one of the most significant global public health concerns of the century. It started in the wet animal market in Wuhan City, China. The virus has a zoonotic origin and easily transmits from person-to-person. The COVID-19 pandemic indicates that there are considerable challenges in predicting when, where, and how the corona pathogens emerge.

COVID-19 spreads from person to person in close contact of two meters or less and through a) respiratory droplets produced when an infected person coughs or sneezes; b) close and prolonged personal contact; c) touching an infected area and touching mouth, nose or eyes before washing hands [23]. The incubation period for COVID-19 ranges from a few days to 14 days. The symptoms are similar to cold or flu, which include cough, fever, difficulty breathing, and pneumonia. The disease can be milder for some people, yet the person might transmit the virus. However, the disease is more contagious when the infected person is more symptomatic. When the viral load is higher, the person is more symptomatic, and he/she is more likely to infect others. COVID-19 can survive on objects, and it might spread through contact with the contaminated surfaces or objects. It is now proven that the disease spreads quickly and can sustain itself in the community.

### 6.1. Prevention Strategies to COVID-19

We have no drugs that cure or vaccinations that help us develop immunity for COVID-19. Given that the virus is new, no one has pre-existing immunity. The only tool we have is the prevention of the infection by containing transmission. Therefore, public health institutions need to strive to promptly identify the contact for infection, isolate the confirmed cases and follow up with the close contact cases, and provide public health education and promote healthy social policies. COVID-19 spreads from person to person in close contact of 2 meters and/or through the respiratory droplets. The best prevention tool is avoiding being exposed to the virus by keeping away at least 2 meters from the suspected individual and preventing touching the respiratory droplets produced when an infected person coughs or sneezes. To mitigate and prevent the risks of this deadly COVID-19 public health recommends washing hands often with soap for at least 20 seconds. If not, it is recommended a hand sanitizer that contains at least 70 percent alcohol. The recommendation

includes avoiding touching your mouth, nose, and eyes before washing hands.

### 6.2. How is the Ethiopian Government Reacting to the COVID-pandemic?

Before I embark on answering the above question, I want to visit the functions of public health briefly. Public health science evolved and continues to do so. As we continue to exploit our natural world and contribute to causing climate change, the types of pathogens change. Also, as our social environment changes, the ways people react to pathogens change. Ethiopian public health has inadequate surveillance, laboratory capacity, and a scarcity of human resources. It is not prepared to manage the pandemic of the COVID-19.

During this unsettling time, when we say public health, it means “what societies do collectively to ensure the conditions in which people can be healthy;”. In understanding that some people are more vulnerable than others, public health intends to achieve public good. The major works of public health agencies are assessment, policy development, and assurance of services [24]. Assessment means collecting data, analyzing data, and identifying the risk and preventive factors. Policy development is setting preventive strategies and mitigating the damage. Assurance services involve designing, implementing, and evaluating programs. Those essential public health activities are dependent on the ways we collect information, analyze the data, and understand the health risks and magnitude of the problems. This makes the assessment, policy-making, and assurance prone to political maneuvering.



Figure 2. The Means of Transportation, April 2020

As stated above, COVID-19 was recognized as a contagious disease in December 2019. At that time, Ethiopian Airlines was making six flights carrying cargo and 4000 passengers from and to China. Indeed, Ethiopia is seen as the main gateway to Africa. When the infection started, the Ethiopian airline used to fly to China 35 times per week. As the Global world aggressively reacted to COVID-19, the demand of people in Ethiopia intensified to stop the flight, so in February, they just reduced their flights by 30 percent.

Knowing that Ethiopia cannot manage a pandemic like COVID-19, the government was supposed to act rapidly and deeply think about its policies. With neither treatment

nor vaccine and pre-existing immunity and appropriate public health institutions, the impacts of COVID-19 could be devastating. The best public health practices use social spacing. Another social factor that is responsible for the risk of COVID-19 is health status and social spacing. Overcrowded families and communities are at a higher risk.

The COVID-19 pandemic has already taken an enormous toll across the globe, and it is inevitable for Ethiopia. COVID-19 is a major pandemic, and the Ethiopian government was supposed to plan strategies to reduce its transmission and minimize the impacts. For example, the World Health Organization (WHO) recommends social distancing; however, the Ethiopian government forced people to attend state-sponsored meetings. Instead of encouraging social distancing and being part of the solution, the Ethiopian government neglected the WHO's advice and let the cultural/religious gatherings to happen as usual. The overcrowded means of transportation continued as they did in the past. At this unprecedented pandemic time, there are over twenty-thousand Oromo political prisoners, and they are kept in overcrowded conditions.

In Ethiopia, the concerns about COVID-19 are several folds. Most of the people are already live in formidable economic and social challenges. Those hardships increase the risks to COVID-19. The living and working conditions of people are highly conducive for transmission. Most people live in overcrowded inter-generational households that often lack running water and basic sanitation. Allowing the social and economic activity to continue unchecked could lead to millions of infections within months. This can quickly overwhelm the weak public health and clinical care system. For over a hundred and ten million people, Ethiopia has a few hundred ventilators and less than 500 intensive care units. Among the hospitals in the country, only about 2 percent of them have oxygen in their clinics [25]. Most of the people live in poverty, and at this critical time, trying to restrict the social and economic activities of the poor is upward movement. Food, water, shelter are the necessities of life, and people do anything to acquire those physiological needs. Human rights violations are widespread, and when the unprecedented social conditions resulted from COVID-19 added, the potential to sow chaos in the country increases.

There have been no times in history that the Ethiopian government has respected human rights and set policies having human rights principles in mind. Like his predecessors, Prime Minister Abiy Ahmed's government of Ethiopia has a fear of intellectuals. Intellectuals who associate with the government are also conditioned to self-censor, and they are most unlikely to work on what they know and what their conscience guides. For those reasons, the Ethiopian government failed to set appropriate public health orders and set social protection systems.

The Ethiopian government has never respected human rights and set policies having human rights principles in mind. Like his predecessors, Prime Minister Abiy Ahmed's government of Ethiopia has a fear of intellectuals. Intellectuals who associate with the government are also conditioned to self-censor, and they are most unlikely to work on what they know and what their conscious guides.

For those reasons, the Ethiopian government failed to set appropriate public health orders. For example, in their Facebook pages, the high Ethiopian government officials such as Taye Dendea, Alemu Sime and Fekadu Tesema, presented their political opponents as if they were the immediate coronavirus and accused those who promoted the need to reinstate landline telephone, cellphone, and internet as collaborators. The statement of those officials not only makes it clear that they do not understand the magnitude of the pandemic, but they are deeply hated, political opponents. It is a worrisome attitude. What type of social policies would those leaders develop to contain the COVID-19, pandemic?

In the case of HIV/AIDS, the disease went from the towns and cities to villages [21]. Instead of learning from past epidemics, one of the public health measures that the Ethiopian government took was closing universities and sending students home. There is a fear that the COVID epidemic is going to be in Ethiopia for a long time. If COVID-19 is mild among the young, it could be that the infection has been going on among the students. If this is true, those students can take the virus to their villages and towns. The government supposed to isolate them for 14 days.

### 6.3. Challenges Containing COVID in Oromia

Prevention strategies are complex, and they take place at different levels and require coordinated efforts. The WHO recommended prevention strategies are social distancing and personal hygiene. Social distancing means being two meters apart, avoiding public meetings, and restricting travel [26]. The Ethiopian prisons are overcrowded with political prisoners, and they are kept in inadequate clean water. The Ethiopian security forces are engaged in killings, imprisoning, and harassing civilians going from place to place. Armed conflict and the widespread human rights violations conditioning people to flee from their homes and displace them locally and making them international refugees. The movement of the security forces and displacement of people is creating fertile ground for the transmission of COVID-19 and putting the local and global community at risk.

The social and physical conditions of Oromia can either create risks or better opportunities to contain the pandemic. Some of the risk conditions are as follows:

- Close social contacts are part of the Oromo culture. Charging that cultural practices in the short term is not an easy task.
- Breaking the chain of transmission of infections is possible if we effectively communicate the risk and roots of transmission. Until the last week of March 2020, for four months, over 25 million people in Oromia have no access to landline phones, cellphones, and the internet. Stopping access to these essential tools is hindering people from accessing information and knowing the risks and preventive measures.
- In Oromia, access to clean water is very limited. Limited access to clean water is a significant risk factor. For example, the WHO recommends frequently washing hands as a preventive measure.

Most Oromo people cannot frequently wash their hands.

- In Oromia, the literacy level is not high. Education is one of the social determinants of health, and when we are dealing with a pandemic, it seems even more critical.
- Most Oromo people are poor, and they live in overcrowded housing. Most of them cannot create the mandatory two meters of social distancing.
- Evidence shows that seniors and people with other underlying health problems are more vulnerable to COVID-19. It is becoming clear that young adults and children with compromised immune systems are also susceptible to COVID-19. Most of the Oromo people are malnourished and live in unhygienic conditions. Malnutrition and unsanitary conditions mean their immune systems are not well developed or suppressed.
- Rubber hand gloves and medical face masks are hardly available. The absence of those essential preventive tools further increases the risk for health professionals and families who are caring for loved ones to get infected.
- There are not enough health professionals to manage the pandemic, develop coping strategies, provide appropriate health education and clinical care during this pandemic.
- No adequate personal protective equipment for health care providers

#### 6.4. Opportunities for Containing COVID in Oromia

We can learn from the past, manage the present, and predict the future. In the Northern hemisphere, when there is winter, there is flu. In this geographical zone, the flu season starts in November and ends in March. The time for the flu season precisely matches the winter season. Indeed, the word influenza comes from the Italian word, which means astrological influence - referring to a respiratory disease that usually emerges seasonally [26,27].

Temperature influences the host's reaction to the flu virus and the ways the virus is transmitted. One of the mechanisms in which the season affects the hosts' response could be malnutrition. When days are shorter during the winter season, inadequate sunlight leads to the deficiency of vitamin D and melatonin. Ultraviolet UV radiation, on the one hand, helps the hosts to synthesize vitamin D. On the other hand, UV radiation has shown to have antimicrobial effects and inactivates flu virus [26,27,28]. Low temperature and low humidity increase the survival of the flu virus, and a high wind increases the chance of flu transmission [28]. Although our knowledge about COVID-19 is limited, in a warmer climate, it might be less virulent. In tropical regions like Oromia, it might require less effort to contain the COVID-19 pandemic during the dry season (November to April). The challenge might be more significant during rainy seasons.

## 7. Discussions

As I have mentioned above, public health is “what

societies do collectively to ensure the conditions in which people can be healthy.” Public health works to achieve public good, and it is different from clinical medicine geared to meet individuals good. Public health agencies are expected to make the assessment, develop policy, and assurance of services [24]. Assessing means collecting data, analyzing data, and identifying the risk and preventive factors. Policy development is about setting preventive strategies and minimizing impacts. Assurance services involve implementing policies and evaluating programs. Assessment, policy development, and assurances have never been neutral actions. In Ethiopia, the ethno/national demand to exercise the right of people to self-determination is about freely assessing their social problems, developing their policies, and assuring the implementations. Such morally justifiable demands are not accommodated, and it remains the primary reason for the political and armed conflicts. The century-old conflict makes the marginalized groups most likely face compounding risks to COVID-19.

From the public health perspective, understanding the problem is halfway in finding the solution. Influenza epidemics are influenced by biological, physical, and social conditions. Physical: weather temperature, UV radiation, wind, and humidity. Social: distancing, overcrowded, nourishment, vitamin D deficiency. Biological: host susceptibility, suppressed immune system, prior health problem [27,28]. In Ethiopia, where the rights of people to self-determination is not guaranteed, the dominant group set policies in their interest and perspectives.

Given that there are no political representations, the Ethiopian government policies are not either inclusive, transparent or took into account the need of Oromo people. For example, from December 2019, the Ethiopian government has banned landline telephone, cellphone, and internet services from twelve zones of the Oromia region. Banning those essential services has disrupted and halted many social functions. As a result, families and friends are disconnected, and the means to support when they need the most is halted. Businesses, farming, and schooling are significantly hampered. When COVID-19 is declared a pandemic, those zones have no access to information.

Let me take you back to what the Ethiopian authorities have said on their Facebook pages. Those individuals described their political opponents as if they were coronaviruses and accused those who promoted the need to respect the rights of people to know, freely communicate and advance the need to reinstate landline telephone, cellphone, and internet as the collaborators of their opponents. The statements of those officials make it evident that they do not understand the challenge of a pandemic. Research from public health education shows that only reliable and respected individuals and institutions can effectively deliver public messages. Also, the types of social policies people eagerly accept would depend on whether policymakers are respected.

The history of public health makes it clear that the social, economic, and political status of people either reduces or increases their risks. The case of COVID-19 will not be different. As we now know, personal hygiene and social spacing are the primary preventable tools. For over a century, the Oromo people have been denied the right to decide on their social, economic, political, and

cultural affairs. The Ethiopian social-political policies have disempowered, impoverished, and kept them uneducated. Powerlessness, impoverishment, and illiteracy limit the choices of Oromo people and make them vulnerable. For example, in the last ten years, over half a million Oromos have been evicted from their homes in the Finfinne area, and many of them are now left on the street or in overcrowded housing with no adequate access to clean water.

Because public health strives to achieve public good, it is one of the most trusted institutions. However, in Ethiopia, public health is seen as the state institution, and one of its significant challenges is establishing public trust. Because the ultimate role of public health is to convince the public to live a healthy lifestyle, its success is dependent on the response of people and complying with public health guidelines. The most important public health actions during a COVID-19 influenza pandemic is to act swiftly and impartially.

The significance of effective communication in health education has been widely discussed in academic literature. During public health emergencies, the public needs to know what health risks they face and what actions they can take to protect their health or reduce the risks. During the pandemic, public health institutions are facing enormous challenges to fulfill their duties effectively. The World Health Organization (WHO)[29] gave guidelines in communication during emergencies. According to the WHO guidelines, public health institutions and governments are expected to strive to achieve the following ten significant points:

1. Build Trust
2. Communicate uncertainty proactively
3. Engage communities
4. Message well
5. Establish and use listening and feedback systems
6. Use Social media as appropriate
7. Risk communication operations require resources
8. Treat Emergency risk communication as a strategic role, not an add-on
9. Establish coordination and information systems
10. Build capacity for the next emergency

COVID-19 is a major public health threat. It is testing communist, democratic, and dictatorial states. The Ethiopian government policies have proven that undemocratic governments are not flexible and adaptive enough to lead a country during a pandemic. Prime Minister Abiy's team revealed how much they are unprepared to govern. They have failed the people on many levels. The first significant failure of the Ethiopian government was refusing to suspend flights to and from China. Second, they disconnected landline, cellphone, and internet for over 25 million people. Third, refusal to release the twenty thousand political prisoners who are kept in overcrowded prison cells. Fourth, the Ethiopian government openly claimed to have found a curative medication to COVID-19 and gave false hope. Why does the government make such a fictitious claim? People are unsatisfied with Prime Minister Abiy's policies, and the government is worried about a possible political uprising. Therefore, to present themselves as if they are doing something right and calm the angry people, they claimed what is far from being true. The public health significance

of the fictitious claim is that it does not encourage people to change their behavior.

In Ethiopia, human rights violations are widespread. This terrifying intergenerational violence is not known to the global community because Ethiopia is the most secretive state. There are times when hospitals doctored the death certificates of people killed from torture and named them natural causes or accidents. On several occasions, the Ethiopian government either entirely hide or underreport the magnitude of infectious diseases and famine. For example, in 2017, in Ogden and Oromia region, cholera killed over 776 and infected about thirty-three thousand people. The Ethiopian government denied the existence of a cholera epidemic and named the disease as acute watery diarrhea [30]. The Ogden and Oromo opposition groups accused the Ethiopian government of failing to recognize the magnitude of the problem. They explained the failure of the Ethiopian government is part of longstanding discriminatory social policies and practices. It is not the first time the Ethiopian government is accused of being indifferent to the need of people in those regions.

The development of public health is the result of tenacious and protractive efforts [31]. Hence, the development of public health infrastructures is dependent on the social, economic, political, cultural, and environmental capacity of people. In turn, those capacities built if the people are freely deciding on their socio-economic, political, cultural, and environmental affairs. At the COVID-19 pandemic, when the global health advice social distancing, the Ethiopian government is holding public meetings and forcing people to attend, in packed halls, for political indoctrination. The Ethiopian government's actions are neglecting and even prudently violating the global health advice of social distancing. Also, historically it is known that the movement of soldiers unwittingly led the spread of infectious diseases from one place to another, at this time, the Ethiopian army is deployed to several regions and harass the supporters of the opposition groups. The harassment of people is creating conditions for internal displacement and generating international refugees.

## 8. Conclusions

This paper captured the short history of pandemics in Oromia and made the following conclusions. First, like all other pandemics, COVID-19 is caused by biological agents and propagated in certain social conditions. Developing policy by merely understanding the biology of the agents is not adequate in managing the pandemic and preventing it. It necessitates addressing the pathologic social conditions in Oromia and elsewhere.

Second, in Oromia, there are fertile social conditions for COVID-19 pandemics. In this region, human rights violations are widespread, food insecurity is high, no adequate clean water and housing. This puts the Oromo people at a higher risk of the pandemic.

Third, the Ethiopian security forces are engaged in killings, imprisoning, and harassing civilians going from place to place. Armed conflict and the widespread human rights violations conditioning people to flee from their

homes and to displace them locally and make them international refugees.

Fourth, when we understood that public health is “what societies do collectively to ensure the conditions in which people can be healthy,” this means if society wanted to enhance their public health conditions, they need to work collectively. Oromo people are denied the right to decide on their collective rights, i.e., social, economic, political, and cultural rights; they have difficulty in developing the capacity to build public health preparedness. Therefore, advancing collective rights should be seen as the effort the society make in building the capacity of Oromo people their public health preparedness.

Fifth, preventing epidemics requires developing essential public health infrastructures, and in turn, it necessitates building the social, economic, political, and cultural capital. Those capitals effectively built if the rights of people to Self-determination are respected. When the rights of people to freely decide on their social, economic, political, and cultural rights violated, their public health preparedness is curbed and made them more vulnerable to pandemics. As we have observed in the case of Blacks in the USA, the marginalized groups who have been living in unhealthy social conditions would remain vulnerable to the known and unknown diseases.

## References

- [1] CDC Human Coronavirus Types <https://www.cdc.gov/coronavirus/types.html>.
- [2] Curtis, Sarah & Taket Ann. (1996). *Health & Societies: Changing Perspectives*, Arnold, London.
- [3] Dugassa, Begna. (2018). The Significance of Collective Rights to Public Health Development: The Case of Oromia Regional State in Ethiopia, *American Journal of Public Health Research*, 2018, Vol. 6, No. 5, 203-214.
- [4] Dugassa, Begna. (2019). The Significance of The Rights of People to Self-Determination to The Development of Public Health: The Oromo Experiences, *The Journal of Oromo Studies* Vol. 23, No. 1&2, pp 99-128.
- [5] Dugassa, Begna. (2014). *Human Rights and Public Health: Toward Understanding the Root Causes of Social Problems in the Oromia Regional State, in Ethiopia*, Lambert Academic Publishing.
- [6] Holcomb Holcomb & Ibssa, Sisay. (1991). *The Invention of Ethiopia. The Making of a Dependent Colonial State in Northeast Africa*, The Red Sea Press, Trenton, NJ.
- [7] 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.
- [8] Dugassa, Begna. (2004). Human Rights Violations and Famine in Ethiopia. *The Journal of Oromo Studies*, Vol.11, Number 1 and 2, page 47-68.
- [9] Dugassa, Begna. (2006). Ethiopian Language Policy and Health Promotion. *Journal of Sociology and Social Welfare*. Vol. XXXIII, No. 4, Page 69-86.
- [10] Amnesty International, Ethiopia: Authorities crack down on opposition supporters with mass arrests, <https://www.amnesty.org/en/latest/news/2020/01/ethiopia-authorities-crack-down-on-opposition-supporters-with-mass-arrests/>.
- [11] HRW, 2020. Millions of Ethiopians Can't Get COVID-19 News, Refusal to Restore Communications Threatens Public Health (Retrieved March 30, 2020), <https://www.hrw.org/news/2020/03/20/millions-ethiopians-cant-get-covid-19-news>.
- [12] Berry, Deborah (2020), Black people dying from coronavirus at much higher rates in cities across the USA, USA TODAY, <https://www.usatoday.com/story/news/nation/2020/04/07/who-dying-coronavirus-more-black-people-die-major-cities/2961323001/?fbclid=IwAR2iESjufEmsF-RKpuBGYSWAj9vRBWdxD5r9facil07nn4aXnUlu4QiYW6Y> (Retrieved April 16, 2020)
- [13] Watts, Sheldon. (1997). *Epidemics and History: Disease, Power and Imperialism*, Yale University Press, New Haven and London.
- [14] Chandra, Siddharth and Kassens-Noor Eva. (2014). The evolution of pandemic influenza: evidence from India, 1918-19, *BMC Infectious Diseases*, 14:510.
- [15] Kitaw, Yayehyirad and Kaba Mirgissa. (2018). A Century after, Yehedar Beshete (The Spanish Flu in Ethiopia): Are We Prepared for the Next Pandemic? *Ethiopian Journal of Health Development*, 32 (1) 1-5.
- [16] Jalata, Asafa. (2005) *Oromia and Ethiopia. State Formation and Ethnonational Conflict 1868-2004*. Trenton, NJ: The Red Sea Press, Inc.
- [17] Birri, Debela (2014) *Divine Plan Unfolding: The Story of Ethiopian Evangelical Church Bethel*, Lutheran University
- [18] Dugassa, Begna. (2018a) Colonialism and Public Health: The Case of the Rinderpest Virus in Oromia Regional State in Ethiopia, *Journal of Preventive Medicine*, ISSN 2572-5483.
- [19] De Silviac Martial. 1901/2005. *An Ancient Great African Nation. The Oromo*. Translated by Ayalew Kannno. Father Martial de Salviac Missionary (O.M. CAP) Paris.
- [20] Dugassa, Begna. (2009). Women's Rights and Women's Health, During HIV/AIDS Epidemic. *Journal Health Care for Women International*, Vol. 30, No. 8, page 1-17.
- [21] 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.
- [22] Dugassa, Begna. (2005). Women's Rights and Women's Health: The case of Oromo Women in Ethiopia. *Journal Health Care for Women International*, Vol. 26, No. 2, page 149-169.
- [23] WHO (2020) Coronavirus disease (COVID-19) Pandemic, <https://www.who.int/emergencies/diseases/novel-coronavirus-2019>
- [24] Mann, Jonathan; Gruskin, Sofia; Grodin, Michael and Anna George. (1999). *Health and Human Rights*, Routledge, New York.
- [25] Commentary (2020) Managing the Politics of Ethiopia's COVID-19 Crisis, The International Crisis Group, 15 APRIL 2020, [https://www.crisisgroup.org/africa/horn-africa/ethiopia/managing-politics-ethiopia-covid-19-crisis?fbclid=IwAR2L2BXhltvFWMsz5LA6a1SnxjNw9D-5pYVldlv\\_vCOHawW6HXF-JwmO048](https://www.crisisgroup.org/africa/horn-africa/ethiopia/managing-politics-ethiopia-covid-19-crisis?fbclid=IwAR2L2BXhltvFWMsz5LA6a1SnxjNw9D-5pYVldlv_vCOHawW6HXF-JwmO048).
- [26] Harvard University, The Graduate School of Arts and Sciences. (2014). The Reason for the Season: why flu strikes in winter, <http://sitn.hms.harvard.edu/flash/2014/the-reason-for-the-season-why-flu-strikes-in-winter/>.
- [27] Lowen Anice & Steel, John. (2014). Roles of Humidity and Temperature in Shaping Influenza Seasonality, *Journal of Virology*, p7692-7695.
- [28] Fuhrmann, Christopher. (2010). The Effects of Weather and Climate on the Seasonality of Influenza: What We Know and What We Need, *Geography Compass* 4/7, 718-730.
- [29] WHO. Communicating risk in public health emergencies A WHO guideline for emergency risk communication (ERC) policy and practice, [https://www.ncbi.nlm.nih.gov/books/NBK540729/pdf/Bookshelf\\_NBK540729.pdf](https://www.ncbi.nlm.nih.gov/books/NBK540729/pdf/Bookshelf_NBK540729.pdf), (Retrieved on March 31, 2020).
- [30] The European Centre for Disease Prevention and Control (2017) Increase of cholera cases in the Horn of Africa and the Gulf of Aden – risk for EU/EEA citizens 19 May 2017, <https://www.ecdc.europa.eu/sites/portal/files/documents/rapid-risk-assessment-cholera-horn-of-africa-may-2017.pdf>.
- [31] Caten JL, Kartman L. Human Plague in the United States 1900-1966. *JAMA*. 1968; 205(6): 333-336.

