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## Oromo Cultural Education for Nurses

Claire Passey Tahiro  
*St. Catherine University*

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Oromo Cultural Education for Nurses

DNP Project  
Submitted in Partial Fulfillment  
Of the Requirements for the Degree of  
Doctor of Nursing Practice

St. Catherine University  
St. Paul, Minnesota

Claire Passey Tahiro

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ST. CATHERINE UNIVERSITY  
ST. PAUL, MINNESOTA

This is to certify that I have examined this  
Doctor of Nursing Practice DNP project  
written by

*Claire Passey Tahiro*

and have found that it is complete and satisfactory in all respects,  
and that any and all revisions required by  
the final examining committee have been made.

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Gwendolyn Short

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Date

DEPARTMENT OF NURSING

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### Abstract

Minnesota has the largest population of Oromo outside of Ethiopia and nurses have limited Oromo cultural knowledge. Minority groups, such as the Oromo, are identified as having decreased access to health care and poorer health outcomes. Cultural competence interventions improve culturally competent care provided to patients, no matter what the specific type. A one-time live pilot education session was given to a convenience sample of emergency room nurses at Hennepin County Medical Center (HCMC) with paired pre- and post- educational analyses. Pre- and post-analysis used a Likert scale, and the post-survey included additional open-ended questions. Results found that participants believed that receipt of cultural education improved knowledge of the Oromo culture, community resources and methods to help the Oromo, thereby increasing cultural competence and sensitivity. Implementation of ongoing cultural education at HCMC will improve culturally competent care provided to Oromo and other ethnic groups, increasing patient satisfaction, patient outcomes, and improving the mutual respect and understanding between patients and staff.



## Oromo Cultural Education for Nurses

### **Introduction**

Minnesota has the largest population of Oromo outside of Ethiopia, estimated to be over 40,000 people (Oromo Community of Minnesota, 2016). The exact number is difficult to determine because the Oromo are an ethnic group, speak multiple languages, and come from multiple different countries (O. Hassan & A. Ali, personal communication, June 9, 2016). Diversity in the United States (US) is ever-increasing requiring health care providers to deliver pertinent, successful, and culturally responsive care, also known as culturally competent care (Zuwang, 2005). With the large number of Oromo in Minnesota there is an accentuated need to address their culture and needs in health care, especially in the Twin Cities area.

Racial and ethnic minorities have been identified as having higher rates of: (a) chronic diseases; (b) decreased health outcomes; (c) decreased life expectancy; (d) decreased quality of health care; (e) decreased routine procedures; and (f) delayed treatment due to cultural insensitivity or unfair treatment (Ehlich, Kendal, Sanjoti, & Walters, 2016; Lyons & Levine, 2014; Institute of Medicine [IOM], 2002; Flores, 2000). Lack of culturally competent care leads to increased emergency department visits and hospitalizations, and decreased patient satisfaction rates (Georgetown University, 2004). Organizations practicing cultural competency have increased community participation, mutual understanding and respect from patients, and improved health outcomes (Wilson-Strong & Mutha, 2010).

The IOM's (2001) publication, *Crossing the Quality Chasm; A New Health System for the 21<sup>st</sup> Century*, established six aims to improve patient outcomes; one aim was providing patient-centered care (Campinha-Bacote, 2011). When caring for ethnic and minority populations patient-centered care includes providing culturally competent care. The cultural

beliefs and values of diverse populations can vary immensely, creating a challenge for health care providers. Lack of cultural knowledge creates a gap between practice and positive health outcomes, creating disparities in health care access and health status. In order to decrease the disparities and improve health outcomes for the Oromo population, culturally competent care must be implemented and this requires knowledge of the population and its health behaviors (Center for Substance Abuse Treatment, 2014).

## **Background**

The gap created by lack of culturally competent care produces health care disparities (Bentancourt, Green, Carrillo, & Park, 2005). Two and a half million refugees have fled Ethiopia since 1973, and at least half of the refugees are Oromo (Amnesty International, 2014). Due to continuing conflict, Oromo refugees continue to migrate to the US, especially Minnesota (Amnesty International, 2014). Discussions with nurses and health care staff at Hennepin County Medical Center (HCMC) revealed that little was known regarding the Oromo population for whom they were caring, including origin, health practices, health needs, or traditional health practices. The Diversity and Inclusion Department at HCMC reported that no culture specific education is currently provided, only basic annual cultural competency education that addresses the global issues of cultural sensitivity and competency (M. Johnson, personal communication, June 7, 2016). Discussions were also held with the nursing administration in the emergency department (ED) regarding the need for improved cultural education and improved cultural competence in the ED. Currently, practices in cultural competency include listing the dos and don'ts regarding specific cultures, but this is only an initial step (Kodjo, 2009). Cultural competency as health care providers involves self-awareness, understanding and accepting these differences, and adapting the plan of care for these diverse differences (Kodjo, 2009). Part of



reducing the gaps in the care provided to the Oromo includes improving cultural knowledge. A need was identified for a cultural competency intervention related to the Oromo at HCMC.

### **Literature Review**

Based on a literature review, there are a large number of cultural competency interventions being used in practice (Gallagher & Polanin, 2015; Hart & Mareno, 2014; Nomie, 2014; Troung, Paradies, & Priest, 2014). Implementation of any intervention, no matter the type, was found to improve cultural competency (Gallagher & Polanin, 2015; Hart & Mareno, 2014; Nomie, 2014; Troung et al., 2014). In addition, no specific intervention was identified as most effective (Troung et al., 2014).

Review of the literature also revealed that there was a lack of knowledge of health needs among the Oromo population in Minnesota. The first general assessment study of the Oromo was performed by Wilder Research (2016) of the Oromo community in Minneapolis. The only health related information gathered by Wilder Research (2016) stated the Oromo thought that, overall, they received high quality health care in the US. Any other needs assessments performed of the Oromo examined the needs of the East African population, but these were not specific to the Oromo and included many cultures of Africa. In order to gather more health-related information on the Oromo population in Minnesota for this project, discussions were held with a community health worker for the Oromo Community of Minnesota and an Oromo physician who is on the board of the Oromo Community of Minnesota (O. Hassan & A. Ali, personal communication, June 9, 2016).

The purpose of this study was to develop and implement an educational module on the health practices of the Oromo for the nursing staff at HCMC's ED, and incorporate this training into ongoing employee orientation sessions. The specific aims of the study were to (a) identify

the knowledge base on the Oromo population of nursing staff in the emergency department; (b) determine the desire for cultural education; (c) find out how beliefs on how Oromo cultural education would impact practice; and (d) determine if an educational session would improve staff knowledge.

### **Theoretical Framework and Application**

Two different theoretical frameworks were used in this project, including Purnell's model for cultural competence and Leininger's theory of cultural care diversity and universality.

Purnell's (2002) model for cultural competency identified 12 domains describing culture that help determine variations in values, beliefs, and practices within a culture. Identifying these variations helps to build the nurse-client relationships and the creations of patient-centered care.

Leininger's (1995) theory of cultural care and universality addresses the cultural dynamics identified in the nurse-client relationship and how they influence the outcomes of providing culture-specific care and the universal practices of nurses in promoting health and well-being.

Identification of knowledge gaps among nurses, then addressing those gaps is essential when determining the 12 domains identified by Purnell. It is the responsibility of the nurse to ensure that culturally competent care adapts to the patient's cultural needs and preferences, defined by Leininger as culturally congruent care (Leininger & McFarland, 2002). Nurses who understand their patient's culture, then assessing their values, beliefs, and practices, help to improve patient outcomes by individualizing their care (Narayan, 2003).

According to Purnell (2002), providing culturally competent care requires individuals to have an increased consciousness of diversity. Purnell (2002) states that this is a process that requires nurses to move from unconsciously being incompetent, to becoming conscious of their actions, and lastly meeting the last stage of providing unconsciously competent care. Providing

unconsciously competent care means that the individual provides culturally congruent care to patients in a variety of cultures (Purnell, 2002). The goal of providing cultural education is to improve the conscious delivery of culturally congruent care.

## **Method**

This researcher performed a one-time educational session with a quantitative pre- and post-educational analysis. The pre- and post-educational analysis surveys had eight identical questions using a Likert scale evaluating nurses' knowledge regarding (a) health disparities based on race, ethnicity, and language; (b) beliefs and values of the Oromo; (c) dietary practices; (d) family dynamics; (e) community resources; and (f) methods available to assist Oromo patients. The Likert scale was a scale of one to five, with one being strongly disagree and five being strongly agree. The post-analysis also included five additional open-ended questions for nurses to provide thoughts on what they wish they had learned, desires for future cultural educations, and beliefs on how the information they learned will impact the care they provide.

**Sample and Data Collection.** Participants consisted of a convenience sample of nurses who work in the emergency department at HCMC. Participants were recruited with a flyer placed in the emergency department staff breakroom and an email invitation that was sent through work email addresses. Registered nurses were the only individuals targeted for participation. Demographics of participants were not collected because of the potential for a small sample, and an inability to maintain confidentiality of participants if this information were collected. A small sample size of six participated in the one-time pilot educational session at HCMC in the ED.

Once participants arrived at the educational session, the researcher reviewed the letter of consent, and explained that consent was voluntary and that individuals were not required to

participate in the research. Participants were given time to fill out the pre-survey. Participants turned in the pre-survey they were provided; if they chose not to participate, then they turned in a blank survey to maintain confidentiality. In this way, the researcher was not able to determine who chose to participate or not.

The education session was then presented. Following the educational intervention, participants filled out the post-survey. The same process was used to turn in the post-survey. All surveys were collected, whether completed or not, and were monitored by someone other than the researcher.

**Interventions.** The educational session was provided by the researcher in a one time live session, with a correlating slide show. The educational session included information on general cultural competency and sensitivity, including their importance in providing care. Information on the origin of the Oromo population and their migration to the US was also included; cultural practices and needs were identified. Nurses were also provided with information on providing culturally competent care, and available resources within the community to help meet the needs of the Oromo community. The educational session, including the time to fill out the surveys was an estimated 60 minutes. Participants were given a traditional Ethiopian meal as an incentive to participate.

### **Hypotheses**

The hypothesis of this researcher was that nurses at HCMC have little knowledge of the Oromo population and their health care needs. Additionally, the researcher hypothesized that education on the cultural competency and the Oromo culture would improve nurses' knowledge, and create an attitudinal change so that the nurse participants believe that they will, in the future,

provide more culturally appropriate care for the Oromo population in the Hennepin County Medical Center emergency department.

## **Discussion**

**Outcomes and Interpretation.** The sample obtained through participation was too small to be of significant statistical analysis ( $n = 6$ ) but did support what previous studies have found that any type of cultural competency intervention improves outcomes. Participants in this study showed improvement in their knowledge of Oromo specific cultural beliefs and values including (a) health, (b) illness, (c) emotional well-being, (d) health-seeking behaviors, (e) traditional healing practices, (f) gender roles, and (g) diet. Improvements in participants' Oromo cultural knowledge were identified with the pre-education analysis reports of strongly disagree to disagree and post-education surveys reporting agree to strongly agree for all participants. Improvements in participants' understanding in methods that could be used with the Oromo population and community resources available also improved with the educational intervention. All nurse participants reported understanding the presence of health care disparities related to race, ethnicity, and language on their pre-education analysis and following their educational session nurses did not report an increase in knowledge regarding these disparities.

The open-ended questions on the post-educational analysis can be found in Table 1, with a sampling of answers provided by nurse participants. The answers to these questions identified that nurses believed that the education improved their ability to be more culturally sensitive and aware, and improved their ability to provide culturally competent care. Participants also believed that all HCMC employees would benefit from the education provided, improving culturally competent care, specifically the care for the Oromo population. Nurses expressed a wish for more community resources and information on how to deal with patients' unmet needs. This

additional information can be added to future educational sessions to improve nursing knowledge.

Plans for implementation of this type of culture specific educational intervention into ongoing emergency department orientation are being evaluated. Fiscal restraints have created difficulty in implementing the intervention into practice, but there are other potential options being assessed in order to determine the best way to introduce the educational intervention to nursing, and potentially other ED staff. A slideshow voiceover recording of the presentation has been given to the ED nursing administration, as well as the presentation without a voice recording for future use. Nursing administrators are currently discussing viability of creating similar presentations that address other specific cultural groups frequently using HCMC services.

### **Strength and Limitations**

Improvement of nursing knowledge of the Oromo community and identifying the Oromo patients in their care will help to nurses provide culturally competent care; this is a strength of this research as very little health research has been done with this group. An additional strength is that the education session provided nurses with the opportunity to contemplate the care they provide patients, noting where improvements can be made to make their care more culturally competent. The ability to collect information in a timely manner (with a single educational session) was another strength of the intervention, as there is very little time in a busy emergency department to allow for educational programs of this type.

The small number of participants was a limitation on both the impact that the intervention will have on practice, and identification of any statistical significance among the knowledge of the participants. Another limitation is that the information was provided to

registered nurses in the emergency department only, and nurses are only one part of the interdisciplinary care team within the ED.

### **Conclusion and Implications**

The study found that the original hypothesis, that HCMC ED nurses had little understanding of the Oromo population and their needs, was true. The literature review identified that any cultural competency intervention would improve the cultural competency provided to patients, so any reasonable approach to address this gap would be helpful. The participant sample size was limited, both in number and provider type, but the study shows an association between the cultural education provided and the intent to provide culturally competent care to the Oromo population.

Nurses who participated in the study believed that the educational session provided information that would improve their provision of culturally competent care. If the nurses who received the education session improve their provision of culturally competent care, then the emergency department at HCMC may have a decrease in health disparities, improved health outcomes, and improved patient satisfaction among the Oromo. Implementation of the education session with a larger population of nurses and staff within the emergency department would improve the impact and ability to evaluate the impact provided by increased cultural education. Educational sessions related to other cultures seen at HCMC may also improve patient care and outcomes.

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**Table 1.** Post-education Analysis Open-ended Questions and Answers.

<b>What impact do you think the information you learned in this presentation will have you're your care for the Oromo population, if any?</b>
<ul style="list-style-type: none"> <li>• “Better ways to communicate with Oromo patients.”</li> <li>• “Definitely more awareness of my approach. More cultural sensitivity.”</li> <li>• “Better understanding; Providing choices.”</li> <li>• “More understanding of patient needs”</li> </ul>
<b>If the information in this presentation were added to the HCMC orientation program for all employees what impact would this have on patient care?</b>
<ul style="list-style-type: none"> <li>• Better ability to care for patients in this community.”</li> <li>• “Would make staff more culturally sensitive and aware.”</li> <li>• “I think that an emphasis on cultural sensitivity and awareness in our orientation would benefit all employees.”</li> </ul>
<b>If educational sessions were provided on other cultures what impact would it have on the care provided at HCMC, if any?</b>
<ul style="list-style-type: none"> <li>• “It would be helpful to have our top 2-3 cultures in a presentation similar to this.”</li> <li>• “Better understanding and care.”</li> <li>• “Think it would benefit all providers to give our patients better care.”</li> </ul>
<b>Is there any other information that you would have liked to have learned that was not presented in this educational session?</b>
<ul style="list-style-type: none"> <li>• “More referral resources for the community</li> <li>• “What are their responses when we can't meet their needs? Like-meds, appointments, etc. How to answer?”</li> <li>• “Great covered all topics”</li> </ul>