The barriers and challenges to Health Promotion in Africa

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Introduction

Health promotion is the process of enabling people to increase control over and to improve their health so as to reach a state of complete physical, mental and social well being. The World Health Organisation which was created in 1948, where some 190 countries exchange their knowledge and experience with the aim of making possible the attainment by all citizens of the world a level of health that will permit them to lead a socially and economically productive life. Unfortunately Africa is riddled with corruption, debt, conflicts, wars, rape, child soldiers, HIV/AIDS, land mines, unemployment and the list is endless; which are formidable barriers and challenges to health promotion.

(SA Fam Pract 2005;47(10): 39-42)

Health care professionals have always practiced their professions in a three-fold objective: curing, caring and preventing.[1] The pattern followed is curing and if this is limited, then caring with minimal emphasis on prevention is followed. The biomedical model is based on diseases and curative principles and the biopsychosocial model encompasses a holistic approach. The two models represent different approaches about health and disease.[1] Therefore both models provide complementary explanations rather than being alternatives or competing ones.

How do health promoters, within all the constraints in Africa, promote biopsychosocial-environmental health? In Africa, most peoples have poor health status. This leads to difficulty in sustaining development and economic viability. Therefore countries in Africa experience difficulty in promoting and maintaining health of its peoples. In 1986, the World Health Organisation (WHO) adopted the **Ottawa Charter** which identified five action areas to Achieve Health for All by the year 2000 and beyond.[2] The prerequisites for health include *peace, shelter, education, food*, *income*, *a stable ecosystem, sustainable resources, social justice and equity.*[2] All of these are problematic to Africa.

The Jakarta Declaration on Health Promotion (1997) stated that there was clear evidence that: "*Comprehensive approaches to health development are most effective, settings offer practical opportunities for implementation of comprehensive strategies, participation is essential to sustain effort and health learning fosters participation* which are core elements of health promotion".[3;4]

Determinants of Health

Assessing health determinants (*personal behaviour; lifestyle; influences within the community which can sustain or damage health, living and working conditions; access to health services; general socioeconomic, cultural and environmental conditions and genetics and screening)* provides insight into the burden of diseases and this may assist in establishing intervention programmes.[1]

Review objective

To critically examine the barriers and challenges to health promotion strategies and intervention programmes in Africa and make recommendations based on the study review.

Methods

Study Design

A review of the literature on health promotion in Africa and systematic reviews of health care interventions, barriers and challenges to health promotion was done.

Search Strategies for Study

- Google, Yahoo, Medline, Pub med, Cochrane Controlled Trials Register, Global Health, World Health Organisation, Medical Research Council
- Hand searched journals and books

Economic implications on Health Promotion

According to Peters, *et al* the median annual per capita government expenditure on health in Africa was nearly US$ 6, averaged US$3 per capita in the lowest income countries and US$72 per capita in the middle income countries.[5] If African countries are spending an average of US$6 on curative medical care, how then do these countries build in health promotion into their budgetary constraints? African countries with different levels of GNP (Gross National Product) therefore vary in health expenditures, services and health outcomes.[6] Ethiopia is classified as one of the lowest income groups, Kenya, a low income group and South Africa, a middle income group with no high-income groups in Africa.[6] Table I shows the statistical profiles on health

Table I: Health Expenditure[6]

Country	Health expenditure Total % of GDP (1997-2000)	% of total health expenditure (1997-2000)		Health expenditure per capita (1997-2000)
		Public	private	$
DRC (lowest-income)	1.5	73.7	26.3	9
ETHOPIA (lowest-income)	4.6	39.4	60.6	5
MALAWI (lowest-income)	7.6	47.8	52.2	11
ANGOLA (low-income)	3.6	55.9	44.1	24
KENYA (low-income)	8.3	22.2	77.8	28
SUDAN (low-income)	4.7	21.2	78.8	13
BOTSWANA (middle-income)	6.0	63.1	36.9	191
SOUTH AFRICA (middle-income)	8.8	42.2	57.8	255
EUROPE EMU	*9.1*	*73.4*	*26.6*	*1 808*
UNITED STATES	*13.0*	*44.3*	*55.7*	*4 499*

expenditure in some African countries compared to European countries and United States.[6] The per capita government spending raises serious concerns about the long-term feasibility of governments' financing of a minimum package of health services. In all African governments, secondary and tertiary levels of care can absorb more than 80% of health care budgetary allocation.[7] In the lowest income countries, donor contributions accounted for 53% of public sector health expenditures.[6] Can African governments and the New Partnership for Africa's Development (NEPAD) be able to encourage economic development and investments, thereby simultaneously improving health expenditure per capita and build in a health promotion budget?

Shift from rural to urban settlement

In recent decades most African countries have experienced an unprecedented growth in their predominantly low-income settlements of urban populations. The available statistical information suggests that poverty, poor living and working conditions can cause infectious diseases, chronic degenerative diseases, pathogenic conditions associated with stress (often precipitated by social isolation, insecurity, dissolution of family relations and cultural conflict).[7] The prerequisites for health include *peace, shelter, education, food*, *income*, *a stable ecosystem, sustainable resources, social justice and equity* as adopted in the Ottawa Charter (1986).[2] All these are well-known to be deficient in most of Africa. Therefore the core elements of health promotion also cannot be sustained.

Influence of physical and structural barriers

The major structural barriers to health are usually legislative, policy or regulative measures that hinder the practice of good health.[8] Sometimes the barriers are physical e.g. the lack of water or adequate sanitation, contamination of water, poorly ventilated housing, overcrowding and improper waste disposal become breeding grounds for infectious and parasitic diseases. Sectoral Statistical Profile on Ethiopia (World Bank-WDI, 2000) documented that rural access to a water source was 13% and 6% had improved sanitation.[9] These unhygienic conditions in the rural and urban areas serve as enabling environments for infectious diseases (most of which have re-emerged in the past two decades) which have proved difficult to control and prevent.[7,10]

Effects of conflicts

Africa is plagued by conflicts and the OAU identified both external and internal factors that contributed to 26 conflicts affecting over 60% of Africa's population from 1963 to 1998.[11] The consequences of war - death, injury, long-term disability, rape, torture, post-traumatic stress and long-term mental health problems were documented.[11] Such conflicts also resulted in lack of adequate medicines (which could result in drug-resistant strains of microbes), human rights abuses, child soldiers, internally displaced populations (IDP), mass exodus of people, and loss of social networks and influx of refugees. The 6 072 900 refugees in African countries need food, water and shelter as the main priority.[11] The goal of all host governments is to return the refugees home with little or no disease. Over three quarters of the African countries are low-income or even lowest-income countries and nearly all have weak health management systems.[6] The relationship between conflicts and HIV/AIDS in Africa has been well documented and adds to the economic burden. The Study, Health Expenditures, Services and Outcomes

Case study

A case study documented about 50 years ago showed that most Zulu families (in South Africa) had fowls and eggs in plenty. It was considered uneconomical to eat an egg that could be sold. It was also considered a sign of greed and eggs were thought to make girls licentious. Today eggs are a common item in the diet of Zulus. The question of milk proved more difficult and complex. In addition to being in limited supply, milk was deeply rooted to customs and beliefs. Among the Zulus cattle was closely associated with the veneration of ancestors. Only relatives of the head of a household can use milk produced by his cattle. Traditionally no family could supplement its milk supply from another family outside the kin group. During her menses or when she was pregnant a woman was traditionally thought to exert evil influence on cattle and could not pass near a cattle enclosure or drink any milk. It is still customary for girls to drink no milk after puberty. In the face of deep-rooted beliefs convincing people of the nutritional value of milk could not by itself be expected to bring about change. Fortunately it was possible to overcome this difficulty to a large extent by introducing powdered milk. Even the most orthodox husbands and mothers-in-law had no objection and over the years a large number of families bought milk powder as a supplement.[1]

Source: *Cassel J. A comprehensive health program among South African Zulu. In: Health Promotion and Community Action for Health in Developing Countries (WHO, 1994).*[1]

in Africa by Peters, et al 1997, found that the lowest income countries had the smallest proportion of GDP devoted to health expenditure and had the highest military-to-government health expenditure ratio.[5]

A study in Sierra Leone in 1999, implicated Peacekeepers and Humanitarian workers in the 1 862 female victims of sexual abuses, 55% of them were gang raped and 200 were pregnant resulting in fatherless children of war.[11] A continent in conflict is a public health hazard to all and efforts should be undertaken to support peace, health promotion and economic development in Africa.

Influence of culture on health

Airhihenbuwa ("Health and Culture: Beyond the Western Paradigm", 1995) suggested that health promoters should not look at the role of culture as a barrier but rather embrace the cultural dimension in health and to not equate health development to westernization.[4,7] People are more likely to engage in health-promotion if they have the incentives to do so, the health changing behaviour has the outcome they want and that they believe they are capable of performing this health changing behaviour. The following case study depicts the challenge of culture on health promotion.

Influence of literacy on Health

Health literacy (as defined by the Center for Health Care Strategies Inc., 2000) is the ability to read, understand and act on health care information. In contrast, the US Healthy People 2010 defines health literacy as the capacity to obtain, interpret and understand basic health information and services and the competence to use such information and services to enhance health.[12] Africa has the lowest female literacy rate with South Africa and Zimbabwe having a literacy rate of about 80% while in Niger and Burkina Faso only 10% of women can read and write.[12] In developing countries it

Table II: Mortality Rates in certain African countries compared with Europe EMU and United States: 2003 World Development Indicators, World Bank

Country	Physicians (per 1000 people)	Life expectancy At birth (years)		Infant mortality Rate (per 1000 live births)		Under-five mortality Rate (per 1000 live births)		Adult mortality rate Per 1000		Survival at 65 % of cohort	
								Male	female	male	female
	1995-2000	1980	2001	1980	2001	1980	2001	2000 -	2001	2002	2002
DRC (lowest-income)	0.3	49	45	88	81	125	108	475	406	35	44
ETHOPIA (lowest-income)	-	42	42	143	116	213	172	594	535	26	30
MALAWI (lowest-income)	-	44	38	157	114	265	183	701	653	20	23
ANGOLA (low-income)	0.1	41	47	158	154	265	260	492	386	34	39
KENYA (low-income)	0.1	55	46	73	78	115	122	578	529	28	33
SUDAN (low-income)	0.1	48	58	86	65	142	107	341	291	53	58
BOTSWANA (middle-income)	-	58	39	62	80	84	110	703	669	13	18
SOUTH AFRICA (middle-income)	0.6	57	47	65	56	90	71	594	543	27	33
EUROPE EMU	4.1	74	78	13	4	16	6	125	58	80	90
UNITED STATES	2.8	74	78	13	7	15	8	141	82	81	91

has been shown that female literacy of 70% to 83% also shows a reduction in infant mortality rate of 50 per 1000 babies (Save the Children, 2000).[12] The other spin off is: working mothers and educated women are likely to delay marriage and childbirth thereby giving better health care to their families, sending their children to schools and contributing to the overall economic growth of their countries (Filmer,1999).[12] The paradox is that although South Africa and Zimbabwe have the highest literacy rates in Africa they are also the countries most severely challenged by HIV/AIDS.[12] Table II depicts the mortality rates in certain African countries compared with Europe EMU and United States.

Influence of Information Technology and language on health

Disease prevention activities are multi-pronged, involving the use of various forms of interpersonal channels of communication and the mass media and there are a number of constraints that thwart these efforts. The new electronic learning technologies might provide learning opportunities that are more visual and interactive than pamphlets and older more didactic forms of health information. However, the realty is that there is unequal access to information technology in African countries. Every 4 out of 5 websites are in English while worldwide only 1 in 10 people speak English. Africa has 12% of the world's population yet only 2% of telephone lines with South Africa taking up 90% of the connectivity of the continent.[12] Language is also a barrier to health promotion.[13] There are over 1000 indigenous languages spoken in Africa.[7] South Africa has 11 official languages while other countries may have a national language to facilitate communication amongst its people. Public health campaigns may face resistance if these messages are not language – specific.[7,14]

Conclusion

Creating supportive environments occurs at two levels, one at the level of nations and communities and the second is at a global responsibility. Both levels are complex and inter-related and both must be encouraged to reciprocate maintenance.[8] It has been described that a prosperous country hails a healthy nation. In Africa, most peoples have poor health status and this leads to the difficulty to sustain development and economic viability and without economic and social stability, countries experience difficulty in promoting and maintaining health. The only way to know if public health policy is achieving its objectives is by evaluating health promotion projects, assess health determinants and evaluating key health outcomes e.g. morbidity and mortality statistics on an annual basis.

Recommendations

- Health promotion strategies and programmes must be adapted to the needs of individual countries encompassing cultural, social, religious and economic systems
- The determinants of health promotion must be a coordinated action by the health sector, national government departments, social and economic sectors, nongovernmental and voluntary organisations, local authorities, industry, media and community participation
- Developing, promoting and evaluating national campaigns
- Developing, promoting and evaluating occupational health services
- To include a socio-ecological approach to health by protecting and maintaining our environment and natural resources at both a national and global level
- To address and resolve conflicts and wars in Africa and to maintain stability
- To encourage economic development and investment in Africa, improve infrastructure and technology
- To improve and encourage education and literacy
- To do a national audit of all health promotion resources, develop health promotion infrastructure and delivery to its peoples
- To address health promotion training at an academic and community level

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