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Health Equity: A Challenge and Achievable Goal for Africa

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Abstract

The conditions in which people are born, live, grow and age are important and impact greatly on their health. However, equity is not about sameness but each and every individual deserving the same opportunity concerning health, education, housing, working and living conditions.-Health inequities are found worldwide at different levels and stem from various factors. Africans are experiencing health inequity related to the social, economic, cultural and political environment in which they live. Immediate actions, coupled with a good political will substantially reduce the existing gaps and ensure that we achieve health equity in a nearer future.

Keywords: *Health, equity, inequity, social determinants.*

Introduction

The conditions, in which people are born, live, grow and age are important and impact greatly on their health (1). Equity is not about sameness, but each and every individual deserving the same opportunity concerning health, education, housing, working and living conditions in order to maximize their chances to fully achieve physical, moral and psychological well- being (2).

Globally, the work of the commission of social determinant of health has raised awareness about the importance of acting on factors other than health care and behavior to reduce ill health. Inequities in health are perceptible worldwide, they occur along different axes on the social stratification; including ethnic, socioeconomic, political and cultural factors.

Almost 40 years after Alma Ata, Health for All remains an elusive goal. In the developed world where universal access to health care is a reality and the epidemiological transition has taken place; differences in health outcomes stem mainly from an ethno-racial driver as in Australia and Canada with the aborigines and black American in the USA.

However, in low and middle income countries and in Africa particularly; the epidemiological transition is gradually taking place, infectious and parasitic diseases remain the main causes of death among people (3), infrastructures including health care facilities are lacking in remote and deprived area and where they exist ;skilled health care professionals are absents and usually conctrated in big cities (4). The poor- rich health gap is still persisting between and within countries and multiple socio– economics, cultural, political, ethnic and racial factors are influencing differences in health outcomes in developing countries.

This paper examines the different factors (poverty, education, gender, health coverage, gender) that play a role in health disparities in Africa and approaches that can reduce the gap.

Methods

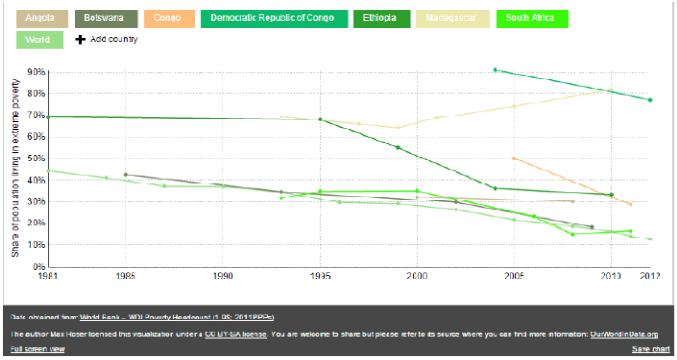
This paper is based on a review of the literature (scientific publications) on health equity in Africa and worldwide, as well as on information gathered from the experience of the author and from grey literature by conducting google research.

The poverty factor

According to the World Bank Organization, one third of people living in extreme poverty are Africans. Such figures are more prominent in countries like DR Congo and Madagascar where almost 80 % of the population lives with less than 2$ a day (Table II);out of pocket spending being the most preferred method of payment across the health care system and

social protection is almost non- existent. In countries like Botswana where social services are effective, access to health care services can be hindered by the cost of transport and difficulty of access (5) and the lack of food in the household can be the reason of non adherence to ART (5). Therefore, with a high poverty rate and the strong link existing between poverty and ill health (6); investing in health care alone to prevent the spiral of ill health poverty in the continent will certainly not be enough. Real policies addressing the cause of the causes (reducing unemployment, improve working conditions and wages) led by ministries of health and other stakeholders across governments seem to be the key in reducing health inequities in the continent. Investing the benefit of economic growth in empowering people will lead to more sustainable and continuous growth as this will contribute in producing skilled and competitive main power.

Table 1. Extreme poverty rate in some African Countries, 1981 to 2012

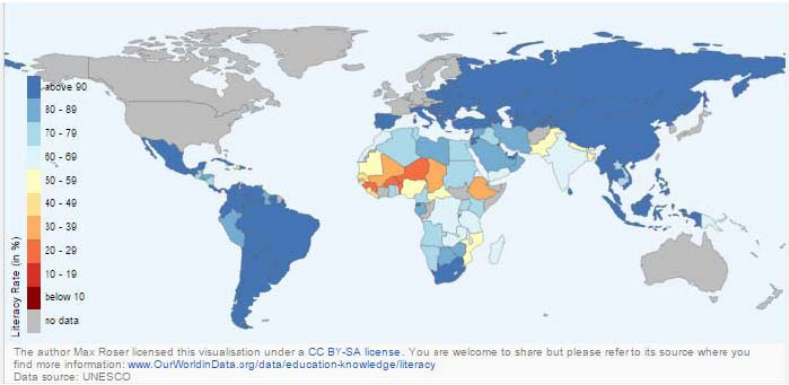


The education and literacy factors

Education is one of the main factor affecting people's health. Its impact spreads across the continuum of an individual life and of its offsprings; influencing his income, the choices he makes concerning his life and his children too. Education and literacy constitute the base and affect the cognitive of individual making them more receptive to health education messages (7) and are associated with significant reduction in under five mortality (8). According to UNESCO; in Sub Saharan Africa, about 30millions primary school aged children are not going to school and with the lowest literacy rate registered in countries like Tchad and Burkina Faso where almost 80 % are illiterate (9);many lives are prone to ill health. The lack of formal education is strongly associated with high infant morality (10) and elevated maternal moratlity (11). Zimbabwe with more than 90 % of literacy rate (9) can build on a stronger base though literacy does not equate to education.

Education and literacy are key factors in achieving equity between and within countries. Their impact on health outcomes are strong; therefore, efforts (increasing literacy rate and augment primary school intake) should target those two drivers to reduce inequities in health.

Table 2. World Map Literacy of Adult (15+)



The ethnic (Indigenous) factor

Approximately 50 millions of Africans are indigenous (12); from Southern Africa, home to the San passing by Pygmies of Central Africa and Maasais of Kenya to the Tuareg in North and Western Africa; indigenous people have been facing a common fate of deprivation and discrimination from governments and countries' counterparts. The paucity of data regarding indigenous leads to underestimate their poor health and precarious conditions in which they live. However, without health care access in most cases, mortality among pygmies in Central Africa is higher than national averages (13). In Southern Africa, especially in Botswana where the majority of San resides, infant mortality is higher in rural area where they are the main residents than urban area (14). Moreover, indigenous have been removed from their lands and deprived of their traditional livelihoods and cultures across the continent; such move impacted negatively on the groups' balance and behaviour increasing alcohol consumption and violence.

Despite different programs such the Remote Area Development Program launched more than a decade ago by the government of Botswana, little has been achieved in uplifting the life of indigenous (15). This results from governments to willingly ignore the ethnic factor; main driver, behind the marginalisation they suffer. Acknowledging that there is a problem and ensuring health inequities are measured within countries is a platform for action (16).

Therefore, governments should steward efforts to recognize and assess the conditions in which indigenous lives and take appropriate measures to uplift their lives and integrate them in the mainstream of their respective countries. Such move would ensure a substantial reduction of health inequity across the continent.

The gender factor

Gender inequity affects most social factors associated with health such education, income, literacy, unemployment, power distribution in societies and health care services' accessibility.

The gender factor plays a crucial role in women health issues such as birth control and sometimes due to the prevailing gender norms and values as well as the distribution of economic resources in the family; they usually face challenges in accessing health care services (17). The gender based inequity is again more proeminent in the case of diseases such HIV; seventy-five percent of new HIV infections occur among young girls and female adolescents in Southern Africa (18). Thus, a particular importance should be given to this factor in the path of achieving health equity in Africa.

In 2014, Africa has closed its gender gap to 67% with an increase of 4,8% since 2006(19);such results though encouraging are still insufficient as compared to inequalities registered in male dominant African societies regarding employment, education, income, work and high maternal mortality rates. Acting now on reducing gender inequity across the continent will contribute in improving the life of one of the most marginalized population; healthier mothers will be more educated, will have a higher income and healthier babies with a better education ultimately a more productive working class for the development of Africa.

African governments are more aware than ever about the importance of reducing gender inequities, but there is a need to move from concepts to action in order to achieve health equity.

The health coverage factor

More than 30 years after Alma Ata, accessibility to basic health services remains a far-fetched dream in most countries of Sub-Saharan Africa. In countries like DR Congo, Niger and Central African Republic; the collapse of the health system already weakened by political instability has left millions without accessibility and Non Governmental Organizations are in certain places the only provider of health services. On the other hand; in countries like Botswana and South Africa where people can enjoy a better health coverage, skilled health care professional and quality services are lacking, perpetrating the continuous gap of health equity within and between countries. A fierce example of inequities in accessing quality

health care can be given in South Africa, where most specialists doctors, pharmacists and allied health professionals are tied up in the private sector serving only 16% of the population (4) with approximately R10000 spent per medical aid scheme member while only R1900 was spent per individual dependent on public sector (20). Such discrepencies are also noted between rural and urban area in coverage of key health services such as skilled attendance birth, immunization and diagnosis and treatment of common diseases (21).

Though in both cases, scenarios differ, the results remain identical, health inequity is still palpable in the continent at different levels and hindering people's chances to achieve their full potential in life. In this context, universal health coverage is becoming a rallying call, with a focus on how best universal coverage can be financed, to ensure financial protection against the costs of ill health and access to needed health care for all (World Health Organization 2010).

Thus researches are needed to find effective and culturally sensitive way of financing and fairly distributing countries health expenditure.

Conclusion

Can Africa as a continent achieve health equity? Given the current situation and approaches used, one would rush to say not today not in the near future but with the potential the continent has and evidences from experiences of others, Africa has a particular opportunity of redirecting its efforts. The unique character of health requires a holistic approach from different components (socio-cultural, economic, political) of the African society through a continental organization such the African union to join efforts and reduce health inequity in the continent. Current isolated efforts directed toward health equity in different countries through gender empowerment and minority based program constitute a crucial step but remain insufficients.

It appears, then, that achieving health equity in Africa is not impossible, but requires a long term process which should be initiated today. Certainly, such efforts will need a systemic and systematic approach (continental efforts involving all African countries and involving sectors other than health between and within countries) as the gaps are across all the sectors of the African Society. Therefore, African leaders should demonstrate their good will and own the stewardship of this movement to implement the reforms needed.

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References

[1.] Ataguba JE, Akazili J. Health care financing in South Africa: Moving towards universal coverage. Contin Med Educ [Internet]. 2010;28(2):74–8. Available from: http://www.ajol.info/index.php/cme/article/viewFile/55239/43707

[2.] Alaba O, Chola L. The social determinants of multimorbidity in South Africa. Int J Equity Health [Internet]. 2013;12(1):63. Available from: http://www.scopus.com/inward/record.url?eid=2-s2.0-84884234648&partnerID=tZOtx3y1\nhttp://www.equityhealthj.com/content/12/1/63

[3.] Editorial G. Towards global health equity: opportunities and threats. 2012;1:2011–3.

[4.] Gakidou E. Education, Literacy & Health Outcomes Findings. 2014;

[5.] Hardon A, Davey S, Gerrits T, Hodgkin C, Irunde H, Investigator P, et al. No Title.

[6.] Kanmiki EW, Bawah A a, Agorinya I, Achana FS, Awoonor-Williams JK, Oduro AR, et al. Socio-economic and demographic determinants of under-five mortality in rural northern Ghana. BMC Int Health Hum Rights [Internet]. 2014;14(1):24. Available from: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=4144693&tool=pmcentrez&rendertype=abstract

[7.] Karlsen S, Say L, Souza J-P, Hogue CJ, Calles DL, Gülmezoglu AM, et al. The relationship between maternal education and mortality among women giving birth in health care institutions:

analysis of the cross sectional WHO Global Survey on Maternal and Perinatal Health. BMC Public Health [Internet]. 2011;11(1):606. Available from: http://www.biomedcentral.com/1471-2458/11/606

[8.] Marmot M. Closing the gap in a generation. Heal Equity Through Action Soc Determ Heal [Internet]. 2008;246. Available from: http://www.bvsde.paho.org/bvsacd/cd68/Marmot.pdf\npapers2://publication/uuid/E1779459-4655-4721-8531-CF82E8D47409

[9.] MacPherson EE, Richards E, Namakhoma I, Theobald S. Gender equity and sexual and reproductive health in Eastern and Southern Africa: A critical overview of the literature. Glob Health Action. 2014;7(1):1–9.

[10.] Macpherson E, Richards E, Namakhoma I, Theobald S. Dimensions of gender equity in health in East and Southern Africa In the Regional Network for Equity in Health in Southern Africa (EQUINET). 2012;(May).

[11.] Marmot M, Friel S, Bell R, Houweling TA, Taylor S. Closing the gap in a generation: health equity through action on the social determinants of health. Lancet. 2008;372(9650):1661–9.

[12.] Mills A, Ally M, Goudge J, Gyapong J, Mtei G. Progress towards universal coverage: The health systems of Ghana, South Africa and Tanzania. Health Policy Plan. 2012;27(SUPPL.1):4–12.

[13.] Mo C. The Remote Area Development Programme and the integration of Basarwa into the mainstream of Botswana society. 2002;16(2):123–34.

[14.] Ohenjo N, Willis R, Jackson D, Nettleton C, Good K, Mugarura B. Indigenous Health 3 Health of Indigenous people in Africa. 2006;

[15.] Profile CH. Botswana. 2012;

[16.] Report I. The Global Gender Gap Report 2014 [Internet]. 2014. Available from: http://www3.weforum.org/docs/GGGR14/GGGR_CompleteReport_2014.pdf

[17.] Solar O, Irwin A. A Conceptual Framework for Action on the Social Determinants of Health. Organ Mund la Salud. 2010;79.

[18.] Sheet UISF, Rates GL, Numbers P, Adults FOR. Adult and youth literacy. Unesco Inst Stat [Internet]. 2012;(26):90–3. Available from: http://www.uis.unesco.org/FactSheets/Documents/fs20-literacy-day-2012-en-v3.pdf

[19.] Session T, Forum UNP, Discussion II, Central T, Republic A, No ILOC, et al. Indigenous Peoples in the African region. 2013;(May):1–2.

[20.] Sie A. Cause-specific mortality in Africa and Asia: evidence from INDEPTH health and demographic surveillance system sites. 2014;25362:1–10.

[21.] Whitehead M. The concepts and principles of equity and health. Int J Health Serv. 1992;22(3):429–45.