Culture, Public Health and Community Development

Dr. Madiha El-Safty
Professor of Sociology

Health and Environmental Education Association of Egypt (HEEA)

October 2001
# Table of Contents

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>African Culture: Both diversity and Similarity</td>
<td>3</td>
</tr>
<tr>
<td>Tribalism: the Traditional Backbone</td>
<td>5</td>
</tr>
<tr>
<td>Formal Health Systems vs. Folk Medicine: Why the Bypass</td>
<td>5</td>
</tr>
<tr>
<td>A Health Profile: Health and Survival Indicators</td>
<td>8</td>
</tr>
<tr>
<td>Women and Children: The Vulnerable Group</td>
<td>10</td>
</tr>
<tr>
<td>HIV/AIDS: The Modern Epidemic</td>
<td>14</td>
</tr>
<tr>
<td>Female Genital Mutilation: A Case of Violence</td>
<td>16</td>
</tr>
<tr>
<td>Socioeconomic Factors: Poverty and Relevant Variables</td>
<td>18</td>
</tr>
<tr>
<td>What Can Be Done:</td>
<td>20</td>
</tr>
<tr>
<td>A. Traditional Midwives: Training for Efficiency</td>
<td>20</td>
</tr>
<tr>
<td>B. Targeting Men: A Positive Approach to Health Services Utilization</td>
<td>20</td>
</tr>
<tr>
<td>C. HIV/AIDS: Facing the Problem</td>
<td>21</td>
</tr>
<tr>
<td>D. Access to Safe Water: Private Involvement</td>
<td>23</td>
</tr>
<tr>
<td>E. Female Education: A Key to Development</td>
<td>23</td>
</tr>
<tr>
<td>F. More Egalitarian Distribution and Better Quality: The Role of NGO’s</td>
<td>24</td>
</tr>
<tr>
<td>G. Addressing FGM: Legal Intervention and Awareness Raising</td>
<td>25</td>
</tr>
<tr>
<td>A Final Word</td>
<td>25</td>
</tr>
<tr>
<td>Bibliography</td>
<td>27</td>
</tr>
</tbody>
</table>
African Culture: Both Diversity and Similarity

The health status of African population, like that of most developing countries, reflects a number of problems, and as such can be characterized as significantly low, when measured by the standard health indicators. Life expectancy is short; infant mortality rate is high, so is maternal mortality rate; also the percentage of population without access to health services is high; similarly, is the case with respect to the percentage of population without access to safe water nor sanitation. However, it must be mentioned that there is a variation in the degree of incidence of the above indicators. In addition, regional disparities exist. The rural-urban dichotomy constitutes, for the major part, an obvious polarization, which at times, can be very striking. Nomadic life can likewise represent a still more inferior health status. There is, further, a gender gap that pervades all indicators in almost all cultures.

It is feasible to add in this respect that different societies in the broad African milieu include specific health problems pertinent to specific local conditions in the respective countries for reasons that have their roots in the environmental, cultural, economic, social, historical and even political situation. Nevertheless, if one is to approach the health status of African population, one cannot disregard the common factors that tend to characterize the general condition. Neither can one overlook the many cultural elements that have their impact on this condition. There is somehow a common denominator of cultural similarities that tend to cut across the region, albeit in different degrees. The strong interrelationship between culture on the one hand and the health status of the population on the other creates an inseparable bond that is tightly intertwined and overlapping in such a way that makes it impossible to understand one without understanding the other.

It is interesting to note that with the existence of similar cultural elements in Africa, the fact remains that it is a continent of diversification in belief systems, ethnic groups and languages, and even in its geography. There is an Arab culture in its northern tier which is no different from the other countries in the Arab region. There is black Africa with its specific cultural conditions. Cultural diffusion has somehow resulted in creating similar patterns of living, yet retaining the predominance of each respective local culture. One aspect of this diffusion has been the
missionary activities of the three religions – i.e., Islam, Christianity, and Judaism, whether taking an overt form as movements or acting in a subtle, indirect way. However, the impact of these missionary efforts has not done away with the local cultures. The practice of the introduced religions still remains mixed with native cultural elements in each respective society. Consequently, it becomes difficult to draw the line between what pertains to any one religion and what is based on cultural elements. They are very much closely interwined. Folk religion tends to dominate, for the major part, including a mixture of respective belief systems and native cultural practices, the latter prevailing in most cases.

The history of colonialism has had its impact on most of Africa. Political analysts may differ in their perception of this impact, as either positive or negative. Slavery exploitation, and impoverished conditions tend to support the latter point of view. On the positive side, there is the view that attributes the process of modernization to foreign intervention. The role of missionaries in this respect is also highlighted. In most parts, Ghana as an example, missionaries were instrumental in laying the foundation in education and health care. This paper attempts to address the health status of African societies in line with the general features that tend to characterize the culture, not excluding the specific conditions that create a variation in this respect and that appear in each respective society. The paper approaches health from a cultural perspective, with the objective of highlighting the relationship between both variables, as an existing situation constituting major challenges, followed by possible prospects of the future based on current conditions.

**Tribalism: The Traditional Backbone**

The major feature that stands out characterizing African Society is its tribal structure. A long history of Western colonialism could not eradicate tribalism as the overpowering force of the continent as a whole. For some political analysts, it has actually enhanced it. In the process of transformation towards modernity, some societies have replaced the tribe with the extended family. Contrary to the western concept of the nuclear family, the African family is still the extended structure, where the traditional concept remains, including not only husband, wife, and children, but a whole number of blood relatives. If the requirements of modernization have enhanced the role of the nuclear family in response to economic changes in some societies, mostly in the urban areas, the fact remains that kinship relations and authority patterns still retain the traditional structure, for the most part. The latter case is more obvious among rural and nomadic cultures.

---

1 This paper is based on intensive research by the author in the area of “Health and Culture”, most of which is
The African family is patriarchal. It is male-dominated. Although Africa includes a number of different religions and religious practices, the above situation is the system. Moreover, African society is dominated by traditionalism. The traditional backbone still operates as a triggering force in social relations/practices.

**Formal Health Systems vs. Folk Medicine: Why the bypass?**

The health status of the population can be understood in the light of the above-given socio-cultural milieu. To start with, the traditional dominance highly enhances traditional healing systems. Although there is a variation in the health practices within this systems in the respective societies, it tends to be the major source of health providers. In spite of the spread of formal health systems in the different countries, as well as the expansion of health services, they are bypassed for the traditional providers. Traditional midwives, health barbers, herbalists, magic practitioners, and even priests from the different religions are the most favored providers of health care.

Studies have shown that health facilities, although made available by the different governments, are, for the most part underutilized. The question of accessibility is therefore raised. If the health services are presumed to be available to the population, what intervening variables account for underutilization of these services, and consequently the poor health standards? Specifically, what are the existing conditions among the various communities of intended beneficiaries that might account for bypassing the government health care delivery system? The question is simply: why the bypass? (see ElSafty: “Planning for Primary Health Care”).

To answer this question a set of complex factors in the socio-cultural milieu can be detected. In the first place, the traditional healers are part of the culture in comparison to the formal health system which may represent an impersonal “alien” approach to health care. The former is characterized by social proximity to the clients. As such, a strong affinity exists between patient and healer. Marlene Ried sums up this relationship in her study in Tanzania as follows: “Traditional health practitioners were people oriented with a personal approach; most modern health practitioners were oriented with an impersonal approach”. (“Patient/Healer Interactions in Sukuma Medicine” in African Healing Systems: p.146)

What strengthens the role of folk medicine in these societies is seen in the clients’ perception of causation in illness. In folk medicine, causation is rooted in the interpersonal world of tradition, magic, and the supernatural, while in the so-called “scientific-modern medicine”, it is rooted in the non-personal observable, and manipulative laws of nature. The traditional healer, therefore,
interacts with the client through the channel of a shared belief system which is strongly rooted in their culture, and shapes the way of thinking of both healer and client. It is the same mentality. This is not, however the situation vis-à-vis the “modern-scientific” interpretation of the causal factors in illness. (ElSafty:1983)

It must be added that the traditional patriarchal structure of the family places the elderly in an important role vis-à-vis health care. Their wisdom, expertise, and age are seen as qualifications for healing powers.

The important role of traditional health practitioners can be emphasized through the results of the study of Marlene Reid in Tanzania in 1966. In spite of the introduction of modern health practitioners, basically in the public health realm as health inspectors, nurses, and laboratory technicians, among others, the belief continued that traditional health practitioners could treat most illness better than modern ones. The potential clients’ point of view is that modern health practitioners had no curative treatment for ancestor–caused illnesses, nor sorcery–caused illnesses. (Same Source)

Moreover, for most Africans the text book distinctions between “religion” and “medicine” are not relevant. (J. Karen and A. Thomas in “Modes of Maintaining Health” in African Healing Systems, p.159). This situation is commonly found in rural Egypt, where religion dominates treatment of illness, as seen in the widespread use of amulets, visits to saints’ shrines, and similar practices of folk religions in healing practices.

Another factor relevant to the underutilization of the available health services is cost. With the trend towards privatization, seeking medical care has become a costly burden on the family. Next comes the distance of health services facility to the residential areas of the target beneficiaries. In the rural milieu, in particular, one medical center may service a number of villages/hamlets that are spread around quite a vast area. It follows that seeking the service from this center becomes a tedious task to the clients. Furthermore, in Egypt some clients of health centers have reported their discontent with the quality of health services provided in terms of equipment, attitude of providers, and even work hours. (El Safty).

**A Health Profile: Health and Survival Indicators:**

In line with the above, the following table gives a health profile of some African Countries, as available in the Human Development Report of the year 2000.
The above table reveals the predominance of diseases in African countries. Malnutrition, poor environmental conditions, poor sanitation, and poverty can help explain the situation. Furthermore, repeated droughts in many parts, coupled with the almost continuous civil strife, have been seen to add to the plight of quite a big number of African countries.

To complete the picture, the following table gives the survival indicators for African countries, as given by the UNDP Human Development Report for the year 2000.

The above table reveals the low survival indicators of African countries in comparison to the global arena, especially with respect to the industrial countries. It is interesting to note that most of the African societies lie in the United Nations classification of “Low Human Development” in the Human Development Index (HDI). A contrast to this inferior situation can be seen in the brief presentation of the same indicators in some selected Arab countries.

In Kuwait, Bahrain and Qatar, the percentage of those not expected to survive to age forty (40) are 2.8, 4.6, and 4.8 respectively. Those without access to safe water constitute only 6% of the population in Bahrain, whereas the figures are not given for the other two (2) countries. Health services are available to all in the three countries.

The picture is different when seen in the industrial world. The population of people not expected to survive to age 60+ (and not 40) is 9.2 for Canada, 8.9 for Norway, 9.7 for Switzerland, and 8.8 for Greece as examples.

**Women and Children: The Vulnerable Group**

The male-dominated structure of the African family places women in an inferior status, creating a situation of inequality with respect to rights covering most facets of life. In this drama of injustice, comes the right of women to health care. They come last in the list of seeking medical services, even in the case of pregnancy and childbirth. In addition, they rank at the bottom of the family hierarchy in nutritional concerns. The prevalence of poverty may be an intervening factor in this respect, being responsible for this unequal treatment, when limited financial resources are in action. However, even among the better-off families, women are neglectful of health care. It is not a priority. This situation is a reflection of their discriminatory status.

Reproductive health entails a number of problems for women in Africa. In the first place, the traditional perception of pregnancy and childbirth is that of a natural condition, not requiring special health care. Because it is a normal fact of life, there is much neglect of the women’s health in its duration. In the second place, women tend to be the major clients of the traditional healers. It follows that they are then denied proper care. The natural outcome of this situation is a higher rate of maternal mortality.
It is interesting to mention in this respect that one reason why women bypass the formal health system in favor of folk medicine is seen in their negative attitude towards the former, which, in many cases, results from bad experiences as reported by many of them. The situation occurs especially in relation to childbirth, when it becomes so complicated that the traditional midwife cannot handle. The woman is therefore transferred to a clinic, when, in most cases, it is too late. The resulting death/ complications are consequently associated with the service providers at the clinic, hence the negative attitude towards it. (El Safty)

The low health status of women in Africa is also correlated with their role in the informal labor sector. This sector is highly congested with women. It even includes women in unpaid labor activities- i.e, agriculture. The latter activity is, for the most part, seen as a family obligation, hence unpaid. The number of women in agriculture in Africa is very high. Moreover, the majority of other activities that fall under the informal sector are female jobs. Here, there is no guarantee for their rights, including medical care. They are very often exposed to health hazards of a serious nature, especially in relation to reproductive health. It must be mentioned, however, that the health hazards in the informal labor sector are not limited to the female sex. Laborers, male and female, work under hazardous conditions, with no guarantees for their rights- e.g. mining, transport, road construction. It is even believed that such activities have had a role in spreading diseases among the workers, especially contagious ones.

The low health status of women is coupled with a similarly low health status of children. As an illustration of the vulnerability of these two groups, the following table gives data for infant mortality rate, maternal mortality rate and the percentage of women with anemia in Africa.

As shown in the table, a major health problem in Africa is the high infant mortality rate. Dehydration, respiratory infections, and malnutrition are the most common causes, being closely associated with problems of water, hygiene and sanitation, in addition to the poor health status of mothers.

Although efforts are being made in African countries, not only through the governments, but also through the serious attempts of both national and international nongovernmental organizations (NGO’s), the progress in health indicators is slow. The following table gives a picture of this progress for under-five mortality rate in developing countries.
It is interesting to note that in table (4) none of the African countries appears among those with the fastest progress, except Tunisia. Almost all of countries with the slowest progress are African. Similarly, countries with the lowest under-five mortality rate, do not include any from Africa, while those with the highest under-five mortality rate are almost all African.

The seriousness of the high maternal mortality rate in African countries is aggravated when seen from the perspective of a high value laid on a woman’s fertility. It is actually a major part of her identity. In some countries—such as the case in the rural subculture of the Arab region—fertility is an asset for a woman, whereas her inability to reproduce is very good grounds for her divorce or for her husband to take another wife. Reproductive health, if not properly protected, can create serious health problems in a region where fertility stands out as a major value.

The magnitude of the low health indicators of the African countries appears when comparisons with the industrial countries reveal a drastic difference. The percentage of pregnant women with anemia is absent in these countries. A few other countries include this situation, however. The incidence in the Czech Republic, Argentina, Kuwait, Chile, and Uruguay as an illustration is 23, 26, 40, and 13, and 20 respectively. The same applies to rates of infant and maternal mortality. They are very low, practically insignificant for the developed countries. They appear among some other countries, but with a relatively lower incidence when compared with African countries. Examples can be cited here with reference to the infant mortality rate for the above mentioned countries—i.e., 5, 19, 12, 11, and 16 respectively. The maternal mortality rate for the same countries are 9, 38, 5, 23, and 21 respectively.

The question may be raised here as to not only the availability of the health services, but to the quality provided in the case of the lower health conditions. However, the earlier mentioned cultural factors are major constraints to the utilization of health services, even when provided.

**HIV/AIDS: The Modern Epidemic**

The disastrous spread of HIV/AIDS looms as a devastating threat to African people. Not only does it affect them and acts as a serious health hazard, but more so it has its strongly negative impact on human development in general. The reason here lies in the fact that, for the most part, it attacks people during the productive age. The UNDP Human Development Report of 2000 gives an estimate of the incidence of the epidemic in Africa and its impact on the health status of the population.

More than two in every five adult deaths in rural Uganda are related to HIV/AIDS. HIV-related illness kills twice as many people of all ages as die of malaria in Namibia, the latter ranking as number two killer. In Botswana, 48% of pregnant women are HIV positive in the urban center of Francistown, while in Bait Bridge in Zimbabwe, 60% of the women share the same plight.
It follows that the epidemic threatens life expectancy in those countries that it hits. In Botswana, where 25-30% of people between 15 and 49 are infected with HIV, life expectancy has been reduced to that of the late 1960’s. In some parts of Uganda, life expectancy is shorter by 16 years, while it is expected that by the year 2010, the life span will be cut by 25 years. The same applies to child mortality. It is estimated that in the coming five years, the epidemic will raise the child mortality rate by 150% in Zimbabwe and 100% in Guyana and Kenya. (UNDP Human Development Report: 2000, pp.34-35).

The impact of HIV/AIDS on children is not limited to their mortality. It further raises the number of AIDS orphans, who have lost one or both parents. UNDP reports that in some African villages, there are households headed by children, in this case having been orphaned by the epidemic. (pp. 34-35)

A society with the above health conditions is undoubtedly one that is impoverished both at the family and community levels. Productivity is likewise affected. The underlying factors behind the spread of HIV/AIDS are very much rooted in human behavior. Drug abuse, promiscuity in both homosexual and heterosexual relations are major causes. An intervening variable here is poverty, which may act as a triggering factor to the above causes. In addition, the lack of health education/ awareness does not act as a productive shield in this respect.

It must be mentioned that the Arab sector of Africa may reflect a different situation with respect to the epidemic. Because Arab culture places a strong taboo on sex, the incidence of the disease is veiled with secrecy. The reason here is its association with sexual relations in the minds of people. The misconception is the result of strict / rigid cultural taboos that prohibit discussion of such matters. True enough, the prevalence of the epidemic is much lower in the Arab African countries in comparison to the other countries in the continent. The fact remains that it is still under-registered/ underreported because of the stigma associated with it. Religious values, both Islamic and Christian, are strong in these societies. They tend to act as a shield for many, since promiscuity, in homosexuality and heterosexuality, is strictly prohibited. Cases of the epidemic exist, nevertheless. The whole stigma/ shame creates a veil of secrecy around it.

**Female Genital Mutilation: A Case Of Violence**

Globally, at least 2 million girls a year are at risk of genital mutilation, approximately 6,000 per day. An estimated 85 to 114 million girls and women in the world are genitally mutilated, most of which live in Africa. (Tobia, *Female Genital Mutilation, A Call for Global Action*, 1993)

Underlying the practice of female genital mutilation (FGM), also known as female circumcision, is the traditional culture related to female sexuality. The rationale here is to reduce
this sexuality, in line with prevailing values. A predominant misconception about the Islamic origin of the ritual has led to its widespread practice in the Islamic cultures of Africa. It is, however, a secular ritual. One proof of this situation is that it is practiced by both Moslems and Christians in countries like Egypt. Moreover, it is not practiced in the Arab countries of North Africa, with the exception of Egypt. Neither is it restricted to the Islamic cultures of Sub-Saharan Africa.

FGM covers a range of operations, its extreme case being infibulations. Tobia reports that in Sudan, Somalia, and Djibouti, 80 to 90 percent of all FGM is infibulations. Information is also known about its practice in Mali, Ethiopia, Eritrea, Gambia and Egypt. (p.11) It is not practiced in Southern Africa (p.22). The following table gives its incidence in African countries.

The negative impact of FGM is not limited to the reduction, in fact possible loss, of the sex drive among women. It extends to other physical and psychological complications. On the physical side, hemorrhage, infection, and soreness are common after-effects. Long-term complications may extend to urinary tract infections, irregularity and pain of menstruation, pain during sexual intercourse, and even obstructed childbirth. The psychological trauma associated with FGM cannot be underestimated. Fear, pain, and suffering occur during the operation. The later frustration results from the inability of women to be stimulated sexually.

In most cases, FGM is performed by traditional practitioners, mostly the traditional midwife. In Sierra Leone, circumcisers are highly respected women leaders who are more of priestesses in the culture (Tobia, p.29).

With the rising call to eradicate the practice, the profession has come to include a more “scientific”, less traditional personnel. In some cultures, midwives and other health personnel are trained for the job. Some doctors even provide the services. In Egypt, there was a call to increase the involvement of doctors in performing FGM, the rationale being to guarantee against health risks. The controversy over the issue led to a ministerial decree in the late nineties, prohibiting the practice. African cultures still retain it, nevertheless. Accurate data about its prevalence cannot be available because in most cases, the ritual is veiled with secrecy, let alone the fact that it may be legally banned. The above table is an estimate, which can give indications in this respect.

**Socioeconomic factors: Poverty and Relevant Variables:**

An approach to the cultural factors affecting the health status of the population cannot disregard the socio-economic situation. According to the UNDP Human Development Index (HDI) most African countries fall in the “low human development” category, as has already been mentioned. Some, however, are classified in the medium range. For the latter, Egypt, Tunisia, Algeria,
Namibia, Morocco, and Zimbabwe are examples. The former group includes most other countries. The fact remains that all African countries fall short of the developed world in terms of GDP per capita. The gap is very wide. Income poverty is a common feature in most countries, and acts as a serious threat to economic and social stability, especially in sub-Saharan Africa. UNDP estimates the people of this region as the poorest in the world. Poverty has a strong correlation to a low health status. Next comes illiteracy. The illiteracy rate is high in Africa. To cite some examples, it is 44.3 in Sudan, 44.8 in Togo, 58.8 in Mauritania, 37.7 in Djibouti, 46.3 in Egypt, 33.5 in Namibia, and 65.4 in Gambia. (UNDP Human Development Report: 2000). The rate is, of course, higher, among females, because of the prevailing values and norms that create a gender gap. Moreover, cultural constraints combined with poverty are variables of great significance in denying female their right to education. When a choice has to be made between a male and a female’s education in a family of limited financial means, the outcome is always in favor of the boy, he being seen as the future breadwinner for the family. (El Safty)

A higher illiteracy rate among women is a serious threat to the health condition of the whole family, among other family concerns. Studies have shown that an illiterate mother not only raises the rate of maternal mortality, but also that of infant and child mortality as well. Furthermore, it is responsible for malnutrition, diseases, and other health hazards among family members. (El Safty)

African society likewise includes other internal conditions that contribute to health problems. Urbanization and labor migration have both created a socio-economic milieu increasing the incidence of disease, since the migrants, for the most part, live under impoverished conditions, and may lead a life of obvious marginalization.

Unemployment, child labor, single parent families, and different forms of broken homes are serious problems, strongly correlated to poor conditions. In some societies, teenage pregnancy, stands out as a threat to social stability. All above factors combine to constitute fertile ground for all sorts of health hazards.

**What Can be Done:**

**A. Traditional Midwives: Training for Efficiency:**

It is no secret that the African health status is low. In addition, in line with the above, traditionalism still prevails. In spite of the modernization process, traditional healing systems have managed to survive, their tenacity and persistence have resisted total eradication. Moreover, the health system operates in a complex of socioeconomic factors. An attempt at improving the health conditions of African societies has, therefore, to take into consideration all
elements of the respective cultures, in order to help bring about successful results. One good formula that can help ensure acceptability of the “modern” health system is to make constructive use of the elements of the indigenous health care system by incorporating them in the former.

One positive step in this respect has been taken by the Egyptian government, when it under-took training programs of the traditional birth attendants. These play an important role in society, especially in rural areas – in fact, their role supersedes that of the health practitioners of the formal system, for reasons mentioned earlier. A realistic approach of this role led the Ministry of Health to design training programs for the traditional birth attendants, with the objective of giving them the right, “more scientific” expertise in their practice, also avoiding common complications that usually arise from frequent forms of their malpractice.

B. Targeting Men: A Positive Approach to Health Services Utilization:

One other recommended approach that can help in raising the health status of African population is targeting men to increase the use of health services. In a male- dominated society, men have the upper hand. They control household resources; they are the major decision-makers in all family matters, health included. Reaching them with the proper information about health concerns, the use of health services, and negative consequences/ complications of health problems is a positive step in seeking health care for family members, not excluding women. Findings of a study in rural Benin, funded by the U.S. Agency for International Development led to the emphasis on the role of men in order to increase the use of modern health care services: (African Population and Health Research Center: 2000). By approaching men in the community, the utilization of the services, formerly having been low, was raised. Similar suggestions are being made by social scientists in other countries, Egypt as an example, in the pursuit of achieving more acceptability of the formal system (ELSafty)

C. HIV/AIDS: Facing the Problem:

The widespread epidemic of HIV/AIDS in many African countries necessitates an intensive/extensive campaign against it. The realization that the disease has socio-cultural implications needs to be considered a priority. A successful experience in Uganda, one of the countries infected by the epidemic, needs to be highlighted. Authorities in this country recognized that the problem, to be tackled, has to take a multisectoral approach. They addressed the socioeconomic issues underlying the spread of the disease, such as urbanization, migration, poverty, and gender disparity. Moreover, by empowering communities, Uganda aimed at reducing the vulnerability of the target population. Discrimination against infected workers is avoided. Surveys of the situation have proved that this approach has yielded good results. (UNDP Human Development Report: 1997)
South Africa has likewise adopted a positive approach to the HIV/AIDS situation. In response to the United Nations call to respect human rights as crucial in dealing with HIV/AIDS, it has endorsed the resolution and recommended that the parliament adopt a charter on HIV/AIDS (UNDP Human Development Report: 1997)

The UN approach basically centers around governments’ responsibility for multisectoral approach and accountability. In this context, there arises the need to establish a solid legal support system to avoid discrimination, guarantee protection for public health, improve the status of marginalized/vulnerable groups, such as women and children. Furthermore, UN efforts highly recommend support from civil society in the form of NGO’s and the community. (Ibid)

It is feasible to refer to a successful experiment conducted by Care in collaboration with the Planned Parenthood Association and the Makeni Educational Center in Zambia, targeting adolescents, who are at “high-risk” of unwanted pregnancy, sexually transmitted infections (Stis), and HIV infection due to early sexual initiation, low use of contraceptives and condoms, and other high-risk sexual behaviors (from “Frontiers in Reproductive Health”. Peer Education can promote safer sex behavior:1999). Adolescents were trained as peer educators, then they conducted counseling sessions. They were able to reach between 4 to 15 percent of the adolescents in their area. Findings of the project reveal that peer education and half of their targeted audience increased abstinence and monogamy. They also talked about greater knowledge of ways to prevent HIV/AID. Such and similar experiments can be duplicated in countries where incidence of the infection is high.

The above approach by the UN, and as adopted in some African countries raises questions as to its validity in the northern tier of African countries of the Arab World. The open dialogue about the disease is still in its very embryonic stage. The associated taboo, stigma, as mentioned earlier, are a case in point. The cultural constraints act as a barrier for its prevention. The problem is that lack of access to information about the risks of the epidemic, ways of infection, and its complications may contribute to its spread among the population. Moreover, education about the potential targeted groups who are in a vulnerable situation can help in controlling the spread of the epidemic.

It follows, therefore, that a realistic attitude be adopted in those countries where information about HIV/AIDS is still veiled with secrecy. The shame, seclusion, and even denial associated with the infection must stop. Respect for human rights necessitates that people infected with the disease are not subjected to discrimination.

In Egypt, the realistic approach, although still in its early stage, has led to a hot line for HIV/AIDS, emphasizing the guarantee of secrecy and anonymity. Public knowledge about the
line is, however, not widely spread. Slow, sporadic steps are being taken by both government and NGO’s to disseminate information about the disease.

D. Access to Safe Water: Private Involvement:
Water-borne diseases are a major source of health problems in most African countries, especially in the rural milieu. Attempts are being made by the different governments to extend safe water to all its population, especially in the remote areas. In Egypt, the water authority is increasing its efforts in this respect. The problem remains with the small hamlets, where access to safe water is lacking.

A successful attempt has been made in Guinea through the provision of public- private alliance. In the 1980’s less than 15% of the population in Guinea had access to safe water. Currently, the percentage has increased to almost 50%. The progress came as a result of restructuring the water sector in Guinea and creating a joint venture company to operate and maintain the facilities. Consequently, technical efficiency and coverage have improved. (World Bank information in UNDP Human Development Report: 1998)

This lesson can be extended to other African countries where safe water is not available to all the population, especially as the trend is towards more involvement of the private sector in vital projects. The private sector, as national or international, might be able to help implement such vital projects, if government funds are deficient.

E. Female Education: A Key to Development:
Reproductive health raises many problems for women in Africa, since there is an obvious neglect in this respect, with all the resulting complications / deaths. Efforts to extend maternal health care are systematic in the respective countries. If they do not succeed in achieving full coverage of the target population, the need arises to tackle the problem through an indirect approach. Empowering women, guaranteeing their rights, and raising their status are efficient ways that can help improve their health conditions. Education is one significant relevant variable that is the triggering factor for other indicators of empowerment. The high illiteracy rate is a major constraint against female empowerment, among other aspects of developmental concerns. It becomes necessary, therefore, that education in general, and for females in particular, be a target for policy concerns if any pursuits for development aim to achieve their goals. Female education, although highly important in gender concerns, is even more important on a broader national scale, when programs for development are made. Female education is a necessary variable relevant to concerns dealing with children’s welfare, and that of the whole community.
F. More Egalitarian Distribution and Better Quality: The Role of NGO’s

Since underutilization of health services has been partly attributed to distance and poor quality, the need arises to upgrade the services when made available. More so, it is a necessity to increase the numbers of available centers, especially in the rural areas; in order to make them more accessible to a wider range of target beneficiaries. In addition, more care must be given to the quality of the service. The pattern for health care centers is one where rural areas are short in their availability, poorer in quality, whereas the concentration is in the urban areas and their quality is higher, an inequality which tends to enhance the disparity between city and countryside in all aspects of development, health included. In most cases, African governments lack the budget for this expansion. The shares allocated to health care are usually low, when compared to these of the developed countries. Here is where the NGO’s can interfere to fill the gap. There is a much needed role for NGO’s in this respect, considering their high numbers in most countries of Africa. In many parts of this region, NGO’s provide health services, especially, for women and children. Tunisia, Egypt, and Nigeria are examples. The need is to increase this role all over the continent.

Not only can NGO’s provide health care, but they can more so design awareness campaigns whereby they can reach the community members for health education. NGO’s have more credibility than health providers in the formal system.

G. Addressing FGM: Legal Intervention and Awareness – Raising:

The serious problem of the prevalence of FGM necessitates a closer look at the cultural background behind the practice. The attitude towards females, their inferior status, gender disparities, as well as their sexuality are all variables to be addressed in the fight against FGM. The Convention against all Forms of Discrimination Against Women (CEDAW) directly tackles the problem as one of violence against women, in addition for its being a health hazard with serious implications/ complications. Most African countries have endorsed the convention. It follows therefore that governments strictly adhere to its items, in trying to implement their content. The situation may necessitate legal intervention, when laws are codified to ban the practice and ensure sanctions in the case of violation. More so, the legislative action need be strictly enforced.

The idea here is that the legal aspect is to act as a support for the indirect approach to the cultural variables of the problem as above mentioned. The attempt to modify cultural belief systems is to be backed up by a strong legislative base, if any success is to be achieved. Parallel to these efforts comes the importance of awareness campaigns that clarify the negative implications/ repercussions associated with FGM. Media, NGO’s, the school system, and health
providers can combine for an educational program in this respect. Especially in the Islamic segment of Africa is this task significant, with the objective of shedding light on the religious point of view, which is no way associated with FGM. Addressing the prevailing misconception in a rational way is a recommended approach to reduce its wide practice. The media, NGO’s as well as the school system can participate in this task.

**A Final Word:**

This paper has attempted to present the health situation in African societies, making use of available data/literature in this respect. Africa is a continent of diversity, in language, geology, ethnic groups, and belief systems. However, this diversity does not exclude the existence of similarities in cultural patterns. Inflicted by a multitude of problems in the form of poverty, drought, civil strife, epidemics, among others, African societies face a number of challenges of serious implications. The health status stands out as one significant challenge, its different indicators ranking low by all standards. A general profile, as above given, undoubtedly emphasizes the necessity of serious action to upgrade the health situation. The paper has addressed some suggestions in this respect, stemming from the existing conditions. The implementation is no easy task. The realization of the problem/challenges can act as a first step to help face them.

A final emphasis has to be made here with respect to the call to enhance the role of the NGO’s in the different African societies, each in relevance to its respective needs. The increasing demand for NGO participation on a global scale is doubly needed here, when and where governments are, for the most part, unable to perform their obligations to full capacity because of deficient budgets, or otherwise. Providing health care stands out as a crucial role for NGO’s, considering their already perceived success in this area in many countries. More widespread participation can help achieve the objective of upgrading the health status in Africa.
Bibliography

Feierman, Steven and Janzer, John, eds. The Social Basis of Health and Healing in Africa. University of California Press, USA:1992


____ “Arab Culture, Values, Beliefs, and Practices in Relations to AIDS” in the Workshop on HIV/AIDS. UNESCO, UNAIDS, AICCD, CIACD, INP. Cairo: May 2000


