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Why Multi-Sectoral Approaches Are Rarely Applied in Community Health Interventions in Some Countries in Sub-Saharan Africa?

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Abstract

The objective of this work is to analyze the reasons why community health interventions in Africa do not consider multisectoral approaches. To achieve it, we perform a mini-review of health development policies and plans available online in seven countries from four regions of Sub-Saharan Africa. Thus, two main reasons have been highlighted. First, national strategic plans and policies for health development, in their formulation, neither sufficiently emphasize multisectoral approaches, nor sufficiently make these approaches operational in strategies and activities. Second, the mindset of health professionals due to their initial training orientation based on the biomedical approach, stands that disease is only a result of a physiological imbalance in the body; therefore, to restore health, such an imbalance only needs sophisticated procedures and interventions to be overcome. Such an orientation completely ignores the social, cultural and economic context in which the individual lives, which has an irretrievable influence on the health imbalance. However, health, influenced by the conditions in which people are conceived, born, grow, live, work and aged, cannot be effectively improved in a sustainable way without taking into account all these conditions. Whence the importance of approaches based on every sector of human activity that influences the living conditions.

Keywords

Multisectoral Approach, Community Health Interventions, Health Professional Training, Health Policies and Plans

1. Introduction

Initiated in 1978 during the thirtieth World Health Assembly at Alma-Ata as an action to promote health for all, community health care was introduced in order to improve communities' health, especially, the more needed [1]. It is based on primary health care (PHC) and all countries had to comply with the principles of community-based health actions. Among these principles are communities' participation and empowerment, the multisectoral approach, and actions aimed to address the determinants of health. However, it is worth highlighting that currently, health systems in Africa tend not to comply with these principles, thereby compromising the outcomes of the health programs and interventions. According to WHO Europe [1], health is understood as being an outcome of all the factors that affect human beings. Sustainable development requires paying attention to the determinants that shape health [1]. A health system can be defined as a set of actors, means and processes implemented to promote, maintain or reestablish health. In other words, the health system definition integrated into the Tallinn charter ([2]: p. 1) stated that: "*Within the political and institutional framework of each country, a health system is the ensemble of all public and private organizations, institutions and resources mandated to improve or restore health. Health systems encompass both personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health.*" A key aspect of this system is public health whose unifying principle is its essentially "public" nature and the fact that it is mainly focused on the health of the whole population. Multisectoral coordination refers to deliberate collaboration among various stakeholder groups (e.g., government, civil society, and private sector) and sectors (e.g., health, environment, economy) to jointly achieve a policy outcome [3]. A multisectoral approach is based on the recognition of the importance of the social health determinants in attaining the overall health goals. However, a health system encompasses activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health because these determinants are the conditions in which people are conceived, born, grow, live and work, as well as mechanisms in place to deal with diseases. No action can be effective without influencing these conditions. Nevertheless, in the last century, the medical profession has mainly focused on developing specific interventions to counteract disease in individuals instead of addressing the needs of the population as a whole [1]. The medical model underpinning disease-focused interventions views the body as a machine and considers health the polar opposite of illness. Why?

The objective is to analyze reasons why multisectoral approaches are not being used in community health interventions in the African regions.

2. Methodology

A mini-review of the National Development Policies and Plans documents of

some countries in Sub-Saharan Africa was conducted. The content analysis of these documents was done in order to identify the Social Determinants of Health concept appropriation, priority issues related to multisectoral approaches, strategies related to the approaches and the targeted determinants of health. Google and Google Scholar search engines were used to identify policy documents available on the website. Two countries by region were chosen according to the availability of policies documents on the web, except one country for Austral region of Africa because this region has only five countries. **Table 1** shows the distribution of the chosen countries according to the region.

3. Results

Table 2 presents the content analysis of the health policy documents for the selected countries.

Zambia's document [4] was one which used the most Determinants of health (five times) and Social determinants of health (six times) concepts. Kenya's [5] used a lot Social Determinants of Health while Chadian's document [6] has focused on Determinants of Health (four times).

The multisectoral approach was implicit in the priority issues in the documents of Benin, Ghana, the DRC, Tanzania and Zambia [4] [7] [8] [9] [10], with explicit attention in those of Kenya and Chad [5] [6].

Healthy strategies had been formulated of the documents of Kenya and Zambia (See **Table 2** for more details), but the document of Chad envisaged revitalizing the multisectoral approach in the implementation of health activities at all levels of the health system.

The targeted determinants were not clear in the Benin and Chad documents among all types of determinants including social ones; few determinants were affected in the DRC and Kenya documents, while all SDHs were targeted in Ghana, Tanzania and Zambia documents.

4. Discussion

After highlighting the limits of the study, we dealt with some reasons that could explain this situation, namely the adequation level of national health development policies and plans, the conditions for implementing community health interventions at the operational level by using the example of Parakou-N'dali

Table 1. Repartition of selected countries through Sub-Sahara African regions.

	Number of countries	Number of selected countries	Countries selected
West Africa	16	2	Benin, Ghana
East Africa	19	2	Kenya, Tanzania
Central Africa	9	2	RDC, Tchad
Austral Africa	5	1	Zambia

Table 2. Comparison of the content of health policy documents from 7 countries in 4 regions of Sub-Sahara Africa.

Region	Country	Covered period	Occurrence of SDH concept uses	Priority issues related to multisectoral approach	Strategies related to the approach	Targeted determinants of health
West Africa	Benin	National health development plan (PNDS) 2009-2018	- Determinants of Health: None - SDH: 0	Insufficient intra- and intersectoral collaboration	- Advocacy for in-depth intra sectoral collaboration, - Development of a model of partnership agreement, - Periodic evaluation meetings, - Strengthening the MoH in health communication	Not clear: - education sector: School Health - employment and labour sector: occupational health
	Ghana	National Health Policy 2020	- Determinants of Health: One - SDH: 0	No problems identified, but an explicit recognition of: - WHO definition of Health, - Ecological model of health	- Not the strategies, - But the 5 objectives are oriented towards SDHs	- Physical environment, - Socioeconomic status, - Healthy lifestyles, - Health system, - Population dynamics
Central Africa	Tchad	PNDS 2017-2021	- Determinants of Health: 6 - SDH: 0	- Multisectoral dynamics in the health sector are weak, - Health in all policies not promoted	- Revitalization of multisectoral approach in implementing health activities at all levels of the health system	- No
	RDC	PNDS 2019-2022	- Determinants of Health: 1 - SDH: 0	Intra- and intersectoral collaboration not optimal to: - Improve population health; - Support supply and demand of quality health care services	- Establishment and/or strengthening of existing intersectoral consultation frameworks	- Action plans of joint implementation between MoH other sectors (food security and the fight against malnutrition, water, hygiene and sanitation)

Continued

East Africa	Kenya	Health Policy 2014-2030	– Determinants of Health: 0 – SDH: 4	No priority problems statement, but explicit recognition of: – multisectoral approach based on SDHs in achieving the overall health goals	– Minimize exposure to health risk factors, – Strengthen collaboration with private and other sectors that have an impact on health	– Lifestyles; – Physical or economic environments
	Tanzania	The National Health Policy 2017-2027	– Determinants of Health: None – SDH: One	The Government will enhance institutional linkages between health promotions with other stakeholders The health and social welfare sector will: – Collaborate with other sectors; – And advocate for the inclusion of health promoting and health protecting measures in other sectors' policies and strategies	– Not clear, – Strategies were formulated by sector, denied the multi or trans-sectoral approach. – A lot of Determinants were targeted in a fragmented way.	– Health services organisation – Water; Sanitation, Hygiene and Food Safety; – Occupational Health and Safety; – Environmental health; – General environment (acts et legislations
Southern Africa	Zambia	PNDS 2017-2021	– Determinants of Health: 5 – SDH: 6	– No identified problems, but use of a model that incorporates underlying socio-economic factors impacting health behaviors, – SDH model postulates that poor social and economic factors (at individual, societal, and physical environment levels) impact health throughout an individual's life	– Strengthen multi-sectoral collaboration, community linkages, and coordination in line with the decentralization policy to address SDHs and within the Health in All Policies framework	– Not explicit, – Great priority on primary community health care, – All SDHs.

health district in Benin and the current orientation of training of health professionals. Then we ended with a discussion on a health system organization by taking into account actions on health determinants for effective results on beha-

vior change.

The study is not a systematic literature review on health policies and plans chosen with keys word on lot of data base. So, we have no generalization purposes. It is a mini review of health plans and policies documents from seven selected countries in the four Sub-Sahara Africa regions. Our objective is to give some insight of the appropriation of social health determinants and multisectoral approach in the process of elaboration and implementation of these documents available online in the African regions which results do not lack interest.

Inadequate health policies and health development plans

Therefore, for actions to succeed, community-based programs need to be implemented in accordance with some principles of primary healthcare, namely equity in the distribution of health services and interventions, participatory approach to deliver interventions, multi-and intersectoral approach on lifestyles, environments and health care to achieve health goals, reorientation of health services. A comparative analysis of health policy documents for 7 countries [4]-[10] across 4 Sub-Sahara African regions (**Table 2**) permits to notice that most of these documents recognize a problem of not optimal multisectoral approach utilization. A part of these countries [6] [7] [9] have a vague strategic formulation for the approach without clear actions toward health determinants while the other ones [4] [5] [8] have the sound strategies oriented toward health determinants even if generally the application of their strategies need to be improved. In Ghana for instance, Nyaaba and his colleagues [11] found that between interwoven factors key challenges thwarting the effective implementation of the national NCD policy, there is a poor coordination and intersectoral engagements. In the same vein, Juma *et al.* [12], in a study aimed to generate evidence on the extent of multisectoral action application in NCD prevention policy development in five Sub-Saharan African countries, found that although most countries had at least nominal engagement of sectors outside the health sector during the development of NCD related policies, most of the countries indicated that this engagement was limited to providing information or viewpoints and was not a true collaborative effort.

In other words, in Africa, health programs do not take these principles into account. In the study on the strategic evaluation of community health activities in the Parakou-N'Dali health district in Benin [13], almost all actors (community health workers and supervisors) recognize that, despite the most flexible evaluation criteria of the relevance of activities to the components of primary health care in Benin, there is a high degree of implemented activities that were ill-founded because without a direct and clear link to these components (from 11.4 for component 6 prevention of local endemic diseases to 88.0% for component 7 proper treatment of diseases and accidents), most of them (69.0%) believe that they do not have an adequate profile for employment and for 40.5% of them, compliance with the principles of community health actions was low because, among other reasons, they did not have the sufficient level of education or the appropriate training to understand and apply these principles.

Another reason could be the health professional training orientation because of their academic training focused on the biomedical model of health. According to this model, increasingly sophisticated medical procedures and interventions are used to treat disease and to make and keep individuals healthy [1]. This partial and vertical approach of health can lead to the failure of almost health oriented programs [14]. Among factors that contribute to this failure, we can point out, for instance, multiple and unconnected sectors, lack of shared responsibility for outcomes, lack of cooperation and collaboration in health systems care, probably because health sectors managers in coordination role are not prepared for that. Houéto and Sambiéni [15] pointed out that one of the main reasons of Sub-Sahara African countries failure to reach Millenium Development Goals (MDGs) was the chronic absence of health professionals in French-speaking countries trained in health promotion with essential competences for implementing real, sound and contextualized public health policies oriented toward social determinants of health.

Why a multisectoral approach?

Since health can be influenced by social and environmental determinants that interact across the life-course with genetics and behaviors, health promotion takes a broad view of these determinants and builds on broad definitions of health and well-being [16]. Another way of representing the effects of the range of health factors in society is the health gradient. The health gradient depicts the effects of a range of factors (poverty, environmental health hazards, unemployment, poor housing, inadequate food and nutrition, lack of education) that can powerfully affect an individual's ability to achieve health, especially acting in combination. The steepness of this gradient is different in every sectors of society. The agencies responsible for these factors must act in a focused way to improve the health of the groups in society that have an increased load [1]. That is why a 'Health in all Policies' approach should be applied in attaining the objectives of this policy. The whole philosophy of "health for all" is based on the fact that health can only be improved and maintained when prerequisites such as peace, adequate nutrition, income, education, housing, a rewarding occupation and fulfilling social relationships are effective. In the countries and regions where "health for all" moved from policy formulation to actions, the right politician was in place to initiate the process, and without such a political commitment, the policy process cannot move forward. In some cases, politicians in power were enthusiastically and personally committed to "health for all" approach, and this had a widespread impact [17].

Chewe and Hangoma [18], estimating the effect of a rich set of socio-economic, environmental, health system and lifestyle factors on life expectancy and infant mortality have used a panel of 30 Sub-Saharan African countries with a dynamic Generalized Method of Moments (GMM) estimator and have focused on the period between 1995-2014. They found that increases in health expenditure, educational attainment, and health care access quality are associated with increases in life expectancy and reductions in infant mortality; in the same vein, higher

HIV prevalence rates are associated with reductions in life expectancy whereas urbanization, per capita income growth and access to clean water are positively associated with life expectancy. These factors they found are not others than the social determinants of health: health expenditure (general environment), educational attainment (individual environment), per capita income growth (general economic environment), and access to clean water and urbanization (physical environment), health care access (health system organization). That is why these authors concluded that increases in life expectancy and reductions in infant mortality can be accelerated by paying particular attention to interventions linked to these determinants.

Integrated community-based intervention programs are comprehensive packages in which different kinds of feasible activities are combined to produce a synergistic effect. These components were: 1) Health education and media campaigns have played a prominent role in many community-based programs; 2) Health service interventions with the systematic involvement of primary health care centers can, in the long run, be one of the most effective intervention tools where the intervention deals with biological risk factors such as hypertension or elevated blood cholesterol; 3) Involvement and collaboration with various community sectors (NGO, lay opinions leaders, industry and business) and collaboration with national health authorities has been important for sustaining the activity and for taking care of national implications [19]. For Nissinen [19], theory and experience show that community-based Non Communicable Diseases programs should be planned, run and evaluated according to clear principles and rules, collaborate with all sectors of the community, and maintain close contact with the national authorities. In the North Karelia project [20], the principles leading to success were the emphasis on primary prevention due to the chronic nature of cardiovascular diseases, the risk factors chosen on the basis of the best available knowledge, a community approach to change lifestyles acting through all sectors involved. The emphasis on the multisectoral approach is explicit. In addition, there are cases of common risk factors with several conditions. According to Rice and his colleagues [21], there was a strong and strongest relationship between malnutrition on the one hand, and an increased risk of death from diarrhea and acute respiratory infection, a potentially increased risk of death from malaria on the other, and a less strong association between nutritional status and death from these infectious diseases. It is clear that a multisectoral approach fight for the improvement of nutritional status by acting on production (agriculture), distribution (trade, transport, logistics) and the availability of food (legislative measures to regulate access) which would allow the best quality/cost ratio of resolutions of these diseases than vertical interventions siloed which fight against each of them.

Investing in a multidisciplinary public health workforce is a prerequisite for a modern effective public health function. A sufficient and competent public health workforce constitutes the most important resource in delivering public health services [16]. Indeed, the essential competencies for effectiveness in health

promotion include the transdisciplinary and multisectoral approach, the expertise of action on social determinants of health and the reduction of health inequalities as well as the "health in all policies" approach, skills in the field of Health Impact Assessment, an important tool for the health sector in collaboration with other non-health sectors contributing to health [15].

Much firm evidence exists for prevention that is why it is time to act from demonstration to national policy. Also, community-based heart health interventions in the USA concluded that "*the community approach in Cardiovascular disease prevention has a high degree of generalizability, cost-effectiveness due to the use of mass communication methods, ability to diffuse information successfully through use of community networks, and potential for influencing environmental, regulatory and institutional policies that shape health*" [19]. Iwelunmor *et al.* [22] stressed on community ownership and mobilization as crucial facilitators for intervention sustainability, both early on and after intervention implementation.

5. Conclusion

There are problems not only in the understanding of concepts but also in the application of these approaches and principles (multisectoral approaches, health in all policies and actions oriented towards health determinants) for a genuine and effective fight to achieve health goals. Therefore, the attention of all must, first, be directed to the training and strengthening of competent human resources for an effective application of these programmatic approaches. It is the formation of a sufficient pool of competent and convinced people on these approaches of health promotion that could gradually change things in order to improve the health status of populations.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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