

RETHINKING HEALTH PROMOTION AND DISEASE PREVENTION IN AFRICA: THE QUEST FOR AN INTEGRATED MODEL

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INTRODUCTION

It is a well established fact that Sub-Saharan Africa is a region of the world weighed down with the heaviest burden of disease. Although this region comprises only a little over 10 per cent of the world's population, over two thirds (67%) of all people living with HIV globally lived in Sub-Saharan Africa in 2008 - that is an estimated 22.4 million people.¹ But the HIV/AIDS pandemic is only part of the story of the heavy burden of disease although, without a doubt, it is the deadliest. Malaria, tuberculosis, respiratory tract infections, diarrheal diseases and a myriad of other communicable as well as non-communicable diseases comprise major causes of morbidity and mortality in the region.

Until recently, much of the discourse on disease in Sub-Saharan Africa had focused primarily on communicable diseases. Today that is no longer the case. There is a growing threat from non-communicable (chronic) diseases such as heart disease, diabetes, stroke, obesity, cancer, and high blood pressure - health conditions that have, until now, been dubbed diseases of "affluence" or "diseases of progress", an apparent reference to the rich industrialized societies.

However, Africa has achieved neither widespread affluence nor enough progress to be counted in the company of the rich industrialized countries. The Global Burden of Disease Report² asserts that more than 50% of adult disease burden in low and middle income countries is caused by non-communicable diseases. Africa suffers from 25% of the world's burden of diseases. The rising health threat from non-communicable diseases on top of the communicable diseases that have for the most part proved to be pervasive and intractable is creating a "double burden of disease."³

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This in a way represents a truncation of the conventional epidemiological transition of disease. The epidemiological transition of disease represents a shift from one set of diseases (such as acute infectious diseases) to a different set of diseases (such as chronic and degenerative conditions) as the primary causes of morbidity and mortality within a population. Most industrialized countries, such as the United States, have, by and large, achieved the epidemiological transition as the result of their economic, technological, and medical development. In much of the developing world, the “premature” epidemiological transition is occurring as the result of the rapid globalization process. The epidemiological transition in the developing world appears to have been replaced by another transition known as the “nutritional transition” which is characterized by the increase in the consumption of foods high in fats (trans-fatty acids), sweeteners and processed foods.⁴ This, in turn, has led to a rapid rise in obesity, heart disease, diabetes, and cancer. Now people in developing countries are dying from diet-related chronic diseases as well as from the already widely prevalent acute and infectious diseases, again, creating the double burden or double jeopardy of disease.

The problem of bringing under control the burden of disease and improving health continues to be one of the major challenges in Africa. Not surprisingly, the dominant reigning disease control paradigms are the bio-medical and life-style change (behavior modification) models. However, these models have had very little success, to date, in the promotion of public health and prevention of disease as will be clear in the section on theories of disease. Why have these models been met with only limited success? Given the expense and relative ineffectiveness of these intervention strategies, what is to be done? Is there a better alternative disease prevention model that addresses the challenges of the double burden of disease facing Sub-Saharan African countries today?

THE PURPOSE OF THE STUDY

The purpose of this study is twofold: First, it attempts to provide a critical assessment of three existing models of health promotion and disease prevention, namely, the bio-medical model, life-style change model, and the political economy model. This is done by looking at their theoretical/ideological underpinnings in order to fully understand their inherent strengths and weaknesses.

Second, it proposes an integrated model of disease prevention and health promotion - a holistic approach that takes into account not only the medical, psychological and behavioral aspects of health and disease but also the broader social context in which all behaviors are embedded. The proposed model is based on the view that disease is as much social as it is medical,

psychological and behavioral. It will address not only the proximate behavior risk factors but also the fundamental causes of disease in an integrated manner. Hence a combined medical, behavioral and social intervention strategies coalescing into broad-based societal interventions that could have the potential to produce substantial health benefits are proposed.

Would it be possible to promote integrated health intervention measures in Africa under the current reigning neo-liberal economic policies? The experience of the east African nation of Rwanda, which is being hailed as the "poster child" for its remarkable success in implementing a comprehensive health care system under global public health framework in the last 15 years is presented to serve as an inspiration for other African countries.

THEORIES OF DISEASE

If the history of Western countries is any guide, the decline in morbidity and mortality and the subsequent improvement in health were by and large the result of rising standard of living of the population, improved nutrition, improved personal hygiene and environmental sanitation, the provision of safe water and better housing accompanied by a distributive social justice philosophy and practical politics.⁵ This shows the limited role of therapeutic measures in the decline of morbidity and mortality. The bulk of the disease burden in Africa is associated with widespread poverty, poor personal and environmental sanitation, lack of safe drinking water, poor housing, lack of access to primary health care services, among many other social, cultural, and economic problems.

Yet, most of the prescriptions for addressing disease burden are either medical intervention or behavior/lifestyle change or both. To be sure, medical and life-style change approaches are necessary but not sufficient in and of themselves in any meaningful campaign against diseases whose etiology is largely influenced by larger social forces. The following section is devoted to a critical evaluation of the lifestyle, bio- medical and political economy approaches.

Lifestyle Change (Behavioral Modification) Model

A life style change approach focuses primarily on individual behavior change to prevent disease. One of the premises underlying the lifestyle change approach is the freedom to make choices. Not only are individuals free to make choices but also responsible for their actions and behaviors.

However, this approach is based on the simplistic premise that individual behavior is free from external constraints. According to this theory,

disease is caused by personal unhealthy lifestyles such as stress, unprotected sex, promiscuous sex, poor personal hygiene, obesity, alcohol, drugs, improper nutrition, ignorance, lack of education, and more. Disease is conceived as an individual's fault and as such its prevention requires personal behavior change.

As Brandt⁶ put it, "the life style change approach rests on a rather simplistic view that the problem can be solved if individuals behave more responsibly, a view that rests on the explicit assumption that an individual's behavior is free from external forces-that a lifestyle is strictly voluntary. Behavior is subject to complex forces, internal psychologies and external pressures, all of which are not subject to immediate modification. Behavior is subject to a number of powerful influences, social, economic, conscious and unconscious, many more powerful than even the fear of disease and death."

Individuals, of course, should be held partly accountable for these behaviors, but the questions of to what extent and whether they should be are not as simple.⁷ The behavioral modification theory maintains that if people become sick, it is their problem rather than society's - a phenomenon known as 'blaming the victim'

Indeed, individuals may be free to makes choices, but those choices are often constrained by structural factors such as poverty, gender inequality, lack of access to health care services, and failing economies and many more. Social structural contexts of choice enable some kinds of choice but constrain others.

Lifestyle change approaches depoliticize the issues of health and disease. Social problems are reduced to personal problems thereby deflecting health responsibility away from governments and the so called "illness manufacturers" such as the tobacco industry, food and beverage industries and chemical industries.

Furthermore, advocacy of changes in lifestyle cost governments little and deflect issues of health policy into issues of personal choice.⁸ In the case of HIV/AIDS in Africa, for example, lifestyle theories focus attention mainly on those who make risky choices (e.g. commercial sex workers, long distance truck drivers, labor migrants etc.) while obscuring the factors that generate or produce such risks (poverty, unemployment, tattered economies).⁹ Not surprisingly, current public policies tend to be fragmentary and focused on the individual.

Individuals' ability to change their behavior is often constrained by circumstances over which they have little or no control. Problems such as poverty, lack of education, unemployment, gender inequality, and failing economies in Africa, for instance, lead to behaviors that expose individuals to the risk of HIV/ AIDS and other sexually transmitted diseases. For years, AIDS researchers were intrigued by the relatively lower HIV infection rates in most West African countries, such as Senegal, Mali, Ghana, Benin than many of the

Eastern and Southern African countries, such as Botswana, South Africa, Lesotho, and Swaziland, where the practice of circumcision has been rare. At first, many attributed the relatively lower infection rates in West Africa to the predominance of the Muslim religion of the region which controls women's sexual freedom. However, it turns out that it was male circumcision that proved to be highly protective against HIV. AIDS researchers believe that circumcision lowers a man's risk of contracting HIV by roughly fifty percent.¹⁰

Policies that emphasize individual behavior change strategies only are unlikely to challenge structural inequalities. Again, this is most evident in Sub-Saharan Africa, where the absence of basic necessities and facilities of clean water, adequate housing, sanitation and sufficient food makes the structural nature of illness and health starkly evident. The advocates of individual lifestyle and professionals whose techniques and skills are biased towards individual behavior interventions argue in favor of reduced responsibility by the state for improving health status.¹¹

Current educational programs on AIDS prevention, for example, constitute an important contribution to the prevention of HIV, but their ultimate success is limited. There is a need for a balance between individual factors that govern behaviors and systemic, social and political and cultural influences of HIV/AIDS transmission.

The sociologically significant issue here is understanding individual behavioral factors in their social context. The task of health promotion and disease prevention, therefore, should be to understand the dialectical interplay between the larger social context and the personal. In the West, we live in a world in which we are driven by the quest for instant gratification and a search for a quick fix for all our social ills. All too often, we forget or ignore the larger social context often at our own peril. We blame individuals or their behaviors for societies' ills and we hold them responsible for the choices they make.

To be sure, individuals should be accountable for their behaviors and actions. However, such individual accountability and responsibility must be viewed within the larger social context in which such behavior is embedded. Individuals do make choices. But too often, those choices are either enhanced or constrained by larger social contexts.

Bio-medical Model

The bio-medical model is in many ways similar to the individual life style change approach. It places far greater importance on cure rather than prevention, the individual rather than the population/community, and pathogenesis of disease with little or no regard for the socio-genesis of disease. To counter this, we need to strike a balance between the curative and

preventive approaches so as to make them mutually inclusive rather than exclusive. A child taking a prescription medication for diarrhea would do well if the treatment regimen is accompanied by a concomitant change or improvement in the child's living environment, such as personal hygiene, sanitation conditions, nutrition and drinking water etc.

The ascendancy of the biomedical model to prominence and dominance followed the discovery of the germ theory. But this single-minded cure-oriented approach to health promotion and disease prevention has not proved effective. This, then, proves the fundamental flaw in the biomedical model- i.e. the search for magic bullets. "Infectious diseases, for example, constitute complex bio-ecological problems in which host, parasite, and a number of social and environmental forces interact. No single medical intervention can thus adequately address the problem. Diseases tell us much about the nature of our society."¹²

The case of AIDS in Africa makes it painfully explicit of the limits of the biomedical approach in the fight against the AIDS pandemic. There is no cure for AIDS to date. No 'magic bullets.' Whatever treatment regimes are available, they are far beyond the ability of most cash-strapped African countries to afford them. "The idea that illness/disease reflects the impact of nature on society and that it will eventually be solved by biomedical science means issues of health and disease can be seen as personal and technical problems rather than social and political ones."¹³ The model fails to explain the non-medical factors that influence both individual and population morbidity and mortality.

AIDS prevention programs based on the biomedical model fail to "see the spread of HIV as a marker of failures in social and economic development... underlying inequalities that lead to poor health or development, lie at the heart of the failure of most health and 'development' policies."¹⁴

Medical specialists as well as policy makers clearly tend to prefer the biomedical approach while at the same time they display great aversion to non-medical broader societal approaches. But why are policy makers averse to the latter approach? For one, such approaches hint at structural change which does not jibe well with those who benefit from the status quo, both internally and globally. For another, the advocates of social interventionist approaches make clear the connections between social justice and health, the need for social change, and the fact that they view the health/disease continuum as part and parcel of development and not a mere technical and/or personal problem.¹⁵ Health systems do not exist in a social vacuum. Their histories both shape their present and constrain their future.¹⁶ Non-medical factors or determinants are as important, if not more important, in the production of good health.

The AIDS tragedy in Africa is a poignant reminder of the danger of becoming solely dependent on the biomedical model at the exclusion of other

social intervention measures. Becoming infected with HIV, for example, shows the degree to which diseases are embedded in the social, political, economic, behavioral, environmental and medical experience of individuals.

Drug resistant parasitic organisms are becoming common now. Malaria and TB are cases in point. The malaria vector- the mosquito- has become resistant to DDT, and the malaria parasite- plasmodium- is now resistant to chloroquine. Lately, multi-drug resistant strains of TB have become rampant in the developing world. Even in the industrialized countries, such as the United States, TB is making a comeback and the causes of the comeback are primarily social, not bio-medical. Medical care is plagued by the scarcity of drugs, equipment and personnel. Overburdened systems are unable to cope with the added demands of AIDS. The availability of and access to antiretroviral drugs, such as AZT, in most Western countries and most recently in Brazil has transformed AIDS into a chronic condition thereby dramatically reducing the morbidity and mortality rates of those infected with HIV. Although there are global efforts to make such life saving drugs available in Africa, their widespread use remains limited due to their high cost and healthcare infrastructural problems.¹⁷ The cost of antiretroviral drugs varies widely from study to study and from one African country to another. At the end of 2008, Sub-Saharan Africa had an antiretroviral coverage of 44% which is equivalent to 2,925,000 people receiving antiretroviral therapy out of 6,700,000 people needing antiretroviral therapy.¹⁸ This hints at the futility of the reliance on the medical model as the sole intervention measure to the promotion of health and prevention of disease in a state of underdevelopment as is the case in Africa. The absence of any medical 'magic bullets' or quick fixes demands a holistic approach that addresses broader social, political, and behavioral issues and not just medicine.

Political Economy Model

This third perspective, unlike the first two, addresses the social production of disease, the role of poverty, social inequality, structure of unequal power relations in the production of disease and the social context in which behavior occurs. "If we aim to affect health behavior, we have to examine the circumstances that generate behavior and understand the relations of choice to non-choice. Choices are always made from among alternatives presented by the social environment, or by circumstances that were themselves not chosen."¹⁹

A political economy perspective recognizes the political nature of health and disease. As Rudolf Virchow, the great mid-nineteenth century physician once put it, "health is politics and politics is health on a large

scale.”²⁰ In order to improve health in any significant way, it is important to address political concerns first in order to reduce social and economic inequalities. Advocates of the political economy perspective locate issues of health and disease in the social structures of society. They emphasize the importance of large scale impersonal forces as the most important underlying risk factors. Issues of health and disease are, in other words, rooted in local, national, and global economic and political relationships - underdevelopment, poverty, urban/rural inequality, gender inequality, and class inequality and the unequal relationship between the West and Africa.²¹ Again, from this perspective, what is currently missing in health promotion and disease prevention endeavors is the social, economic, and cultural contexts in which people live, which determine the nature of the lifestyle and risks.²²

Thus, unlike the medical and lifestyle models, the political economy model addresses the broader social problems that predispose individuals to ill-health and the burden of diseases. In the words of Resenburg and Ngwena:²³

Africa’s health status, burden of disease, and healthcare needs are conspicuously shaped by poverty, malnutrition, infectious diseases, armed conflict, drought, famine, inadequate access to primary and secondary education, lack of safe water, sanitation, and a range of socioeconomic factors propelling inequitable distribution of resources.

Yet, issues of personal choices, lifestyle choices and individual behaviors and their roles in health and disease should not be ignored or submerged in larger social structural forces. Their roles should be properly understood in conjunction with the larger social issues. While the bio-medical and the lifestyle change models tend to depoliticize and desocialize issues of health and disease thereby reducing them to personal and technical levels, the political economy model, on the other hand, de-emphasizes the personal and technical/biomedical. We need to seek a balanced alternative approach that integrates all three.

AN INTEGRATED/HOLISTIC INTERVENTION APPROACH

A Chinese Parable

One day the emperor summoned to his palace the most famous doctor in all of China and asked the healer a question: “Who is the greatest doctor in our land?” No fool this emperor, for here he was, face-to-face with the most famous doctor in his country, but clearly he, the emperor, was able to make the distinction between fame and greatness. So he has asked a very subtle question,

perhaps with the hope of tricking the doctor. But the doctor was no fool, either, and he answered as follows: “I see people at death’s door, in their most dire moments. I operate on them, I draw blood from them. Occasionally I bring them back from the brink of death. And I am the most famous doctor in all of China.” At this, the emperor nodded. “But I have an older brother,” the doctor continued, “and my older brother sees people who are not quite as sick. He sees the earliest forms of their illnesses. He is able to intervene before they knock at death’s door, and he saves far more people than I. And he is famous in my village.” Again, the emperor nodded. “But I have an older brother still, older than he,” the doctor added, “and he sees *the conditions in our country that make our people sick. He changes these conditions before the people become ill. He has saved millions of lives.*” (emphasis mine) The emperor cocked an eyebrow as the doctor paused. “And this man, the oldest of my brothers, is well known in my family,” the doctor finally said. “So I ask you, Emperor, to tell me: Who is the greatest doctor in all of China?” At this, the emperor merely smiled and nodded.²⁴

The above parable is poignant in its depiction of the synergy of primary and secondary preventive measures to save lives. Primary prevention forms the first line of protection for a population and is frequently the most effective in preventing or reducing illness by changing the social conditions and behaviors that put people at risk of illness. Both preventive and curative measures are essential in promoting public health. Changing the social conditions, such as poverty, inequality, lifestyle factors, environmental and sanitation conditions that cause illness/disease is even more effective in promoting good health and preventing disease and making the work of medical professional less burdensome.²⁵

The double burden of disease facing the Sub-Saharan African region should be understood not only in terms of the pervasive nature of poverty, inequality, underdevelopment and inadequate resources but also in terms of the globalized lifestyle changes that are affecting the region at an accelerated pace. The preceding critical appraisal of the theories of disease clearly shows that no single theory can adequately address the complex health problems. Neither is a single theory adequate to address all the complex health problems nor is it suitable for all situations.²⁶ Addressing the challenges of health promotion and disease prevention in Sub-Saharan Africa would require an integrated holistic approach.

A holistic approach consists of an integrated synergy of medical, behavioral, and social structural intervention measures. A holistic model of disease views disease as the product of a complex interplay of social, economic, behavioral, biological, ecological, political, and cultural factors which is irreducible to any one single causal factor. Nor is its control/

prevention reducible or amenable to anyone single intervention measure. An effective policy of health promotion and disease prevention requires an integrated holistic approach. We need to recognize the necessity for concurrent multi-pronged intervention measure that combines medical, social and life style modification approaches.

Interventions should be designed to include systemic social, behavioral, environmental, and medical influences. The synergistic impact of the holistic intervention model is thus much greater than the sum total of the individual intervention measures taken separately.

Individual health intervention approaches taken separately address only part of the health/disease problem and not the whole problem. The holistic approach is certainly useful in terms of overcoming the hopelessly fragmented and fractured approaches to the issues of health promotion and disease prevention in terms of the medical, the social or the personal (behavioral) determinants of disease.

Again, a sensible answer would be to look at the issues in a holistic term. This constitutes a valid and good theory of public health. As Levins and Lopez²⁷ aptly state, "each approach is separately false, but together they are jointly true." They further note, "In the long run, individual action can achieve significant but still limited results, while action at the community level may reduce future damage but perhaps not help the actors themselves very much." As diseases are shaped or influenced by multiple interplay of biological, behavioral, economic, cultural, and socio-historical context, so should be the response. The synergistic benefits of an integrated or holistic intervention far exceed those of individual interventions, as the benefits that accrue from such a synergistic health intervention are far greater than the sum total of those benefits that derive from individual health interventions.

In order to reap the optimal synergistic benefits of a holistic approach, health should be seen as part of a multi-sectoral effort. This means that health is not viewed as the responsibility of a single sector. Rather, health is the result of a synergy of multiple sectors - agricultural programs, land reform programs, rural development programs, improved food/nutrition supplies, community health education, personal hygiene education, improved national income, (with emphasis on equitable distribution), improved sanitation, better housing conditions, the provision of clean water etc. In effect, as these non-medical efforts succeed in reducing and/or eliminating the burden of disease, the task of medical/health professionals becomes a lot easier. In short, health and health care are viewed as essential part of the overall development process and not as a separate or discrete entity. From a personnel point of view, a multi-sectoral approach constitutes a "commitment across society, from political leaders at all levels through to religious leaders, NGOs, the private sector and, where appropriate, traditional leaders."²⁸

The spectacular achievement in health in countries such as Sri Lanka, China, Costa Rica, Cuba and the state of Kerala (India) in the 1970s was made possible through multi-sectoral interventions involving the concurrent implementation of a wide range of programs such as nutrition/food programs, educational programs, income redistribution programs, land reform programs, universal access to health care services programs, the provision of clean water, sanitation programs, rural development programs, poverty reduction/ elimination programs, and agricultural and employment programs. However, the success achieved by these countries occurred long before the advent of the neoliberal economic policies of the World Bank and International Monetary Fund (IMF) in the early to mid 1980s. As a result of Structural Adjustment Programs (SAPs) of the neo-liberal economic orthodoxy, almost all of these countries suffered severe setbacks in their equitable and social justice-oriented development programs.

African countries today face daunting challenges in reforming their health care systems in the face of the global dominance of the neo-liberal economic ideology, on the one hand, and their own ineptness, political corruption, and lack of transparency and public accountability, on the other. Today's *international public health* is characterized by "its emphasis on health sector reform, cost-effectiveness as an important principle in the choice of interventions in the public sector, and public-private partnerships in health, paralleled by a rapid expansion of information and communications technology."²⁹ Lee and Yach³⁰ go further by asserting that we are entering the stage of transitioning from *international* to *global* public health in light of the collective impacts of globalization in the way healthcare is financed, delivered, marketed and regulated. In the current global economic climate and global public health, issues of health and disease have fallen within the purview of a *mélange* of bilateral and multi-lateral agencies, international and local NGOs, grassroots organizations, and other donors. It is this public-private partnership, the fluid coalition of bilateral and multilateral agencies, and all kinds of local and *international* NGOs that have come to characterize the new international or global public health.³¹

Can political will and determination (including democratic governance) on the part of the African state and the participation and involvement of civil societies and grassroots organizations bring about the desired change in the context of the current global public health climate? Where is the inspiration or vision to come from? Political will is defined here as the willingness and commitment on the part of those in positions of political power to effect a broad-based change in the public health arena.

There are a few African countries with inspiring experiences. The experiences of Uganda and Rwanda are used here as examples to provide the

vision or inspiration for other African countries within the global public health framework. The experience of Uganda with the HIV/AIDS epidemic shows that government political will and determination to effect change and social mobilization and empowerment of local communities are crucial in the promotion of health and prevention of infection. Helen Epstein in her book: *"Invisible Cure"* - asserts that the rapid decline of HIV infection rates in Uganda in the 1980s and early 1990s was due, in large part, (of course without discounting the role of abstinence, faithfulness and condom use) to what she refers to as "collective efficacy" – a term she borrowed from the sociologist Felton Earls. "Collective efficacy" refers to the ability of people to join together and help each other. In elaborating on this spirit of collective action and mutual aid, Epstein explains what collective efficacy meant in the Ugandan context:

During the 1980s and early 1990s, while people in most African countries were ignoring the AIDS crisis, hundreds of tiny community-based AIDS groups sprang up throughout Uganda and Kagera to comfort the sick, care for orphans, warn people about the dangers of casual sex, and address the particular vulnerabilities of women and girls to infection. Yoweri Museveni's government developed its own vigorous prevention campaigns and the World Health Organization provided funding, but much also came from the pockets of the poor themselves. Their compassion and hard work brought the disease into the open, got people talking about the epidemic, reduced AIDS-related stigma and denial, and led to a profound shift in sexual norms. This process was very African, but it was similar in many respects to the compassionate, vocal, and angry response to AIDS among gay men in Western countries during the 1980s when HIV incidence in this group also fell steeply.³²

What was unique about Uganda early in the fight against the AIDS disease was the active involvement of the Ugandan government and its mobilizing efforts of local communities and grassroots organizations in the fight against HIV/AIDS. Government slogans such as "love carefully" and "zero grazing" which meant avoiding indiscriminate sexual relations were posted on public buildings, broadcasted on state media, and speeches by government officials were instrumental in the steep decline in infection rates.³³

While the Ugandan government/civil society and grassroots collaboration in the promotion of health and prevention of disease is, by and

large, confined to HIV/AIDS, Rwanda's experience, by contrast, is quite broader in scope. Rwanda is being hailed as the "poster child" for a transformative development in Sub-Saharan Africa. Rwanda seems to have all the elements of the new global public health that entails the public-private partnerships and collaborations in transforming the health care system as an integral part of the development process. Rwanda was flooded with all kinds of international donor agencies on the heels of the 1994 genocide and the HIV/AIDS pandemic. In 2009, there were no fewer than 16 bilateral and multilateral agencies working in the health sector.³⁴

What makes the Rwandan experience unique is that the post-disaster rebuilding is a community-led effort. A key part of Rwanda's development initiative is based on the principle of sustainable development through land use management and rural agriculture in the frame of global development strategy.³⁵ According to Grassroots International,³⁶ the Rwandan government appears to be determined to define and own the national development project by consulting with civil society groups all over the country and unveiling Rwanda Vision 2020, a development program intended to rid Rwanda of international aid by 2020 and emphasize government ownership of aid as a prerequisite for sustainable and high quality health care at low cost. Over 90% of Rwandans are covered by health insurance.³⁷ There is broad access to clean water and rural villages are the centerpiece of the development strategy for the entire country with emphasis on local solutions to local problems. Rwanda is thus reported to have shown impressive progress towards achieving the Millennium Development Goals in its health sector.³⁸

The Rwandan government in partnership with the Boston-based Partners in Health led by Dr. Paul Farmer, who is well known for his pioneering clinical and preventive health care services in rural Haiti and other poor countries, has embarked on a program of providing health services to villages throughout the country (i.e. making medical house calls) using community health workers and trained local villagers. This community health workers model, akin to the Chinese "bare foot doctors" model, aims at providing primary health care (with emphasis on prevention) and breaking the cycle of poverty while treating people for illnesses.³⁹

According to the report of the Ministry of Finance and economic Planning of Rwanda, "the Government of Rwanda has built successful partnerships with the providers of assistance to the health sector, such as the Global Funds for AIDS and Tuberculosis and Malaria Programs to ensure that their assistance is situated within the government's plan to transform the Rwandan health sector as a whole, not limited only to single types of disease or treatment."⁴⁰ Further, Rwangombwa⁴¹ asserts that "where a population- and its government – is able to exert strong ownership of a country's development

agenda, donors should align their assistance to country systems and plans, and participate in common dialogue at the country level, focused on joint and shared development results.”

Rwanda’s success story is certainly far from perfect. One has to wait till 2020 to see if all the target goals are achievable as well as sustainable, especially, after the global donors and partners have left the scene. For now, though, the key aspect of Rwanda’s success lies with the Rwandan state’s political determination to define and own its national development, health programs, and policies in the face of global forces not so benevolent, if not inimical, to any state guided developmental programs. The Rwandan experience could, perhaps, inspire other Sub-Saharan countries to follow suit.

What if the Rwandan experience cannot be replicated in other Sub-Saharan countries? Or, what if it is not sustainable in the long term? Are there viable alternative strategies? It is beyond the scope of this paper to delve into and expound such alternative development strategies. It will suffice to make only a brief mention of two such alternative development paths: self-reliance and the Nordic model of development. Pursuing a self-reliant development places emphasis on the need to get away from an outward-oriented economy in favor of a more inward-looking economy. The inward-looking logic of the national economy as opposed to the external logic of the global economy does suggest a certain degree of delinking from the world economic order which is not the same as autarky or self-sufficiency. Countries pursuing self-reliant development do not have to close off themselves to the outside world, although the self-reliant development logic requires an alternative political, cultural, and economic orientation.⁴²

The Nordic economic development model is based on the experience of the Nordic countries (Norway, Sweden, Finland, Iceland, and Denmark) whose economic success is attributed to a combination of free-enterprise market economic policies and interventionist, welfare state.⁴³ It is worth noting here that in the Nordic economic model, the state retains an active role in regulating the economy. It is also equally worth noting that the World bank, in its 1989 development report titled, *From Crisis to Sustainable Growth - Sub-Saharan Africa - A Long term Perspective*, endorsed the application of the Nordic model in addressing the economic crises in Sub-Saharan Africa. The report emphasized three important areas: restructuring economies, putting people first, and fostering self-reliance.⁴⁴

CONCLUSION

Throughout this paper I have emphasized the importance of viewing the promotion of health and prevention of disease in Africa as an integral part of the development process through an integrated model of health intervention

that addresses the underlying fundamental social, economic, political, medical, and behavioral causal factors of disease. Such an integrated intervention measure views the issues of health and disease as the product of a complex interplay of social, economic, political, biological and behavioral factors that are not reducible to a single causal factor. Furthermore, health is not viewed merely as the responsibility of a single sector but rather as the result of a synergy of multiple sectors many of which are non-health sectors. The synergistic benefits of an integrated-holistic intervention strategy far exceed those of individual intervention measures.

As the Rwandan experience shows and given the current global public health climate, success with an integrated health care approach is likely to depend on a political will and commitment on the part of the state, the involvement and participation of local communities, grassroots organizations, civil societies and the collaboration and partnership with bilateral and multilateral agencies and NGOs. The rule of law, “good governance”, democratic rule and transparency and public accountability are essential to the success of an integrated health care system and the ability to work in collaboration and partnership with global public health organizations and donor agencies. The Nordic and self-reliance based development models also offer viable alternative development paths for promoting integrated healthcare systems.

NOTES

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3. *Ibid.*, pp. 8-12 ; African Union, *Strengthening Health Systems for Equity and Development*, Third Session of the AU Conference of Ministers of Health (Johannesburg, South Africa, April 9-13, 2007).
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