

Equal Access to Health Information in Africa: A Dream or Reality?

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Abstract: Many governments in Africa are committed to equal access to health. This requires well-resourced health systems. People need health information even though many factors mar the attainment of the right to information as set out in various constitutions. People need information on prevention, care and treatment of various diseases and illnesses. With advances in information and communications technology access to health information has improved even though it is not for all. It has been noted that certain diseases affect the rich and the poor differently and that both do not access same health facilities. This divide indicates that there is poor quality health information due to the nature of health system. The rich have access to quality health information while the poor have no access or when it is available it is of poor quality. What is essential is for governments to provide equal access to the right health information, at the right time and in the right formats irrespective of social, economic and geographical status. People should be able to reach clinics and hospitals when they need information and alternatively access libraries. The conceptual framework for the study is based on Buckland's six aspects of access which serves as a barometer in terms of guaranteeing that all people are equally served. The paper used document analysis by referring to health sources such as books, magazines, journals and health reports emanating from various health stakeholders. The results of this paper show that poor people in rural areas do not have equal access to health information due to social and economic factors. The study also revealed that many governments are struggling to provide equal access to health information for all citizens. The paper concludes by suggesting how equal access to health information may be improved.

Keywords: Access, Health facilities, Health information, Unequal health facilities, Health systems

1. Introduction

The need for health information can be traced back from ancient information societies. History shows how ancient nomadic people needed health information for prevention, care and cure of diseases. Information is used everywhere on daily basis (Savolainen, 2000). Information use may be considered as the effects which information has on individuals and what it does to the person and his/her problem or situation (Kari, 2007). Information which a user has to access has to address physical and psychological ailments. Denial of access to information marginalizes people's participation in the modern information era (Lor & Britz, 2007). Miescher & Henrichsen (2004:163) traces African history of health provision by relating how among the activities of the Christian missionary societies since 19th century a high value was also placed on 'health and 'hygiene'. The European missionary societies were pioneers in introducing modern medicines to Africa, and played an essential role in the establishment of health systems. After independence, many African countries gave high political priority to the setting up of fair national health systems (Miescher

& Henrichsen, 2004:163). Various UN institutions as well as private relief organisations and charities played an important role of this process and continue to do so. In the midst of that attempts were made to suppress use of traditional medicines; however, there are still a lot of people who are continuing to consult traditional healers (Chavunduka, 1999).

Health systems in various countries comprise hospitals, clinics where health information is accessed through channels such as radio, television and social media.

It is essential that African health centres make accessible quality health information irrespective of their social status. The South African government (2000) passed the Promotion of Access to Information Act ("PAIA"), No 2 of 2000 gives effect to the constitutional right of access to any information held by the State and any information that is held by another person and that is required for the exercise or protection of any rights. Information is an essential resource for personal development but spread of the information revolution has moved slowly in some African countries. Stakeholders such

as government, Non-governmental Organisations (NGOs), research bodies, institutions of higher learning recognise health information as an important resource or asset and for it to be useful, it must be available, accessible, usable, and absorbed by the recipients of the information (Wagacha, 2007). While there has been a great deal of research on health systems in Africa, the literature still suffers gaps of addressing marginalised groups who fail to access health information. If health information is not accessible it equates to a failure of an individual to efficiently and effectively improve his quality of life. The objectives of this paper are to explain what equal access to health information encompasses in order to be beneficial even to the marginalised groups, outline the marginalised groups and conditions which makes it impossible for them to access health information, identify ICT tools that may be used to enhance access to access to health information beyond physically visiting the library, recognise best practices to ensure equitable access to health information and to show how libraries play an alternative role to enhance access to health information.

2. Literature Review and Conceptual Framework

From the reviewed health literature, it is clear that health information needs to be accessible to all people living in a particular country. There are many definitions of what access to health information means. Accessibility of health care comprises the following factors, namely availability, financial accessibility, geographic accessibility and acceptability (Peters, Garg, Bloom, Walker, Brieger & Rahman, 2008:161).

Since people have to access health information it is imperative for this paper to adopt the concept of access as used by Buckland (1991:78) who identified the following six aspects of access to information. These six aspects were used by Dikotla (2008) in his research study on "Assessment of information delivery systems used for dissemination of HIV/AIDS information by selected clinics as Ga-Molepo, Capricorn district in the Limpopo Province".

The six aspects are as follows:

- **Identification:** This means that users should identify a suitable source. Identification of a source includes two-stage process. The first stage

includes deciding where to look for a source while the second stage involves identifying a specific source.

- **Availability:** The identified source should be physically accessible to the user. Technology may be used to enhance accessibility of the source. If the identified source cannot be located and made physically available, then another source needs to be identified again and made available.
- **Price to the User:** Price refers to costs that the user must incur for using the service. The costs may be in a form of money, time, effort and discomfort of acquiring the source. Effort relates to a client-patient who struggles to locate information. Discomfort relates to the health worker helping the client-patient to ask a well phrased question. The health worker has to make sure that the information given to the client-patient matches the client-patient's query.
- **Cost to the Provider:** The term cost refers to costs incurred by the providers of service. This involves money and effort borne by public health facility as health service providers.
- **Cognitive Access:** After physical access to a relevant source has been achieved, subsequent condition for successful access is the user's expertise to understand it. In case the user does not understand the source, explanation and education will be required.
- **Acceptability:** There are two related issues involved in acceptability. The first issue is that the user may be reluctant to accept the identified source as credible and reliable. The second issue, the users may not accept the evidence of the source because it is unwelcome in what it signifies and conflicts with other beliefs, a matter of cognitive. For example, a user may understand a source but not accept its validity; such user can hardly be informed by that source. This suggests that credibility as a criterion for becoming informed can be questioned.

Latest definition of access to information by Lor and Britz (2007:390) is that information that is available should also be affordable, accessible, timely, relevant, readily assimilated, and in languages and contexts users can relate to and understand. But this paper focuses on Buckland's definition of access.

2.1 Health Information Sources

One cannot doubt that the first prerequisite is well-established health systems to provide health information sources needed by patients and general public. Health practitioners are key sources for packaging health information hence many health clinics hold free health talks. They are also expected to match the query by information seeker with relevant, accurate, comprehensive and complete information. If a user needs information on listeriosis, the health practitioner should not give information on stomach cramps.

Another challenge with sharing health information in many African countries is shortage of health professionals despite having the highest burden of disease. A clear example is that within sub-Saharan African countries, it is widely known that rural communities are the most socio-economically deprived, have the greatest health needs and the poorest access to healthcare (In On AFRICA IOA, 2012). Issue of not having enough health practitioners could be caused by brain drain, health professionals not willing to work in rural areas and challenges to war-torn regions where there is threat to their lives. In terms of addressing brain drain in sub-Saharan Africa, many governments have agreements with Cuba to recruit their doctors. Ghana, for example, employs over 200 Cuban doctors on two-year contracts and these doctors serve some of the most remote areas in the country. In case of remote areas the Senegalese Government is currently developing policy to encourage health professionals to remain in areas defined as 'difficult' (Honda, Krucien, Ryan, Diouf, Salla, Nagai & Fujita, 2019). South Africa has introduced Rural Allowance in 2004 and nurses of salaries in Ghana are already high by regional standards, however dissatisfaction by certain sectors were recorded (Kulansa, Dzodzomenyo, Mutumba, Asabir, Koomson, Gyakobo, Agyei-Baffour, Kruk & Snow, 2012; Dithopo, Blaauw, Bidwell & Thomas, 2011).

2.1.1 Health Practitioners as Sources of Health Information

The existing health care problems in many parts of African countries are exacerbated by the attitudes of healthcare workers. As a result many patients are faced with unwelcoming healthcare workers who do very little to make patients feel welcome, fuelling levels of patient dissatisfaction (Williams, Baker, Honig, Lee & Nowlan, 1998). A study by Dikotla (2008:80) established that nurses working

at Limpopo clinics, in South Africa are not satisfied about the number of people who visit the clinics on a daily basis to access HIV/AIDS information. Failure to visit clinics was based on patients' attitude towards their health status not being protected. In a study conducted in Uganda, it was discovered that patients had a negative attitude towards seeking healthcare in public facilities because health workers tend to turn away poor women who cannot afford soap, clothes and simple gloves (Kiguli, Ekirap-Kiracho, Okui, Mutebi, Macgregor & Pariyo, 2007). This form of discrimination prevails in spite of constitutions of many African countries (such as South Africa, 1996, Angola; 2010; Kenya, 2010; Morocco, 2011; Zimbabwe, 2013 and Egypt, 2014) making provisions to protect the rights of its patients and discourage any form of discrimination (Shyllon, 2016:76).

2.1.2 Alternative Health Information Sources

From the literature reviewed how little has been the about the role of the public libraries in packaging and providing health information at no-cost and in multiple languages. But, in most African countries public libraries are not easily accessible and where they are accessible they are underutilized due to poor reading culture among the communities. In South Africa many public libraries through community engagement projects, visits the local clinics to provide patients with health information which includes information on diabetes and how to manage it. They also target learners in various schools to raise awareness about issues such as HIV/AIDS, TB, Malaria teenage pregnancy, etc. They also target children and teenagers health information is disseminated through story telling. Lastly, the libraries provide health information through what is called "Do It Yourself" (DIY) programme whereby the marginalized groups such as the unemployed, home based care patients and orphans are loaned some books, watch videos and other sources of information that empower them to manage their health conditions on their own.

In an attempt to match the health information needs of those who rely on traditional health information system, South Africa signed the Traditional Health Practitioner's Act (THPA) of 2007 into law in February 2008 (Nxumalo, Alaba, Harris, Chersich & Gouche, 2011:124). The aim of the act is to "serve and protect the interests of members of the public who visit traditional health practitioners," thus suggesting that South Africa use two parallel health-care systems.

2.1.3 Credibility of Information Sources

Generally, information sources should always be credible. This includes health information. So, it is important for end users to know or have the ability to determine whether information source is credible or not. There are criteria that may be used to determine the credibility of health information. According to Anderson, (2019) such criteria include the following:

Authority - this criterion determines whether or not the author or agency that created the information has the credentials, academic background or experience to write authoritatively about the topic. Essentially this criterion evaluates if author have a degree related to the topic they addressing. In terms of the agencies, the criterion checks if the agency has a good reputation in the field they are addressing.

Bias - this criterion checks if there is a reason to believe that the information provided by the author or agency is slanted or designed to persuade the reader by presenting part of the whole story. Therefore, health information sources should provide objective information.

Currency - In terms of currency, the information provided by the source should be current. The date matter because information in some areas and disciplines changes all the time or needs to be up-to-date.

Indicators of quality - This criterion looks whether or not the claims made by the source are backed up with documented and cited sources. Most importantly, the cited sources should be of high quality and really cover what they are supposed to.

2.2 Technological Divide Impact Access to Health Information

In rich countries with advanced telecommunication systems, telehealth is reported to have gained acceptance as a quick, easy method of offering timely healthcare, "particularly for preventive, public health, and chronic care (Peters & Gupta, n.d.; Janz, Champion & Strecher, 2006). In cases where people cannot physically visit the health ICT is an answer. Some of the standard e-health systems include e-prescribing and tele-healthcare systems, whereby patients can manage their own healthcare from the home environment and order repeat prescriptions online. The use of technology

improves HIV test turnaround time and speed transfer of test results to health facilities (Glanz, Lewis & Rime, 2006). In Lesotho, for instance the Elizabeth Glaser Paediatric Aids Foundation (EGPAF) cut down the average HIV test result turnaround time from 12 weeks to 4 weeks (In On Africa IOA, 2012). Similarly, the South African National Department of Health (2014) initiated MomConnect system to support maternal health. The objectives of this initiative are the following:

- To introduce a mechanism for registering electronically all pregnancies in the public health system as early as possible,
- To send targeted health promotion messages to pregnant women to improve their health and that of their infants,
- To provide pregnant women with an interactive mechanism to feedback on the service they have received.

Momconnect use cell phone based technologies integrated into maternal and child health services. Its use is voluntary and free of charge. The messages are available in all 11 official languages. According to Department of Health - South Africa (2019), MomConnect use social media for interaction and information sharing without geographical boundaries and with little or no limitation (Mgudlwa & Iyamu, 2017).

Many social media tools are available for health care professionals (HCPs), including social networking platforms, blogs, microblogs, wikis, media-sharing sites, and virtual reality and gaming environments (Peck, 2014) These tools can be used to improve or enhance professional networking and education, organizational promotion, patient care, patient education, and public health programmes. However, they also present potential risks to patients and HCPs regarding the distribution of poor-quality information, damage to professional image, breaches of patient privacy, violation of personal-professional boundaries, and licensing or legal issues (Chretien & Kind, 2013 as cited in Ventola, 2014).

Although electronic gadgets such as radios also use batteries and are used widely even in remote villages for information, the electricity is a factor which indirectly impacts access to health information. According to Lloyd, Cowan & Mohlakoana, (2004) the vast majority of African households do function

with electricity. Therefore, a simple task of charging a cell phone is no simple matter in rural farming villages far from an electric grid. People walk miles to the nearest town with electricity, drop off their cell phone at a store that recharges phones at a fee and may wait up to three days since demand is so high. Charging a cell phone is costly for most Africans living in rural villages considering that people have to walk long distances and pay for recharging their cell phones (Chic African Culture, 2016).

2.3 Notable Factors for Accessing Health Information

There are factors which should exist in order to access information as indicated by Buckland and others. First factor is the price which is not in monetary terms. Smith (1976) as cited in Buckland (1991) refers to the price as the toil and trouble of acquiring a source. Culnan (1985) also cited in Buckland (1991) considers price to include the effort of learning how to use difficult or user-unfriendly systems. The price, as, must be acceptable to the inquirer. If, the price is not acceptable to a user it becomes a barrier to access to health information.

When considering effort and discomfort expectation are that when soliciting sensitive health information which could be sensitive health practitioners should be accommodating. Some cultural factors may prohibit access to health information. According to Schoeps, Gabrysch, Niamba, Sié and Becher (2011:492), women, may consider male health professionals to be unacceptable for certain issues, and vice versa. Obermeyer (1999:153) adds that within certain cultures, the use of biological or factual names for reproductive organs is sometimes prohibited or regarded as a taboo.

2.4 Health Providers Bearing Costs

Many public health providers provide free services to the poor, of which it may not be a case in some of the poorest countries. In such cases unequal health information is realised. In this case, in the dissemination of pamphlets about cholera, malaria, etc., the government use state resources. The pamphlets would be written in various languages which are spoken and understood by people living in those regions.

2.4.1 Distance from the Health Facilities

Costs cannot be removed from travel distance to access health information. According to Kofi and

Ashanti (2017), travel cost is measured in units of Euclidean or straight line or walking distance along a road or transportation medium. This measure is a suitable accessibility measure for rural areas since the choice of service providers are limited and the one very close to the user is the most likely to be used and not ideal for urban areas. This measure considers all the potential options available to the patient making this measure a bad indicator of availability. Travel impedance combines all the effects of travel and availability (Kofi and Ashanti, 2017). So long as a person pays transport, spends more time travelling a long distance to access health information, this health information is inaccessible.

Like in many rural areas in Africa, for example in Zimbabwe there is no transportation, no roads leading to the nearest health facility. In areas where roads are available, they are impassable (Agere, 1990:33). In Ghana, on average, a patient in the district travels a minimum of 6.62km and a maximum of 21.20km to access health care. And the majority of the roads in Niger are non-paved (90%) (Blandford, Kumar, Luo & MacEachren, 2012). Also 26.39% of the district population were residing beyond the 8km service area criteria. This shows how travel distance to access health care in sub-Saharan Africa need to improve health-care access in order to achieve the Millennium Development Goals. In South Africa the norms and standards of primary health service outline that citizens should not travel more than five (5) km before accessing a health services (Mahlo, 2007 cited in Dikotla, 2008).

In South Africa a household survey combined with a geographic information system analysis in the Hlabisa sub-district of KwaZulu-Natal found that households within 30 minutes of a clinic were 10 times more likely to make use of a clinic than households having to travel for 90-120 minutes to a clinic. Categories of marginalised people who due to geographic location, type of work or physical ability have more serious challenges of accessing health information. They are described in the following ways:

- People with disability who live in the rural areas are also victims of long distances to healthcare. Restricted movement coupled with slow, erratic or non-existent public transportation systems complicates access for many disabled people. Hardware and software are available to all groups with different disabilities.

- » Visually impaired groups who cannot access information due to the format used. According to Adetoro (2010) information can only become usable to persons with visual when they are transcribed into alternative formats. This means that information could be available but not accessible because of the manner in which it has been packaged.
- Herd boys who spend long time tending animals away from home, with the nearest hospital or health centre being a minimum of 50 kilometres away - on foot or on horseback (In on Africa IOA, 2012). Similarly at risk are long distance truck drivers who spend much of their time on the road and hardly have time for regular medical check-ups (Solomon, Doucette, Garland & McGinn, 2004).
- Lesbian, Gays, Bisexual, Transgender, Queer (LGBTQ) also have health information needs but many countries still discriminate them due to laws relating to their sexual orientation. News24 (2019) reported that more than half of the countries in sub-Saharan Africa have anti-homosexuality laws, although others have moved toward legal tolerance. Twenty-eight out of 49 countries have laws penalising same-sex relationships. Many countries such as Angola, Chad, Gabon, Malawi, Mali, Mozambique, Nigeria and Tanzania are not accepting lesbian, gay, bisexual, and transgender (LGBTQ) and in varying ways impose penal codes such as jailing, fining, criminalising sodomy, conservative groups campaigning against sexual education maintaining it promotes homosexuality and refusal to employ or provide services to someone on the grounds of their sexual orientation. Countries such as Botswana, Lesotho are making little headway in addressing LGBTQ status. In 2006, South Africa became the sole African nation to allow gay marriages and this brought some challenges to the country. For instance, the country has become a haven for African homosexuals who flee persecutions from their country of origin.

Muller (2017), conducted a qualitative study whereby some homosexuals were interviewed on access to health care none of the participants had received health information targeted at people identifying as LGBT at a public health facility. One Coloured gay man from South Africa, Cape Town was quoted as saying:

"When I discovered that I was gay it's difficult to get information; because even at the clinics you find pamphlets about TB, about HIV and AIDS and even in the pamphlets themselves, because I remember - I had all of them - for me it was the curiosity that if there is anything mentioned about male to male sex? Nothing at all."

- Many unauthorised immigrants all over Africa, who in some countries are taken to be burdens to host countries and probably having no access to health information.
- To many street kids, mental patients roaming the streets, drug addicts due to use of various substances all so oblivious to their need of health information and bettering their lives.

2.5 Understanding Health Information

Many people in Africa speak a language other than those of former colonisers at home whereas medical officers utilise foreign languages and medical vocabulary which had no correlate in several of the vernaculars spoken in the communities. In a situation where, for instance, an uneducated patient requests health information, communication becomes difficult because patients do not like admitting that they do not understand a certain word (Treas & Wilkinson, 2014:328).

Another issue is "information dumping" on patients and families when they visit clinicians for a follow-up or something more serious (Viable Synergy, 2018). The information is not packaged in such a way that it is easy to understand and manage.

For patients who cannot read, their ability to listen and understand health information is important. According to Ventura and Piña (2018), "the degree to which individuals can obtain, process, and understand the basic health information and services they need to make appropriate health decisions is called health literacy." On the other hand health illiteracy hinders effective patient engagement with health practitioners.

Halperin, Mugurungi and Hallett (2011) agree that low-literacy patients ask fewer questions about their medical care, and this may affect their ability to learn about their medical conditions and treatments.

The results of the study conducted by Menendez, van Hoorn, Mackert, Donovan, Chen and Ring (2016),

produced several noteworthy findings. The study found that low-literacy patients' bids for repetition frequently take the form of short questions which indicate lack of understanding, such as, "My what?" or "Who?" These types of questions do not appear to facilitate the communication of new or meaningful information. Additionally, the questions asked by low-literacy patients often concern basic procedural issues rather than an attempt to seek new medical information, for example, "Where do I get my blood drawn at?" or "Could I come back tomorrow and give the urine test?" Furthermore, the study established that, Patients with higher literacy levels raised other concerns related to self-management of medical conditions, specifically questions related to lifestyle issues (e.g., "You can eat them when you're a diabetic?" or "At this point, what would be more important, the diet or the exercise?" or "If I'm not sexually active, I still have to take it?")(Katz, Jacobson, Veledar & Kripalani, 2007).

The other group involves those with hidden illiteracy. According to Applied Scholastics international, (2019) the illiterate can be very dangerous and destructive because of his or her type of illiteracy, i.e. hidden illiteracy. The hidden illiterates are ignorant of their own illiteracy. This is because their illiteracy is hidden from themselves. And, because it has never been identified, it is hidden from others as well. In essence, hidden illiterates are ignorant of their ignorance; they do not know that they do not know. As Applied Scholastics international, (2019) put it they do not fully comprehend the information and ideas being received, studied, or applied and are not aware they do not understand. In most cases, their actions, feelings and beliefs are founded on their unknown wrong suppositions, ideas and understandings. The problems and results of being a hidden illiterate can range from humorous to disastrous (Applied Scholastics international, 2019).

3. Conclusion and Recommendations

It is clear from the results that, in many rural areas, access to health information is affected by many factors as presented in this study. Failure to provide access to health information is regarded as denying people a basic right to health. The findings of this desktop study suggest a need for learning best practices from each other may help to bridge the unequal access to health information. Governments need to deal with the issue of electricity and access to telecommunications because they indirectly

affect access to health information. In spite of many countries having constitutions that promote access to information, there are marginalised groups that still do not have adequate and equal access to health information. The marginalised groups include homosexuals, street kids, mental patients roaming the streets, drug addicts and poor rural dwellers. Therefore, laws and practices discriminating against others need to be addressed.

Due to low-literacy levels, it is advisable that instead of healthcare professionals assuming that patients understand what they are told, they may take "universal precautions" by assuming that patients do not understand unless proved otherwise (Menendez, van Hoorn, Mackert, Donovan, Chen & Ring, 2016). In this modern era, it is imperative to vigorously involve patients with limited health literacy in the decision-making process by encouraging them to ask questions mainly in practice settings where most sensitive decisions are taken. According to Gathoni (2012), it is important to ensure that information is packaged in a right format. Therefore, it is recommended that health workers should ensure that information is packaged in such a way that it is easy to understand and manage, thus ensuring accessibility of health information to the target audience.

Owing to the underdevelopment of indigenous languages and translating or writing medical books face a serious shortage of words in the vernacular languages, government should assist in training health workers to learn vernacular languages. Health workers who know vernacular languages will be in a better position to package and disseminate health information to the target audience, thus enhancing an equal access of health information for everyone.

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