2ND AFRICA-GLOBAL SCIENCE CONFERENCE ON POVERTY REDUCTION, TECHNOLOGY, ENVIRONMENT & HEALTH

CONFERENCE THEME
Poverty Reduction & Prevention of Infectious Disease in Africa

CONFERENCE OBJECTIVE
The Africa-Global Conference is sponsored by Science Research in Africa and Kwame Nkrumah University of Science & Technology (KNUST) Kumasi, Ghana. The Conference will provide a platform for discussing latest clinical developments and updates on ongoing and new trials on various emerging and re-emerging diseases.

CONFERENCE DATE
Wednesday 19th - Thursday 20th September, 2018

CONFERENCE VENUE
Kamfo Anokye Teaching Hospital (KATH), KATH Polytechnic Conference Room, Kumasi, Ashanti Region, Ghana

TIME: 9:00 am

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Conference Programme

Day One: Tuesday 18th September, 2018 Arrival of Guests/Conferees/Delegates		
Day Two: Wednesday 19th September, 2018 Opening Session/ Plenary		
9:00	- 10:00am	Conference Registration
10:00	- 10:15am	Opening Prayer/Welcome Remark
10:15	- 10:30am	Institutional Brief/Chairman's Opening Remark
10:30	- 12:00noon	Lead Speaker/Guest Speakers
12:00	- 1:00pm	Launch Break/Group Photograph
2:00pm	– 4:00pm	Plenary Session
4:00pm	– 5:00pm	Policy Review Session
Day Three: Thursday 20th September, 2018 Plenary Sessions/Policy Briefing/Communiqué		
7:00am	– 8:00am	Breakfast
8:00am	– 10:00am	Conference Briefing
10:00am	– 1:00pm	Plenary Session
1:o0pm	– 2:00pm	Launch Break
2:00pm	– 4:00pm	Plenary Session
4:00pm	– 5:00pm	Communiqué/Closing Ceremony
Day Four: Friday 21st September, 2018 Departure of Guest/Conferees/Delegates		

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4. Letter of Papers Acceptance and Journal Publication will be issued to author(s) on the 6th week after the conference. Acceptance will be in three forms:

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Proceedings / Abstracts

Proceedings & Abstracts

World Health Organisation
Regional Office for Africa

Poverty and Health Situation in Africa: An Overview

Poverty is associated with the undermining of a range of key human attributes, including health. The poor are often exposed to greater personal and environmental health risk factors, have less access to health care services, and have limited lifestyle-related choices. They are also more likely to experience discrimination, abuse and exploitation. Conversely, illness can reduce household savings, lower learning ability, reduce productivity, and lead to a diminished quality of life, thereby perpetuating or even increasing poverty.

Poverty is often defined in absolute terms of low income – less than US$2 a day, for example. But in reality, the consequences of poverty exist on a relative scale. The poorest of the poor, around the world, have the worst health. Within countries, the evidence shows that in general the lower an individual's socioeconomic position the worse their health. Unclean water, deficient sanitation and food safety play a significant role in the development of cholera and viral hepatitis, and contribute to neglected tropical diseases such as guinea-worm disease and schistosomiasis.

Lack of education and inadequate housing often contributes to high rates of maternal mortality, adolescent pregnancy, sexual assault, and high rates of sexually transmitted infections such as HIV and human papillomavirus (HPV).

Infectious diseases have historically dominated the African Region but poverty impacts noncommunicable diseases such as cardiovascular diseases, diabetes and cancer as well. This concerns call for research and interventions.

Source: WHO Regional Office for Africa
https://afro.who.int/health-topics/poverty

Poverty and health in developing countries: a South African perspective

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There is no doubt that there is a relationship between poverty and health. The impact of this relationship is particularly apparent in South Africa, as compared to other developing countries, because so many of the lives of its citizens were affected by the inequality of the apartheid system. This system created a sense of inadequacy and inferiority among black people whilst cultivating a high sense of achievement and superiority in white people. Black people were to be, according to the founder of the policy, HF Verwoerd, nothing more than drawers of water and hewers of wood (Mzolo, 2005:3).

Under apartheid, black people were forced to live in rural areas where they did not have access to services and facilities which were concentrated in the cities. To find work, black people had to become migrant labourers, moving from their homes to the cities where they lived in hostels. This situation led to disorganized family homes, high rates of divorce, children left homeless and without proper care and low literacy levels. The level of poverty amongst families increased (Fassin and Schneider, 2003:3).

The situation changed rapidly after 1994 when apartheid was brought to an end by the African National Congress (ANC) as the ruling party under the leadership of Dr Nelson Rholihlahla Mandela. The party developed strategies and policies for redressing the past inequalities between races particularly those with regard to women, children, disabled and blacks who are now referred to as historically disadvantaged (HD).The ANC found the whole economy of the country in a shambles especially after the Rubicon speech of President PW Botha in 1985 which indicated political uncertainty in the country and thus discouraged foreign investors (Fourie, 2000:179).

After the takeover, the ANC established an economic development policy, the Reconstruction and Development Policy (RDP). The policy listed five key programmes which were a point of focus in the country: meeting basic needs; developing human resources; building the economy; democratising the state and society; the implementation of the RDP. All five programmes impacted on the improvement of the level of poverty and the health status of the nation. The RDP emphasised the need for affordable health through the introduction of primary healthcare services in order to improve and maintain the health status of the South African population (Seekoe, 1999: 10).

Primary healthcare services were emphasised and implemented as an essential element of healthcare as indicated by the World Health Organization (WHO, 1978:6) declaration at the Alma Ata conference. Health services were reconstructed in order to be accessible to everyone. Some were amalgamated; those serving whites only or blacks only were brought together and some were closed. Healthcare services were made free for all thus accommodating vulnerable groups such as children, pregnant women and geriatrics. Rural areas were particularly in need of health services; resources had to be redistributed. This meant that healthcare workers had to be retrained and encouraged to work in rural areas with the poorest of the poor communities. A policy has been developed by the Department of Health to pay a rural allowance to healthcare workers who agree to relocate (RDP, 1994:50).

However, change came with its own new challenges; the reconstruction of healthcare and the introduction of free healthcare services have brought a burden to healthcare workers. Post-apartheid South Africa, with a population of 40 million people, spends a large proportion of its GDP on health, more than most developing countries, yet it has poorer health than countries which spend considerably less (Abedian et al, 2000:3). High levels of illiteracy mean that people are uneducated; ignorance leads to healthcare problems as people do not have the knowledge or skill to take care of their health. Children in poverty situations are less likely to have seen a physician in the past year, less likely to have been vaccinated, more likely to be overweight and more likely to smoke. There is also a relationship between poverty and the higher incidence of cancer, asthma in children, mortality, coronary heart diseases, adolescent depression, teenage pregnancy, obesity and paediatric hospitalisation (Lustig and Strauss, 2007:194).

This is part of the legacy of apartheid. Public services are overcrowded with clients coming for free services. Healthcare professionals are confronted with long queues of clients on a daily basis and have limited resources to perform their duties; they are, therefore, overworked and underpaid. The salaries remain low which leaves professionals with no option but to migrate and to look for greener pastures in developed countries such as the United Kingdom, Australia and America (Nursing Update, 2006:10).

The issues of poverty are continually being addressed. The growing economy of the country is still a challenge. The inflation rate is rising on a daily basis. The RDP was criticised for not bringing economic growth and so a new economic policy has been introduced: Growth Economic and Redistribution (GEAR). The aim of this policy is to improve the economy, reduce the level of poverty, create employment and continue to ensure redistribution of resources. Fiscal and monetary policies emanated from GEAR in order to ensure economic growth and reduce poverty. The role of the fiscal policy is to ensure growth redistribution through distributing the national budget according to needs in order to improve the level of education, health status, social services and environmental health services. Through this policy poverty is being relieved by the provision of social grants to the HD and the poor (Fourie, 2000:170). Grants for maintenance are issued to children from birth up to 14 years of age, the aged receive old age pension grants. Disability grants are given to the disabled and those with certain diseases, including HIV/AIDS. The Government is now debating the issue of providing a Basic Income Grant (BIG) to all the unemployed poor members of the community.

The provision of free education is still debated, but higher education grants are given in the form of scholarships and student loans to increase the level of education. The government has established a commission which has the responsibility of taking care of the needs of the HD youth. The Umsobnvu youth fund aims to turn young people into entrepreneurs by training them to own and run their own businesses, helping to create employment and lower the rate of poverty. The Skills Development Act focuses on developing skills in HD communities through on the- job training to improve the problem of the skills shortage among black people. There is a programme of learnerships which benefits young people.

Under apartheid the education of black people was the lowest in quality; most of the young people completing grade 12 are now battling to enter higher education either because they cannot make the grades or because their parents are not able to pay. These young people are registered in learnership programmes which are run by private services who receive funding from the government. These programmes enable young people to develop skills for different sectors such as health, basic agriculture, finance, and tourism with a view to either opening their own small businesses or getting employment (Skills Development Act no 97 of 1998).

HIV/AIDS is a particular challenge. AIDS was responsible for 25% of all deaths and mortality from AIDS was 3.5 times higher than in other population groups in women aged 30–39 years (Fassin and Schneider, 2003:3; Whiteside and Sunter, 2000:50). Social inequities in income and employment status are predictors of HIV/AIDS infection. A low income is associated with greater exposure to risky sexual experiences, increased frequency of sexually transmitted infections and delayed or absent diagnosis and treatment. People living in poverty may be less concerned about their health and future because of the harshness of their situation. Children are at risk of being sexually molested by men because of the myth that having sex with a virgin will cure AIDS (Fassin and Schneider, 2003:3; Seekoe, 1999:80). These are all challenges for South Africa today.

Change continues to occur rapidly in South Africa, but history continues to show through the surface of present situations and events; the marks of apartheid are deeply inscribed in the bodies and minds of people who have lived under it. To alleviate poverty and promote health in developing countries such as South Africa, the economy must grow. It is important that the focus of South African policy makers is on human capital, natural economic growth in order to alleviate poverty and socioeconomic development which is sustainable. Economic growth that leads to the alleviation of poverty and the improvement of the health status of the population is fuelled by the creative and physical capabilities of its people.

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Transaction Sex among Urban Men in Sub-Saharan Africa: Implication for Sexually Transmitted Infections

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Abstract

Most of past studies on sexual behaviour focused on women as the instigator of risky sexual behaviour and their varying statuses were responsible for their involvement in the behaviour. The study investigated the transactional sexual behaviour as well as the determinants of the behaviour among men in the selected countries of Africa. Demographic and Health Survey data of Nigeria, Kenya, Lesotho and Zimbabwe were used in the study. The results revealed that in all the selected countries, the distribution of wealth status of the men indicates that most men were rich in all the selected countries, the highest proportion of men with higher education came from Nigeria. In Kenya, highest proportion of men had primary education; in Zimbabwe and Lesotho, highest proportions of the men had secondary education. In all the countries, Zimbabwe had the highest cases of transaction sex, followed by Nigeria, Kenya and Lesotho. Age, age at first sex, marital status and religion of the men significantly influenced transactional sex in Nigeria and Zimbabwe ($p < 0.05$) while their level of education only influenced transactional sex in Kenya ($p < 0.05$).

Keywords: *Sex, Urban men, Sub-saharan, Implication, Sexually transmitted infections*

Barriers and Facilitators of Insecticide Treated Nets Use among Under-Five Children in Nigeria

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Abstract

Despite massive and regular distribution of Insecticide-Treated Nets (ITN), malaria remains a major public health problem, posing a risk for 97% of the population, and accounting for 60% of outpatient hospital visits in Nigeria for the 'vulnerable' population (pregnant women and children <5years) as well as the 'non-vulnerable' population. Using a mixed method approach, this study models sleeping under ITN as a means of preventing childhood malaria. The factors that influence utilization of ITNs were examined using quantitative data from 2013 Nigeria DHS and qualitative data obtained from interviews with mothers of under-5 children. The results revealed thatITN utilization was influenced by misconceptions about ITN, preference for door and window nets, child's age, wealth index, religion, healthcare decision and marriage type. The study concludes that policy makers should focus on addressing misperceptions about ITNs and inclusion of window and door nets.

Keywords: *Barriers, Facilitators, Insecticide treated nets*

Note

Note