

Community leaders' perspectives on facilitators and inhibitors of health promotion among the youth in rural South Africa

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Abstract

Introduction: There are a number of factors that influence health promotion activities among the youth. This study sought to gain a comprehensive understanding of the facilitators and inhibitors of health promotion among the youth from the perspectives of community leaders in a rural setting in South Africa.

Methods: The study adopted an exploratory, descriptive and contextual qualitative approach involving community leaders in rural South Africa. Data saturation occurred after individual interviews with 21 participants. Data analysis employed the principles of content analysis.

Results: We found that facilitators of health promotion were access to education on the benefits of health promotion activities, efforts of organizations and community leaders/teachers, access to health care services and engaging in physical activities, and youth motivation and positive role modelling. The themes that described the inhibitors of health promotion were inadequate recreational and health facilities and health personnel, the impact of stringent religious doctrines, unemployment, social vices and poor parenting.

Conclusion: We concluded that there is the need to implement more engaging activities and opportunities for the youth and parents in rural communities to enhance health promotion.

1. Introduction

The youth is the future of every community and nation and their health issues are of importance to all community leaders, health professionals, educationists, non-governmental organizations, governments and other agencies across the globe. The youth constitute a significant percentage of the world's population. The youth is challenged with a lot of health problems such as substance abuse that lead to social and psychological instabilities (Fergusson, Boden, & Horwood, 2013). There are HIV infections and teenage pregnancies with complications due engagement in premarital unprotected sex and exposure to pornography (Bhuiya et al., 2017; Coetzee et al., 2014). Although there have been attempts to address these problems by several key stake-holders, the youth in many countries including South Africa continue to experience challenges that led some to attempt suicide (Acedański, 2016; Cluver, Orkin, Boyes, & Sherr, 2015; Marginean, 2014). The preventive aspect of the health of the youth is important to prevent life-threatening and chronic diseases (McCleary-Sills,

Douglas, Rwehumbiza, Hamisi, & Mabala, 2013; Runton & Hudak, 2016). Community leaders are key stakeholders who can effect changes perhaps, and thus knowing their perspectives could help guide a discussion about strategies in a way to deal with some of the challenges the youth encounter. Therefore in this study, we focused on factors that influence health promotion behaviours from the perspectives of adult community leaders in a rural community. We consider the youth or the young adult in this study to be those between the ages of 15–24 years.

Good health of the youth can be maintained through effective health promotion activities at home, at school and in the community (Bennett, Cunningham, & Johnston Molloy, 2016; Li, Huang, Zhang, & Li, 2016; McIsaac, Mumtaz, Veugelers, & Kirk, 2015; Seigart, Dietsch, & Parent, 2013; Ungar, 2011). Health promotion is the process of enabling people to increase control over their health and its determinants, and thereby improve their health (World Health Organization., 2005). It is known that effective parenting is important to ensure good health of young adults (Boudet et al., 2014; Guillén, Roth, Alfaro, & Fernández, 2015). The commitment to health promotion begins from childhood where the parent plays a significant role. Parents are responsible for nurturing, teaching, counselling and supporting their children emotionally so that they desire to engage in health promotion activities as they grow (Barn & Tan, 2015; Bartkowski & Xu, 2007; Ottoni-Wilhelm, Estell, & Perdue, 2014). Previous researchers have argued that effective parenting keeps young adults away from the streets and reduces their likelihood of engaging in social vices and being school drop-outs (Bettmann, Mortensen, & Akuoko, 2015; Guillén et al., 2015). Conversely, poor parenting can predispose the youth to activities such as involvement in behaviours leading to alcohol addiction and prostitution that could compromise their health (Forrest-Bank, Nicotera, Anthony, & Jenson, 2015; Guillén et al., 2015; Li, Garland, & Howard, 2014; Zhu, Zhang, Yu, & Bao, 2015).

The educational system and teachers also play important roles in health promotion of the youth. Researchers have pointed out that an effective educational system provides adequate curriculum content for various health issues and provide adequate extra-curricular activities that young adults could engage in after school (Bennett et al., 2016; Keshavarz, Nutbeam, Rowling, & Khavarpour, 2010; Pedro, 2015; Sua, 2012). The teachers who are dedicated to health promotion of the youth provide innovative opportunities for them to either educate or engage in activities that promote their health (Bartkowski & Xu, 2007; McIsaac et al., 2015; Sua, 2012). Such an effective engagement in school or after school could prevent lifestyles that can compromise their health (McIsaac et al., 2015). It is noted that an effective transport system in the community could enhance health promotion activities organized after school for students (Ha, Narendorf, Santa Maria, & Bezette-Flores, 2015; Ungar, 2011). Programmes in schools such as sports could be useful for the youth who desire a career in such areas to develop their skills further (Gritton, Kerr, & Moreno, 2016; McIsaac et al., 2015; Sua, 2012). Thus the school system should provide broad curriculum content so that young adults can choose the option they desire and not end up on the street (Sua, 2012).

Another major factor in health promotion among the youth is resources in the local community including hospitals, libraries, recreational facilities and social groups or clubs. Adequate hospital or clinic services in a community would ensure prompt treatment of ailments which would keep them healthy (Wang, Li, Liao, & Fang, 2016). Health facilities should be youth friendly with adequate privacy and flexible hours to enhance accessibility (Ha et al., 2015). The availability of recreational facilities promote healthy engagement of young adults and it helps prevent unhealthy practices that can predispose them to poor health (Bartkowski & Xu, 2007). In communities with library facilities and internet access, young adults access information on various health problems and healthy lifestyles (Nihill, Lubans, & Plotnikoff, 2013). Thus, the authors note that the youth should be guided in their access to the internet to avoid exposure and addiction to negative practices such as pornography. Active participation in clubs or social groups encourages healthy lifestyles because some groups benefit from health promotion activities and health education (Gritton et al., 2016).

Effective community leadership, mentorship, and employment opportunities contribute to health promotion among the youth (Ford et al., 2013). Effective leadership ensures that an enabling environment is created with adequate resources that would help in health promotion activities. The community leaders could implement policies and rules that discourage activities that compromise well-being. Leaders could seek the support of benevolent community members and organizations to sponsor youth programmes to enhance their participation (Chowdhury & Mukhopadhaya, 2012; Ottoni-Wilhelm et al., 2014). Effective mentorship programmes in the community contribute to the young adult's desire to become responsible community members in future and would therefore employ healthy practices that would promote their health (Bakar & McCann, 2015; Villa-Torres & Svanemyr, 2015). Availability of job opportunities for the youth and improved economic status of parents ensure that the needs of the youth are met. Unmet needs may contribute to indulgence in drug peddling and prostitution which could result in teenage pregnancy and its associated problems (Lee et al., 2015; Richardson, DeBeck, Feng, Kerr, & Wood, 2014).

Previous researchers have explored factors facilitating and inhibiting health promotion among the youth in many countries (Barn & Tan, 2015; Ungar, 2011). In South Africa, the youth aged 15–24 years forms 24% of the population and about 52.4% of them are unemployed in some municipalities (United Nation Population Fund[UNFPA] South Africa, 2017). Our literature search shows that there is inadequate exploration from the perspectives of adult community members in rural South African communities. Therefore the purpose of this study was to gain an in-depth understanding of the facilitators and barriers to health promotion of the youth from the perspectives of adults in a rural community in South Africa. This study is part of an ongoing multi-phased bigger study in rural South Africa and rural Missouri, United States of America (USA) that seeks to understand health promotion and leadership issues in the two settings and compare the differences in these two geographic contexts. Our findings would inform specific community-based interventions that could impact positively on the health of the youth.

2. Methods

2.1 Design

The study adopted an exploratory descriptive contextual qualitative approach to gain a detailed understanding of the facilitators and barriers of health promotion among the youth. The qualitative approach enables the researcher to probe and follow-up on emerging themes (de Vos, Strydom, Fouché, & Delpoort, 2011). In this study, community leaders provided an in-depth insight into their perspectives on health promotion among the youth.

2.2. Setting

The study was conducted in a rural community located in the Western Cape Province of South Africa. The community is over a hundred kilometres east of Cape Town in the Riviersonderend Mountains with a population of 5,663 according to the 2011 census. The racial composition of the people in the rural community comprises largely coloured people. The community has a public primary school and a high school. There is an office for Social Welfare Services Department and a facility for health services through a primary health care clinic. In the community, there is anecdotal evidence that the youth engage in alcohol and drug abuse. Small-scale subsistence farming or gardening is common among community members. There are four churches in the rural community and no Mosque.

2.3. Sampling and data collection procedure

Purposive sampling was used to recruit the participants. The inclusion criteria were participants who were rural community leaders with some interaction or responsibility with the youth or young adults such as teachers, health professionals, social workers, religious leaders, librarians etc. They should have lived in the rural community for at least three years and were at least 30 years of age. A community leader helped to identify and recruit community leaders for this study. Individual participants gave consent to be part of the study. Individual in-depth interviews were conducted with a semi-structured interview guide. One researcher (second author) did all the interviews in this study. Interviews were conducted in English. In cases where a participant spoke only Afrikaans, a translator was used during the interview. The interviewer asked open-ended questions that stimulated free expressions. Questions for this study was focused on factors that facilitated or hindered health promotion activities among the youth in the rural community such as ‘please tell me what you think enhance the health of the youth in this community’; what do you think affect the health of the youth negatively in this community?’. Probes were used to gain further elaboration on participants’ comments. Data were taped on an audio recorder. Data collection stopped when no new ideas were generated (saturation) (Patton, 2002). In this study, saturation was achieved with 21 participants. Field notes were taken on non-verbal behaviour of participants during interviews. A trained transcriptionist transcribed all the interviews and the transcripts were reviewed to ensure that the data represented the participants’ true perspectives.

2.4. Management of data and analysis

Two of the researchers read the transcripts separately to immerse themselves in the participants’ world focusing directly on factors that influenced health promotion activities and behaviour of the youth. The field notes were also used to validate the analysis process of

this study. Data analysis occurred concurrently with interviewing so that emerging themes could be fully developed. The principles of content analysis were applied in analysing the data generated (Miles & Hubermann, 1994). Two of the researchers independently coded the transcripts and the themes and sub-themes generated were discussed for consensus. Similar codes were grouped to form themes and sub-themes. The data were then exported to the NVivo 10 software and this was used to manage the data subsequently where aspects of the transcripts that related to facilitators and barriers of health promotion among the youth were sifted to the appropriate themes/sub-themes. Two main themes and five sub-themes were developed in the NVivo and these guided the sifting of the data. In the process of data sifting, the essence of the data was explored and discussed to ensure that findings were meaningful and addressed the objectives of the study. Extracts or verbatim quotes that best captured the fundamental nature of the themes and sub-themes were reported in the findings section.

2.5 Ethical considerations

Ethical approvals were obtained from the University of Missouri South African Education Programme (UMSAEP) Committee with the Deputy Vice-Chancellor of the University of Western Cape (UWC) (UMSAEP 27/5/2015). Only participants who consented in writing were included in the study. Participants were told they could withdraw from the study at any time. Anonymity was ensured by using identification codes on transcripts of participants. A research assistant and transcriber were trained on maintaining confidentiality during the research process. Interviews were conducted in a private room to ensure confidentiality and comfort, and the duration of the interviews were not longer than 30–45 min.

2.6 Trustworthiness

A number of strategies were employed to ensure the trustworthiness or rigour of this study. We ensured that only one researcher conducted all the interviews so that there was consistency in questioning and probing (Silverman, 2004). Concurrent analysis of the field notes and interviews enabled led to rich data categorised in themes. Thick descriptions of findings could assist in transferability to enable replication and application of findings to similar contexts. Independent coding between two of the researchers and discussion of themes and sub-themes ensured that discrepancies were resolved.

3. Results

3.1 Participants' demographic characteristics

There were 21 participants in this study aged between 33 and 81 years and 13 were females and 8 were males. They all spoke the indigenous Afrikaans language and among these, 19 spoke both Afrikaans and English. Sixteen participants had lived in the community for 15 years. Participants were mostly employed and in positions such as school principal, school administrators, clerks, church workers, librarians, health workers or social workers. Nine (n = 9) participants were married, eight (n = 8) were single and four (n = 4) were divorced and widowed. The number of children that participants had ranged between two to four in number, however, four of the participants were childless. All participants had some

form of formal education which included: grade school (n = 4), high school (n = 4), college education (n = 6) and graduate school (n = 7).

Table 1 gives a summary of themes and sub-themes identified in this study.

3.2. Facilitators of health promotion

This theme describes factors that enhanced health promotion among the youth in rural South Africa as perceived by adult community members. It was realized that access to health education on the benefits of health promotion activities, efforts of organizations and community leaders/teachers, access to health care services, engaging in physical activities that contribute to health promotion, and youth motivation and positive role modelling facilitated health promotion among the youth.

3.2.1. Access to health education

The youth acquired education on health promotion at the schools from their teachers who emphasized the need for healthy activities, joining youth groups and engaging in sports.

‘...I talk to them in class about doing healthy activities after school, getting involved in community activities, joining the youth group like the Red Cross Society’ (SA804/3).

‘...we encourage learners to take part in sports; ...an organization also teaches life skills’ (SA805/1).

Health promotion education was also delivered on the proper use of medication and sex education. Health workers, members of the Red Cross organization and student volunteers contributed in providing the education to the youth and the wider community.

‘...health workers come and talk to the people here on how to use the medications regularly; ...Red Cross comes to talk about sexual education; they have the UWC (University of Western Cape) students who work as volunteers’ (SA805/2); ‘In the school, we teach the youth how to be careful and do first aid and to be careful with blood which is a precaution for HIV/AIDS’ (SA804/2).

Participants were of the view that education of the youth should start early in life so that unhealthy indigenous practices will not be learned:

‘I think the education or empowerment should start at a young age. ... they need to understand the different phases of their menstruation. ... there may be a lot of indigenous knowledge that may not be good’ (615/4).

Table 1
Summary of the themes and subthemes.

Main theme	Sub themes
Facilitators of health promotion	<ol style="list-style-type: none"> 1. Access to Health Education 2. Efforts of organizations and community leaders/teachers 3. Access to Health care services 4. Engaging in physical activities 5. Youth motivation and positive role modelling
Inhibitors of Health Promotion	<ol style="list-style-type: none"> 1. Inadequate facilities and health personnel 2. The impact of stringent religious doctrines 3. Unemployment 4. Social vices and poor parenting

3.2.2 Efforts of organizations and community leaders/teachers

Several participants acknowledged the participation of some community members in spearheading efforts to address unmet needs in the community. A good example is the ‘Eye on the Child’ programme in which community members are trained as counsellors and to educate the youth on alcoholism:

‘...there are people in the community that are driving certain projects. ... Programmes like Eye on the Child ...the programmes are run with learners’ (SA805/1).

All four school administrators interviewed, reflected on the importance of vigilance in the school. Teachers, as well as administrators, were expected to observe and identify students at risk of poor health and refer them to social welfare services or the local clinic.

‘We identify the youth that has needs and we contact the social services especially for those who are neglected and we report it to the principal of the School and social services come in to help them’ (SA804/3); ‘some vulnerable youth and orphans are taken to foster care’ (SA615/4).

3.2.3 Access to health care services

The community of study had a clinic that took care of the health needs of the community members including the youth.

‘...we have the local clinic, where people can go with any illnesses. ... they can go there for psychiatric care (SA804/3); ‘...we have doctors, physiotherapists and occupational therapist at the clinic’ (SA804/2).

The clinic in the community has nurses who attend to the health needs of people even during non-working hours, beside the first aiders. In addition, ambulance services were used in major situations of ill health.

'...they have nurses that ...people will go to their homes if there is a major crisis and it's during the night, and the clinic is closed, people will go to them and ask them for help' (SA804/3).

'...we have first aid trained people in the community but we call the ambulance for anything major' (SA615/2).

3.2.4 Engaging in physical activities

Physical activities that promoted health among the youth included cycling, soccer, marble, softball, rugby, net ball and athletics. It was believed that when the youth are kept busy with sports instead of the street and the incidence of teenage pregnancy will reduce:

'We have a cycling club ...for some of the older youth' (SA615/2); '... our youth play soccer, marbles, we do a lot of educational play. ...they do the sport on the sporting field with other churches; ...it's like a local rugby and they've got net ball ...and athletics' (SA612/3).

'We started with softball for the ladies, because most of the ladies are sitting on the street, and if you can occupy them, you will to reduce teenage pregnancy' (SA805/1).

3.2.5 Youth motivation and positive role modelling

The youth in the rural community were motivated to undertake health promotion activities when they were in groups or clubs where they could learn from and witness positive role modelling of adults.

'...the youth also have the Charm Club where they take young girls, from the age of 12, 13 to help them become better citizens in their communities. ...We also have the Eco Club where the youth is involved. It's more about the environment; ... they plant fruits and vegetables and organic stuff and make eco bricks' (SA804/3).

The community electronic center (E-center) offered the youth opportunity to learn about health promotion and seek counselling on other issues. The youth worked in groups at the library and that could be more exciting for them than engaging in bad habits that could adversely affect their health.

'...we have our E-Center at the library and the youngsters who are not sure about a particular decision come to discuss their ideas and they receive some advice' (SA612/4). 'They work in groups and this can be like team work building or developing skills to communicate' (SA612/3).

3.3 Inhibitors of health promotion

This theme describes the factors that inhibited health promotion among the youth such as inadequate facilities and health personnel, impact of stringent religious doctrines, unemployment, social vices and poor parenting. These are described with participants' verbatim quotes.

3.3.1 Inadequate facilities and health personnel

The health promotion activities of the youth were inhibited through lack of recreational facilities in the community such as swimming pool, tennis court and a field for soccer.

'There are no facilities to keep the youth busy especially in the afternoon such as a swimming pool, a tennis court, a field where they can play soccer or rugby, ...the facilities will help keep them fit and occupy them' (SA805/1).

It was realized that the only clinic at the rural community was inadequate to provide both preventive and curative health needs of the youth. The nearest hospital was about 30 km away from this community where a public transportation system was non-existent.

'We do not have enough resources at the clinic to cater for the youth. When they are referred to bigger hospitals like the Red Cross hospital, they go through a lot of challenges' (SA612/2).

Psychologists and social workers were needed to promote the psychological health of the youth. The youth would be able to talk to these individuals when necessary.

'...we need psychologists. There is a school psychologist who comes three times a year but a regular psychologist would help because the youth has a lot of unresolved issues' (SA615/2).

'We need a permanent social worker who can motivate the kids and the kids can go to talk to him/her as necessary' (SA805/1).

There were situations where medications run out of stock and this could hinder health promotion of the youth when they required medications to maintain their health.

'...you go to the clinic and you ask for your medication, but it's not always available. You have to wait a week or two weeks, and in those two weeks, you don't have any medication to use' (SA805/2).

3.3.2 The impact of stringent religious doctrines

Some participants were of the view that health promotion was hindered by the doctrine of the church which did not allow the youth to freely express themselves about health problems. Also, the church did not incorporate health educational programmes into their activities.

‘...I find that perhaps the rigid kind of hold that the church might have stymied the process of allowing people to freely express what they think. So the ideas of young people at health forums might sound taboo’ (SA615/4)

‘...church programmes can be used to educate on HIV/AIDS, TB, and other things, but it is not so. Church members withhold themselves from talking about HIV/AIDS or sex or other things that can improve health’ 612/1).

3.3.3. Unemployment

It was reiterated that lack of employment or jobs in the rural community contributed to the youth engaging in practices that hindered their health such as alcoholism.

‘Most of our youth, because there is nothing in this community, most of them tend to use alcohol from Friday to Sunday’ (SA805/1); ‘...because of poverty and unemployment, people cannot afford basic medication. For example, young mothers have nutritional needs and I’m scared to think about how they cope their babies to thrive’ (SA805/1).

3.3.4. Social vices and poor parenting

Participants reported that health promotion of the youth was hindered by the sale and use of illicit drugs. Some of the youth engaged in premarital sex, pornography and other discreet activities where they got money to buy items such as camera phones.

‘I noticed that there’s the distribution of condoms, which means that young people are engaging in sexual activity. The youth have camera phones so may be engaging in activities unknown to their parents ...some send lurid pictures and make little movies of themselves engaging in sexual acts’ (SA615/4).

The participants thought that inadequate parental support or care contributed to poor health promotion among the youth. Some parents sent their sick youth to school instead of the hospital.

‘...the bigger concern for me is parental negligence. Parents don’t take their children or youth to the clinic but rather send them to school. Parents neglect their children because they don’t have the responsibility as parents anymore, they don’t have time for their children’ (SA804/4).

4. Discussion

This study used the qualitative approach to gain a comprehensive insight into the factors that enhance or hinder health promotion among the youth in a rural community. Through individual interviews, facilitators of health promotion such as: access to health education, efforts of organizations and community leaders, access to health care services, engaging in physical activities and motivation of the youth and positive role modelling were identified. Also, the barriers to effective health promotion among the youth included inadequate facilities and personnel, the impact of religious doctrines, unemployment, poor parenting

and social vices. Most of these findings are consistent with findings from other contexts which presupposes that the youth in many contexts are exposed to similar factors that predispose them to health problems.

We found that health education on a number of health promotion activities including healthy behaviour could provide the right information for young adults to engage in healthy lifestyle activities. This finding is consistent with other studies (Jolley, 2014). The health education was undertaken by teachers, volunteers, health workers, non-governmental organizations and some youth members of the local community (Bennett et al., 2016; Zabaleta-del-Olmo et al., 2015; Zeldin et al., 2011). It was emphasized that early education of young adults could limit adoption of unhealthy lifestyles and indigenous misconceptions that may predispose them to diseases (Bennett et al., 2016). Health education programmes should continue and innovative ways should be adopted to ensure that the youth actively participate in these programmes and also practice what they learn from these programmes. Programme implementers should develop monitoring and evaluation processes that could confirm the impact of health education programmes. Innovative educational programmes could attract the youth to stay in school rather than be absent or drop out of school (McIsaac et al., 2015; Pedro, 2015).

In addition to the health education programmes, community leaders and teachers in the context of this study involved the youth in a number programmes such as gardening that could provide fresh vegetables for feeding the youth and improve their nutritional status. Participants perceived that teachers were often vigilant to identify children at risk of health challenges and referred them for treatment. This pre-supposes that some parents do not take good care of their children (Ottoni-Wilhelm et al., 2014). Education on first aid and adequate provision of health services should be enhanced so that parents could access health care for their sick child/youth (De Buck et al., 2015). Home care services and care provided by nurses and other volunteers beyond office hours are necessary for emergency health services within a community (Suurmond, Rosenmüller, el Mesbahi, Lamkaddem, & Essink-Bot, 2016). To ensure effective health services, there should be adequate supply of commodities (Akpabio, 2006). Health services in rural communities were supported by professionals/specialists from more resourced communities. It demands that access roads to these rural communities should be improved to facilitate these services (Nelson et al., 2015). The continued delivery of specialist services at rural communities demand commitment and effective collaboration from the community leaders. There is also the need for all health services targeted at the youth to be organized such that there is privacy and confidentiality as well as access to these services at their convenience (Ha et al., 2015). It implies that extra effort is required for a rural community for this assurance especially in issues of reproductive health services (Corbie-Smith et al., 2010).

Provision of facilities for engaging in physical activities is an important component of health promotion for the youth. The youth have increased energy and drive for various activities including those that put them at risk such as early sex (McCleary-Sills et al., 2013; Ulloa, Dyson, & Wynes, 2012). Their engagement in physical activities could keep

them in healthy activities such as games (Bartkowski & Xu, 2007). The lack of such facilities could result in streetism and drug addiction which can lead to psychiatric abnormalities (Richardson et al., 2014). The ill-effects of streetism on the youth could in the long term negatively affect the community and the nation (Bender, Yang, Ferguson, & Thompson, 2015). The youth with a physical, psychological, social and spiritual defect may not be able to function optimally in adulthood (Menear, Preskitt, Goldfarb, & Menachemi, 2015). It is therefore of concern to the authors if the youth in the local churches would not engage actively in all health promotion activities such as education on HIV/AIDS. It is noted that the church provides the right environment and access to the youth for various educational programmes elsewhere (Bettmann et al., 2015).

The study included only 21 adult community members and their views may not be representative of all the members of the rural community. We however recruited participants from different backgrounds in the community. In qualitative research, the aim is not to generalize the findings but the findings can be applied to similar contexts. Future studies could adopt the quantitative approach to triangulate findings. A limitation of our study is that we did not include the youth. Thus, the views of the youth on health promotion can be explored in future studies. The researchers are undertaking a quantitative study among the youth to follow-up on key findings from this study.

5. Conclusion

The findings of this study indicate that health promotion among the youth is situated in a complex of facilitators and barriers that impact each other. For example, poor parenting affects use of health services, school attendance and the involvement of the youth in health promotion activities in the rural community. It means that efforts to enhance health promotion among the youth should consider a multi-dimensional approach that is context appropriate to achieve a good outcome. Community leaders should not relent in their efforts to help the young adults undertake different health promotion activities since it is not only the physical health that can be impaired. Therefore, efforts should be made to acquire the necessary resources to facilitate health promotion among the youth.

Declaration of conflicting interests

The authors declare that they have no competing interests.

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