Over the last 20 years there has been a significant acceleration in the development of health promotion in Africa. This development has now acquired a steady pace and the use of health promotion as a means for increasing societal responsibility for health now exists in all African countries. The combined use of diverse approaches to health promotion programmes is becoming the norm rather than the exception, and use of the term ‘health promotion’ per se is increasing. The development of health promotion can be seen, for example, in the comprehensive actions aimed at addressing the underlying causes of health problems, in the large number of professionals both inside and outside the health sector who describe themselves as practitioners, through professional associations which in one way or another include health promotion in describing their work, and by the review and adjustment of structures and policies in health systems to accommodate these developments.

The emerging ‘brand’ bears features that are unique to Africa, but also has some that are common to health promotion globally. The major distinguishing features include the incorporation of cultural and spiritual factors, emphasis on the community, and emphasis on health promotion as a set of tools rather than as a process. The last dimension implies that imparting information and skills is the key strategic option. Together, these features reflect the specific socio-economic and political environments within which the development of the field is occurring in the region.

The community, defined socially as well as spatially, still remains the hub of development action in Africa. The low level of education justifies an emphasis on dissemination of knowledge. The increasing amount of attention being paid to poverty alleviation has necessitated the involvement of non-health professionals in health promotion as an avenue towards reducing poverty. Advocacy for health through lobbying and activism, as with legislative action, has obvious political overtones. They are therefore not widely used in health action, thus reflecting the limited pace of democratization and limited political space in some countries. Two of the global features of health promotion, however, are present: lack of coherent theory and slow professionalization within the field. While these features are not the subject of this editorial, their influence and impact on health promotion programmes is discernable in the following discussion.

Empowerment for health action, primarily through the sharing of health information, has been a key strategy in health promotion in the region for a long time. When the majority of African countries started gaining independence from colonial rule in the 1960s, ignorance was identified as a key obstacle to health development. The reasoning behind this was that people did not engage in health behaviour due to ignorance. This view was part of the public health model of health development, which was fashionable in official health systems throughout the region at that time. Its adoption by many countries in the region led to widescale public information interventions aimed at providing information on the causes of specific diseases and conditions so as to facilitate prevention and control. Such dissemination of knowledge was justified on account of the low levels of formal education among the majority of the population. This strategy was usually spearheaded by official health systems and is still the predominant approach in many countries of the region.

Over the years, ministries of health have developed organizational units of communication or health education to address common problems such as malnutrition, communicable diseases, high fertility rates, poor water and sanitation, and low levels of immunization. In Anglophone countries, health education is the most common approach used by ministries of health, while in
most Francophone countries, information, education and communication (IEC) is the predominant approach. The level of personal hygiene has improved over the years and there is some evidence to show that the level of awareness and knowledge about health on the continent has increased significantly during the last four decades. Unfortunately, the health information imparted is not in most cases coupled with the necessary skills development, resulting in only limited behavioural change. The health behaviour movements so popular in other parts of the world have not really ‘taken root’ in Africa (African Medical and Research Foundation, 1997).

Since the 1980s, poverty, low levels of education, poor leadership, and man-made as well as natural disasters have been recognized as factors in health development. This recognition has been enhanced by the HIV/AIDS pandemic, substance abuse, especially among young people, and the many diseases and disabilities closely connected to these factors. Through self-help initiatives and income-generating activities in particular, communities are contributing to the construction of health facilities, improved food production and nutrition, protection of water sources/building of potable water systems and related developments. In some countries, policies and laws that facilitate prevention of disease and adoption of healthy lifestyles have been put in place. Legislation on tobacco and alcohol, and policies for youth-friendly services are examples of this. Integrated adolescent health programmes are now being planned and implemented with the participation of the health and other sectors. Non-government organizations (NGOs) and communities themselves are driving this second strategy, which emphasizes the process of enabling people to take control over their health through partnerships, networks, alliances and multicultural collaboration (African Medical and Research Foundation, 2000).

Advocacy for health as a strategy for health promotion is not well established within the health sector in Africa. Advocacy approaches have been used in response to disabilities caused by war, and in the anti-female-circumcision movement. Recently, the use of this strategy in anti-tobacco action has become visible in some countries. The reason for the limited use of advocacy-related methods stems from the fear governments have about possible spillover into the political arena. At the moment, therefore, it is only some international NGOs, bilateral agencies, a few development agencies and even fewer politicians that spearhead most of the advocacy for increased investment in, and for, health. This situation is likely to change with increasing democratization and related regional development initiatives that encourage more open societies. The recent adoption of a regional health promotion strategy by World Health Organization (WHO) member states in the region provides an opportunity for countries to use advocacy more widely in health development. The strategy document suggests the use of advocacy, among other methods, to effect comprehensive health promotion action (WHO, 2001).

On the basis of these advances, it can be argued that the foundations for health promotion are well in place in Africa. In order for the grand finale of this development to be reached, however, a number of challenges still need to be addressed. Addressing such challenges requires the cooperation of health promotion practitioners and a wide range of other actors, in particular researchers, development workers and the relevant global professional institutions such as the WHO. The remainder of this editorial discusses these challenges further.

The most visible challenge for health promotion development in Africa arises from the fact that the majority of programmes and activities are in most cases planned, managed and controlled exclusively by professionals, especially from within the health sector. The main actors are specialists whose concept of health is based on the public health model and whose focus is on interventions revolving around curative services. Ordinary people usually participate only passively in the health promotion process. To some extent, countries such as South Africa, Mauritius, Uganda, Guinea and Niger are adopting broad concepts of health that encourage the involvement of players from education, justice, industry and politics. A good example is South Africa, where a diverse set of players has contributed to recent advances in anti-tobacco legislation and policies.

While some commendable collaborative work involving diverse disciplines is reflected in some of the articles in this issue of *Health Promotion International*, on the whole there is only limited cooperation among potential players in health promotion in Africa. In fact, there exists an undeclared ‘war’ for supremacy among different practitioners. While there seems to be consensus that health education practitioners are the protagonists of this ‘war’, medical doctors, nurses,
and professionals from areas such as social mobilization, behaviour change communication and social marketing are jostling for niches in a complex pecking order. The jostling is manifested in limited collaboration and sometimes fierce competition for resources within health systems. It is important for the protagonists to accept the reason why each of the disciplines and methods has a role to play in health promotion. Furthermore, circumstances ‘on the ground’ should dictate which discipline/method is appropriate. National health promotion policies that emphasize health outcomes and not merely inputs may pour oil upon these troubled waters. But all those involved in health promotion need to collaborate more so as to strengthen the impact of programmes.

Lack of indicators for measuring health promotion effectiveness is another challenge in the development of health promotion in Africa. It must be stated, however, that this challenge is not limited to the continent alone; lack of such indicators is also a problem globally. Professionalization of the field has also been quite slow in the region, but again this is very much a global issue. Academic institutions in Africa and elsewhere need to take up this challenge to facilitate a fuller development of the field. There is a need for health promotion researchers to team up with epidemiologists, statisticians and other health systems researchers to agree a minimum set of indicators for health promotion.

Closely related to the lack of indicators is the limited research and documentation on health promotion best practice. There is still little evidence to justify specific strategy choices in health promotion programmes. Such evidence could be derived from effective process evaluation and documentation. The conventional argument for limited documentation is lack of funding. We submit that even within existing budgetary limitations, programmes can incorporate process documentation in health promotion so as to facilitate experience sharing. Such documentation can also be realized with more operational research-based interventions.

In conclusion then, while Africa made her entry into the world of health promotion belatedly, a firm foundation for further development is now well in place. To accelerate the development further, there is need for clear, full elaboration of the theoretical bases of health promotion and the laying of clear plans for professionalization of practitioners. Action on both issues requires both regional as well as global support.

David Nyamwaya
Regional Editor for Africa

REFERENCES
