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Health Promotion and Its Challenges to Public Health Delivery System in Africa

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Abstract

The chapter examines the place and role of health promotion in the drive for sustainable and effective public health delivery in Africa. It conceptualizes health promotion from a multifaceted and multi-professional perspective hinged on the empowerment of communities and individuals to play active roles and adopt behaviour consistent with the goals of good health. The paper drawing on documentary data sees health promotion as critical to the achievement of health goals in the continent and equally reflects on the theories of health promotion, strategies for health promotion and challenges to health promotion in Africa. It argues that health promotion in the continent can be strengthened through such measures as appropriate legislations, robust funding, gender inclusiveness, stepping up research, regular needs assessment and evaluation, setting needs-driven priorities and building capacity of health promotion to target vulnerable and marginal members of the society, among others.

Keywords: health promotion, public health, challenges, Africa, health education, theories

1. Introduction: conceptualizing health promotion

According to Tannahill [1], health promotion is an umbrella term covering overlapping fields of health education, prevention and attempts to protect public health through social engineering, legislations, fiscal measures and institutional policies which entail the combination of the best in terms of both theory and practice from a wide range of expert groups (educationists, behavioral scientists, medical practitioners) and non-professionals including the communities involved. For him, health promotion stems largely from a new focus for health services that recognize some basic facts: many contemporary health problems are preventable or avoidable through lifestyle change; modern technology is a bundle of mixed blessings bringing both benefits and risks to health; medical technology is at the phase of diminishing returns (losing efficacy and connection to ordinary people); such non-medical factors as better nutrition, improved living conditions and public health measures have contributed to both health and longevity even more than medical measures; that doctors can cause as well as cure disease; and increasing public desire to attain better or improved quality of life and at the same time demystifying and demedicalising the attainment (achievement) of good health [1].

For the World Health Organization (WHO), health promotion is essentially about engendering a context in which the health and well-being of whole populations or groups are owned mainly by the people concerned, i.e., enabling citizens of local communities to achieve political control and determination of their health [2, 3]. Therefore, health promotion goes beyond mere healthcare but puts health on the policymaking agenda in all sectors and at all levels, directing policymakers to be cognisant or conscious of the health consequences of their decisions and accept responsibilities for health.

Health promotion can be seen as the whole process of enabling or empowering people to increase control over and improve their overall health. It focuses on creating awareness of health issues, engendering behaviour modification consistent with prevention and attitudes to ill health and motivating increased usage of available health facilities. In the pursuit of good health (physical, mental and social well-being), individuals and groups through health promotion are enabled to identify and realize aspirations, satisfy needs and change or cope with the environment in manners consistent with complete good health.

Health promotion is expected to contribute to programme impact by enabling prevention of disease, reduction of the risk factors or behaviors associated with given diseases, promoting and fostering lifestyles and conditions that are conducive to good health and enabling increasing use of available health facilities. Therefore, health promotion creates both the awareness and conscientisation that leads to disease prevention, control of health situations and usage of health services and facilities. It implies individual and collective control and participation in health focusing on behavioral change, socio-economic lifestyles and the physical environment.

Without doubt the WHO's Ottawa Charter definition of health promotion is very comprehensive and encompasses the core values and guiding objectives of health promotions [3]. It summarily sees health promotion as the process of enabling people to increase control over and improve their health. In line with the above definition, Macdonald and Davies [4] contend that it calls attention to the critical role of the concepts of process and control as the real essence of health promotion. For them, "the key concepts in this definition are 'process' and 'control', and therefore effectiveness and quality assurance in health promotion must focus on enablement and empowerment. If the activity under consideration is not enabling and empowering it is not health promotion" [4], p. 6.

As the burgeoning literature on health promotion over the years indicate it is a community-driven (inspired), multifaceted and multidisciplinary area of concern that also involves critical sociopolitical, economic and environmental elements and dynamics (see [4, 5–10]).

It is important to also understand that even though one can make a distinction between public health and health promotion, in reality both are interconnected and hardly practically separable. In other words, public health is built on health promotion and health promotion is imperative for public health delivery. As has been argued, public health "is synonymous with health promotion in that it aims to implement co-ordinated community action to produce a healthier society" [11], p. 315.

There is no gainsaying the fact that health promotion nowadays has an overwhelming sociopolitical component that is really definitive. In fact, as has been posited, "health promotion activities are by their nature inherently politically based and driven, thus making it impossible to divorce them from the political arena" [11], p. 314. Health promotion becomes a dynamic area of interface between public policy institutions (the state and its agencies), the public (community/people) and the professionals (ranging from the media professionals, public health advocates, social workers to medical practitioners).

The chapter depended on the desk review of extant literature and documents for its information. The main exclusionary criteria in this regard were materials not related to health promotion and materials published before 1984, which were considered extreme-dated. The inclusive criteria were determined by such concepts as public health, public health in Africa, health promotion, health education and awareness and theories and models in health promotion. Such prominent Internet information sites like the WHO, American Public Health Association (APHA), Health Resources and Services Administration (HRSA) and the Universitats Bibliothek Leipzig (UBL) Online Resources were utilized in gathering materials for the chapter.

2. Theories and models of health promotion

There is no gainsaying the fact that effective and result-oriented health promotion practice depends on sound theory [12]. In other words, theory becomes very informative of health promotion practice and activities. In recognition of the above, one would examine briefly the main theories that have implicated health promotion globally. It is important, however, to state here that the choice of a theory or model to guide health promotion should be determined largely by the specific nature of the health issue being addressed, the community or population in view and the sociopolitical context in question. This is because theories and models are simply used in practice in order to plan health programmes, explain and understand health behaviour as well as underpin the identification of appropriate intervention and implement such intervention in ways that are both effective and sustainable.

Despite a plethora of theories and models utilized in health promotion, I will only focus on five of the most popular and commonly used. These are ecological models of health promotion, the Health Belief Model (HBM), Stages of Change Model or the Trans-theoretical Model, Theory of Reasoned Action or Planned Behaviour and the Social Cognitive Theory.

2.1 The ecological models of health promotion

As the name implies, these models focus on the interaction of people with their physical and sociocultural environments. The approach thus recognizes that there are multiple levels of influence on health and health behaviour especially the health seeking behaviour and choices that people make. The ecological models are anchored on five overriding influences which determine and guide health behaviour and response to health issues [13–16]. These influences are intrapersonal or individual factors (these impact on individual behaviour, e.g., beliefs, knowledge, attitude, etc.); interpersonal factors (these are produced through living with and interacting with other people, e.g., family, friends and social groups/networks; these other people can function as both the source of solidarity and support as well as sources of barriers and constraints to health-promoting behaviour of the individual, e.g., dwelling among chronic smokers or having intense interaction with them may expose one to the dangers of either smoking or the influence of second-hand smoke); community factors (these make reference to social norms that are shared by groups or communities, and such norms whether formal or informal can influence health behaviour and health seeking behaviour of the individual and group members, e.g., relationship between institutions, groups and organizations); institutional factors (policies, rules, regulations and institutional structures that may constrain or even promote healthy behaviour in a given society, e.g., the workplace and voluntary organizations to which the individual belongs are prime examples); public policy factors (policies at different level of governance that regulate, structure or support
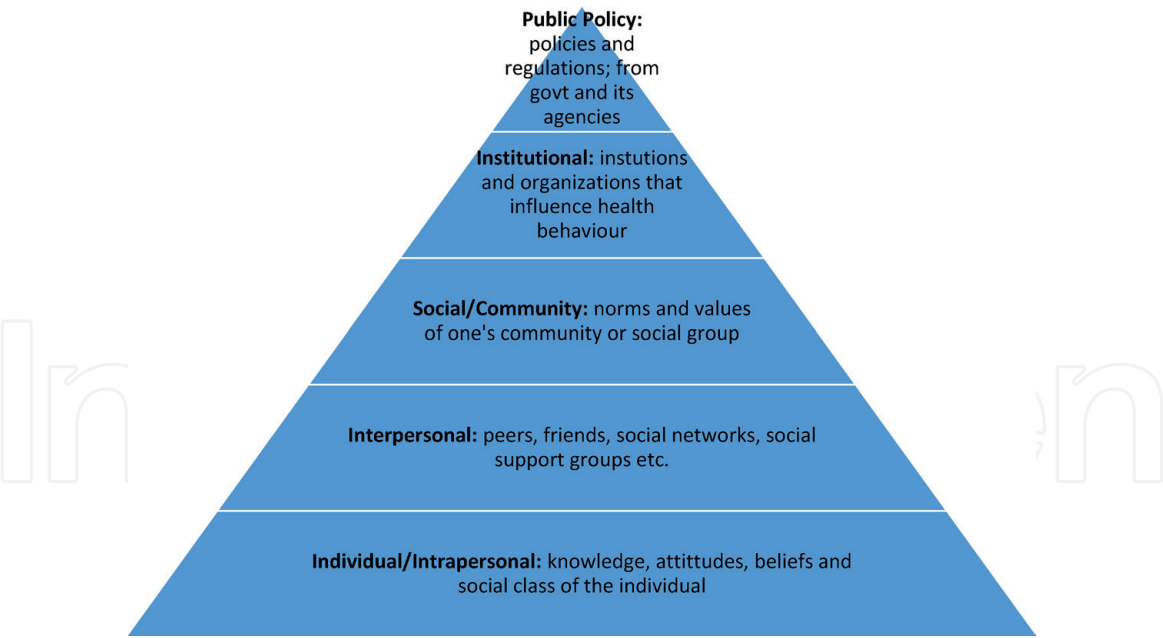
Figure 1.
Ecological models of health promotion (simplified).

actions and practices targeted at health outcomes like disease prevention policies and structures enabling early detection, control or response and management of health crisis in the society; these stem from the position of the government and are critical in achieving the goals of public health delivery) (**Figure 1**).

As the above pyramid, suggests the individual, interpersonal and community factors are at the base. These factors therefore exert more influence and pressure over the individual's health behaviour than the institutional and public policy factors as these are more important. In other words, the institutional and public policy factors are literally far from the individual and do not exert as much pressure on his behaviour as those factors that are very close to him both spatially and otherwise. In an age of increasing pessimism in government, people are much driven by interpersonal and community factors than what comes from a typical further off entity.

Given the above, it is obvious that the ecological approach is very pertinent in the understanding of the range of factors that influence people's health. Its main strength is that it can provide what is called a complete perspective on factors that affect health behaviour and response to health issues especially the role of social and cultural factors or normative patterns on health in the society. It is perhaps very well suited to health intervention and practice in developing societies with an overbearing influence of sociocultural factors on behaviour, attitudes and practice of the people.

2.2 The health belief model (HBM)

This is a theoretical model that has been found useful in guiding both health promotion and strategies for disease prevention. As the name suggests, it focuses on individual beliefs about specific health conditions which predict or direct individual health behaviour [17, 18]. The specific components of this belief that influence health behaviour include perceived susceptibility to the disease; perceived severity of the disease in question; perceived benefits of action (positive benefits of such action) as well as cues to action (awareness of factors that engender action); self-efficacy (belief that action would lead to success); and perceived barriers or obstacles to action (especially if such obstacles are seen as daunting or insurmountable or otherwise).
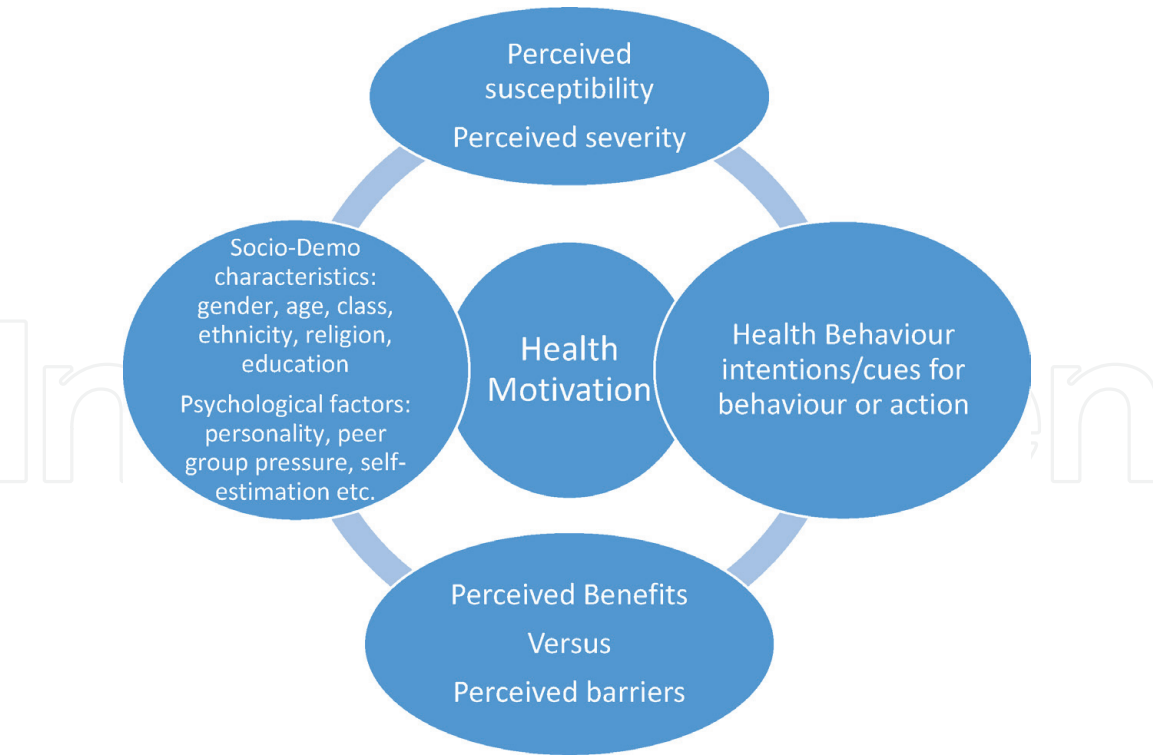
Figure 2.
Health belief model (HBM).

In the utilization of the HBM in health promotion, there are five main action-related segments that would help in identifying key decision-making points and thus facilitate the utilization of knowledge in guiding health intervention. These are: collection of information (through needs assessments; rapid rural appraisal, etc. in order to determine those at risk of the disease or affliction and specify which population or component of the population to be targeted in the intervention); conveying in unambiguous and clear terms the likely consequences of the health issue in question and its associated risk behaviors in order to facilitate a clear apprehension of its severity; communication (getting information to the target population on the recommended steps to take and the perceived or likely benefits of the recommended action); provision of needed assistance (help the people in both the identification of and reduction of barriers or constraints to action); and demonstration (actions and activities that enable skill development and support aimed at enhancing self-efficacy and increased chances of successful behaviour modification targeted at the health issue in question) (**Figure 2**).

In Africa, the HBM has been very useful in understanding people's response and behaviour to HIV/AIDS and other chronic diseases. Being a society very flushed with beliefs, the degree of responsiveness to a health situation is often the direct product of a set of beliefs held by the individual and/or by his immediate community.

2.3 Stages of change model (aka trans-theoretical model)

This model is focused on examining and explaining the individual's readiness to change his behaviour and sees such change as occurring or happening in successive stages. It therefore adopts a quasi-evolutionary framing of behaviour change in which behaviour change, sustenance and termination are encompassed in six stages. These stages are pre-contemplation (existence of no intention to take any action by the individual); contemplation (thinking about taking action and ruminating on

plans to do this soon); preparation (signifies intention to take action and includes the possibility that some steps or preliminary steps to action have been taken already); action (discernible change in behaviour for a brief period of time); maintenance (sustenance of the action taken; behaviour change that is maintained in the long run or long-term behaviour change); and termination (the expressed and discernible desire never to return to prior negative behaviour by the individual concerned).

The above stages are very important in planning behaviour change or modification and recognize that behaviour change is both gradual and takes time. What is needed from the health promoter is that at each of these stages specific interventions or programmes are devised to help the individual progress to the next stage. Also, the recognition that the model may in reality be cyclical rather than lineal, i.e., individuals may progress to the next stage or even regress to previous or lower stages, is important in planning health promotion interventions utilizing this model. It also calls attention to understanding that there are individual differences in the adoption of change, i.e., some people may be swift in behaviour modification, while others may take longer time; but each needs support in order to pull through.

2.4 Theory of reasoned action (theory of planned action)

The main contention of this theory is that an individual's health behaviour is usually determined by his intention to exhibit or display a given behaviour. Therefore, the intention to exhibit a given behaviour (or behaviour intention) is predicated upon or predicted by two main factors, viz. personal attitude to the behaviour in question and subjective or personal norms (an individual's social and environmental context and the perception the individual has over that behaviour) related to that behaviour.

The basic assumption here is that both positive attitudes and positive subjective norms will generate greater perceived control of behaviour and increase the chances of intentions towards changes in behaviour. The theory generally provides information that can be used in predicting people's health behaviour and thus in planning and driving through health interventions. It anchors in recognizing the predictors of behaviour-oriented action and the need for supportive social and environmental contexts that facilitate and sustain desirable health behaviour.

2.5 The social cognitive theory (SCT)

This theory combines both the cognition of the individual and the social context of the individual in offering explanation and understanding of health behaviour and response. It seeks to describe the influence of the experience of the individual, his perception of the actions of other people near him and the factors in the person's immediate environment on health behaviour of the individual. It moves from this general perspective to provide opportunities for social support (defined as conducive to healthy behaviour) and reinforcements that generate behaviour change or modification. In this sense, the SCT depends on the idea of *reciprocal determinism* which denotes the continuing or uninterrupted interaction among the person's characteristics, his behaviour and the social context or environment in which the behaviour takes place.

However, the best way to appreciate the SCT is to examine the main components the theory isolates as related to behaviour change at the individual level. These are self-efficacy (belief in one's ability to control and execute behaviour within a given context); behaviour capability (thorough comprehension of behaviour and the ability to exhibit or perform it); expectations (outcomes or outputs of the behaviour change in question); expectancies (the assignation of value to the above outcome of behaviour
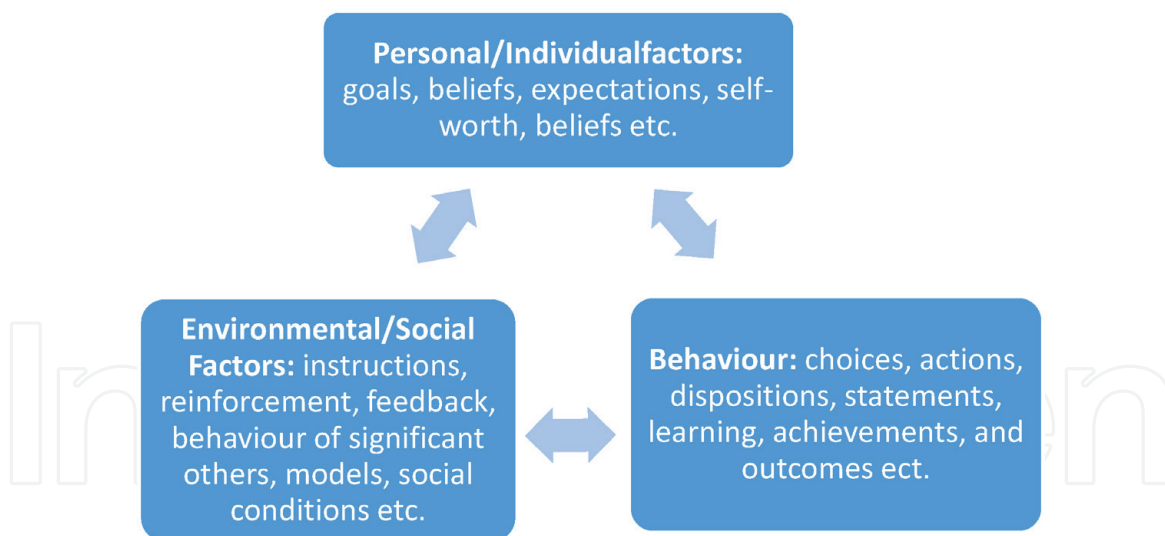
Figure 3.
Illustration of the social cognitive theory (SCT).

and which is important in sustaining the behaviour); self- control (the regulation and monitoring of behaviour of the individual); observational learning (the act of watching others performing the desired behaviour and the outcomes therein as well as modeling that behaviour in question); and reinforcements (incentives and rewards seen as eliciting, encouraging and sustaining behaviour change in the individual) [19].

The three components as the above diagram shows reinforce each other and in the process condition and determine behaviour of the individual even in the context of health as well as choices made therein (**Figure 3**). The SCT is very pertinent in contexts where desirable health outcomes can be achieved by behaviour modification or change. For instance, certain chronic diseases or health conditions can be tackled through healthy lifestyles and dieting that reduce risk factors and chances of individuals succumbing to such conditions. Therefore, the theory can help frame intervention programmes in this area that focus on changing people's behaviour and in the process achieve desirable health outcomes.

Theories and perspectives or models as already indicated are critical in providing explanations of a problem or issue (broadening our understanding and perspective as it were) and also very important in the effort to tackle a given problem or issue in the society especially by way of developing and implementing programmes and interventions. Perhaps, the above underscores why some scholars [20–22] would highlight the difference between the so-called theories of the problem and theories of action, meaning that while the former aids our apprehension of a given issue or social reality, the latter is important in terms of taking actions or evolving activities to tackle the issue in question.

3. Health promotion as sociopolitical engagement

Health promotion generally implicates a huge element of politics and power dynamics in the sense that only political will and cognition can build discernible changes in health. Lobbying and advocacy are critical tools of health promotion and function within the political arena. The sociopolitical contexts and influences are especially recognizable in the public health sector in the developing world where political will and doggedness are often necessary to drive through even the most salutary change or innovation in the health sector. Also, political forces are equally dominant in the provision of crucial health infrastructure and facilities as

well as the reasonable funding demanded by any effective public health system. As Harrison opines health promotion "requires concerted, sophisticated and integrated political action to bring about change and requires professionals concerned with public health to engage with the politics of systems and organizations" [5], 165.

Therefore, health promotion seeks to empower and transform communities by getting them involved in activities that influence public health especially through agenda setting, lobbying and advocacy, consciousness raising and social education [11, 22]. All these are accomplished on terms that are either defined or strictly affected by the socio-economic realities of the people themselves. By its emphasis on the community, health promotion has a heavy sociological frame that prioritizes the values of society as well as mobilization and solidarity in the quest for good and sustainable health. It thus makes assumption that individual members of the society would give equal weight to their own health and the health of their neighbors. In other words, it is often anchored on the uncanny assumption that the health of the individual member of a given society is intertwined with the health of the community as a collective. This means the reference point of health promotion is that one's health is as good as the health of the members of the community or society as a whole, i.e., common health destiny. Therefore, such things as community empowerment, community competence and overwhelming sense of community are all apprehended as contributing to the health of the communities [23].

4. Approaches to health promotion

Traditionally there are five approaches utilized in health promotion. These are medical (the focus here is to make people free from medically defined diseases and afflictions; it is mainly anchored on prevention strategies and the role of the medical practitioner or expert in ensuring that the patients comply with recommendations); behavioural change (behaviour modification approach that recognizes that people's behaviour and lifestyles can be changed in order to enable them attain good health, i.e., facilitate adoption of healthy lifestyle); educational (provision of information and knowledge that enable understanding of health issues and build awareness for informed decision-making and choice among people); client-centred (in this situation health practitioners work with clients in order to identify what they know about a given disease and take appropriate action; emphasis on perceiving the client as equal and building the clients self-empowerment that enable them make good choices and control their health outcomes); and societal change (the focus here is on the society or community rather than the individual and seeks to change or modify both the physical and social environments in order to make them consistent with or conducive to good health).

The conventional health promotion methods (modes of operationalizing health promotion and achieving its goals) include health education (the conscious and systematic effort at providing education or knowledge to people on particular and general aspects of health; it is about enabling people through proper and right knowledge on what to do and how to do it; it is empowering and improving people's capacity to act with regard to their health issues and conditions), information, communication (the above three are often captured in the popular acronym IEC), social mobilization, mediation, community theater and advocacy and lobbying. However, while these methods are okay in differing contexts, a decision on the specific medium to use should be guided by both environment (community conditions) and the nature of the health issue involved. The use of more than one method in any given case is highly recommended especially in Africa where there are broad inequalities in access to social goods and the media. The increasing use of social

media especially among young Africans calls attention to their deployment equally in core health promotion. Social media platforms like WhatsApp and blogs can be very potent in this regard.

5. Health promotion research in Africa

There is an undeniable need to give high priority to health promotion research in Africa. Such research should aim at enabling a realistic and focused achievement of the goals of health promotion. Broadly, health promotion aims inter alia at:

- The prevention of communicable and non-communicable diseases

- The reduction of risk factors associated with diseases

- The fostering of lifestyles and conditions in the general population that are consistent with overall well-being or good health

- The effective/maximal utilization of existing health services and stimulating demand for others where/when necessary

According to the WHO [24] Health Promotion Strategy for the African Region, the contributions of health promotion to the achievement of health objectives include increasing individual knowledge and skills especially through IEC; strengthening community action through the use of social mobilization; enabling the emergence of environments supportive and protective of health by making optimal use of mediation and negotiation; enabling the development of public policies, legislation and fiscal controls which enhance and support health and overall development using advocacy and lobbying; and making prevention and consumer needs the core focus of health services delivery. All these can be positively influenced by research and studies which evaluate the effectiveness of what has been done as well as explore new strategies suitable to the socio-environmental context in question.

However, while research is very critical to achieving the goals of health promotion, it should be concise and focus essentially on the priority health programmes which have been identified by the WHO for the continent. Some of such programmes include the Global Fund for Malaria, HIV/AIDS and Tuberculosis, Immunization, Mental Health, the Tobacco Free Initiative and Reproductive Health as well as the fight against recurrent scourge of Ebola, etc. Such research should focus on identifying effective health promotion approaches and communication media to embody and convey the outcomes to communities through community participation; the extent or effectiveness of these means and seeking to still improve overall programme effectiveness and sustainability. Therefore, health promotion research should focus on ascertaining goals/outcomes of health promotion (to guide policy), provide reliable conditions associated with these outcomes or goals, precisely define the changes intended and delineate reliable mechanisms and indicators of M and E of health promotion strategies in specific country/community contexts.

The importance of research is essentially derived from the fact that it calls attention to the need for verification and evidence-based activities in health promotion. These are without doubt the ways of knowing if real empowerment and enabling has been achieved in the process. Thus,

> *Health promotion is about enabling people to improve their health; and secondly, evidence relevant to health promotion should bear directly on factors that support or prevent enablement and empowerment (determinants of health) activities that support enablement and empowerment (health promotion) and assessing whether these activities have been successful (evaluation of health promotion). [25], p. 357*

The above clearly suggest that health promotion should be anchored on evidence or should rest on experience and reality regarding what works or what is possible and effective in any context. In this manner, "evidence-based health promotion involves explicit application of quality research evidence when making decisions" [26], p. 126. Research is even more foundational in health promotion since health promotion efforts need to be anchored on agreed definitions and values of health promotion. As Seedhouse contends the failure to be explicit about definitions and values generates conceptual confusion in research as well as sloppy practice [27].

The evaluation of health promotion which should be a core research activity may be based on the three main forms of evidence/knowledge associated with health promotion [28]: instrumental (controlling social and physical environments), interactive (understanding of diseases/health issues; lived experiences; solidarity) and critical (reflection and action; raising consciousness regarding causes and means of overcoming them). These three evidences are anchored on the given scientific/philosophical traditions, viz. instrumental (positivism, quantitative, experimental, scientific knowledge), interactive (constructivist, naturalistic, ethnographic/qualitative knowledge) and critical (materialist, structural and feminist theory).

There is also an overwhelming need for health promotion research to be aware of the difference between health promotion outcomes and health outcomes. Health outcomes crudely imply the consequences or benefits of healthcare delivery (e.g., reduction of mortality rate) related to a disease (which may be the case in spite of an increment in number of those affected by the disease). But health promotion outcomes signify the form of control and attitudinal re-orientation groups and individuals adopt in facing a given disease which may impact on the number of people affected by the disease and improve attitudes and behaviour towards those affected by the disease. Health promotion outcomes can be seen directly through community members' perception and interpretations of a given health issue which makes the achievement of control possible.

Health promotion research should utilize both quantitative and qualitative methods. In addition to complementing quantitative methods in health promotion research, qualitative research enables the researcher reach the heart of issues in engagement with community members. In Africa, where a good percentage of the population are still domiciled in the rural areas, qualitative approach offers the possibility of profound insights into the why and how of health behaviors which may not be possible or easily achieved with the quantitative or traditional biomedical approaches. As a result, "the increasing popularity of qualitative methods is as a result of perceived failure of traditional methods to provide insights into the determinants – both structural and personal – of whether people pursue or do not pursue health-promoting actions" [25], p. 359.

6. Challenges to health promotion in Africa

It is important to recognize that in spite of apparent good intentions, health promotion can actually generate negative or counterproductive effects when not

well managed. Thus, "negative outcomes occur where professionally paternalistic and disempowering health policy decisions force health-related outcomes that are irrelevant to sustained community development and are not based on or resourced according to the social reality of the community" [11], p. 315. The above sentiments caution one against embarking on health promotion activities and initiatives that are not anchored on the health realities of the community concerned. Often, overzealous health professionals unintentionally betray the health priorities of communities by assuming knowledge of all there is to know about the health situations and needs of the people.

Perhaps a critical shortfall of some health promotion activities and processes is the adoption of what can be termed the pathogenic paradigm which over-relies on risk instead of emphasizing protective mechanisms. This essentially entails a focus on the failure of communities and individuals to avoid disease or their apparent susceptibility to diseases instead of seeking to unleash their potential and capacity to engender and sustain good health and development. It is an approach that relies too much on health practitioners and experts and hardly gives voice to the people and their own knowledge cum realities.

Generally health promotion in Africa suffers from some of the debilitating challenges which confront the practice of health promotion broadly in many countries in the continent. These challenges, among others, include:

- Poor definition and rudimentary elaboration of expected health outcomes

- Ambiguous elaboration of factors and conditions to be targeted in health promotions

- Ambiguity of health promotion policies and guidelines

- Lack of capacity (or inadequate capacity) to develop, implement and evaluate health promotion programmes

- A general context of inadequate investment in health promotion

- Underdeveloped sectoral collaboration

- Low political will and commitment to health promotion programmes as well as institutional corruption and resource mismanagement

The above challenges have implications for research in health promotions in the continent. There is no gainsaying the need for health promotion to be evidence based because essentially it is the only way to make it responsive to the health needs and interests of the people.

7. Resituating and reinforcing health promotion in Africa

Health promotion combines varied but complementary indicators like legislation, health finance including fiscal measures and taxation, gender inclusiveness, mapping of priorities and organizational change. In spite of their differences, these issues are in reality intertwined or systematically connected in the sense that, for the public health system to function well and optimally, there should be a synergy between these indicators. Briefly:

7.1 Legislation

This revolves around having the political will to make and drive through policies and laws that improve and sustain healthcare delivery. It also involves public health sector governance and leadership which aim at ensuring that only competent and qualified people lead the sector and that activities are governed by a democratic and free process which place emphasis on human rights, dignity and self-worth of all stakeholders.

7.2 Finance

Without doubt efficient health promotion and by implication the entire health delivery system cannot function without finance. In fact, the extent and impact of health promotion depend to a significant extent on the availability of funds. The problem of finance is especially critical in developing nations in Africa where political corruption and competing needs whittle down whatever gets to health from the yearly appropriation of government. However, there is a need to understand that a lot needs to be done in terms of the fiscal policies in these nations in order to achieve the desire for good health and improved life expectancy. In other words, the process of fiscal policymaking and budgetary allocation should prioritize health promotion and health delivery in these countries.

7.3 Organizational change

There is no gainsaying the fact that the health system as a whole is dynamic especially so in Africa where apart from battling known ailments new ones (or novel presentation of the old ailments) spring up now and then. The above entails that the health system calls for dynamic organizational setting that is robust enough to deal with changes while making improvements in the system. There is apparently no denying the fact that health promotion as a critical component of health delivery would benefit from organizational change. This is particularly so in the face of the reality that health promotion in most of the continent is still below the expectation. This is not to deny that health promotion has worked well in specific instances like the HIV/AID scourge and maternal health. However, such grab and slash system which focuses on only one of such delimited issues in the system cannot be seen as either robust or effective in the long run.

7.4 Gender inclusiveness

There is an obvious need to 'en-gender' health promotion as a very critical issue in Africa. This would entail ensuring that those involved in health promotion ensure that in all key phases of health promotion (planning, implementation and evaluation) women and men should be equal partners and collaborators. Gender, in this case, while calling attention to the needs of women, should also ensure that the men are not left behind even in approaching health issues traditionally seen as the concerns of women. Typical example here is in the area of family planning or reproductive health which demands the active collaboration or participation of both men and women to achieve desired results.

7.5 Mapping of priorities

For the WHO [24], the priority interventions in Africa in respect of health promotions include capacity building, development of plans, incorporation of health promotion components in non-health sectors and strengthening of priority

programmes using health promotion interventions. These essentially mean pursuing health promotion through capacity building, action planning, advocacy and multisectoral orientation. They are also in tune with relating to the determinants of health promotion in the continent. These include socio-economic conditions and physical (environment), biological, and behavioral lifestyles which impact on health in Africa. Countries can be encouraged to map out their priorities taking into consideration such factors as disease and financial burdens, threats, intervention tools and agencies, acuity, management capabilities, persistent challenges, etc.

8. Conclusion and recommendations

Generally, there is a need for stepping up health promotion research in Africa in the areas of family and reproductive health targeting such issues as VVF, antenatal care, diabetes, cardiovascular issues, new disease forms/resurgence of old diseases (including Ebola), etc. especially in terms of communicating with those who are marginal to the formal sector of the society or who are less privileged by virtue of education, economic opportunities or physical/mental challenges, etc. in both urban and rural contexts. Health promotion can profit from an acute awareness of the fact that what works in one socio-geographical setting may not work in another since no two societies are exactly the same. This would entail designing programmes that even where the general principles or goals remain the same embody recognition of the socio-geographical peculiarities of the society/community concerned.

Given the usual paucity of funds in the continent, it makes sense that to minimize cost and save time, there should be incorporation of both needs assessment and evaluation into ongoing health promotion activities. This approach offers a smart way of pursuing health promotion goals without elaborate budget.

In spite of country differences and specific structural challenges, there is a need to build a culture of sharing and documenting outcomes and evidences of health promotion between different countries and organizations. This is a step towards achieving the desirable goal of multinational coordination especially for infectious diseases and epidemics. Equally, African nations need to invest more in capacity building for media and theater practitioners in both private and public sectors on health promotion. There is no gainsaying the media's crucial role in health information dissemination. Actually, health promotion is largely media driven and should be programmed as such.

In addition to media practitioners, there should be health programme or intervention specific to health promotion capacity building for different cadres of public sector workers. Such capacity building or training should be anchored on acute awareness of current research trends and best practices globally. There should also be increased attention to the need for specific health promotion for underrepresented health issues and priority to non-communicable diseases should be targeted. It should also improve capacity on how to incorporate methods of targeting members of the society marginal or vulnerable within each country context.

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References

[1] Tannahill A. Health promotion – Caring concern. Journal of Medical Ethics. 1984;**10**:196-198

[2] World Health Organization. Health Promotion: A Discussion Document on Concepts and Principles. Geneva: WHO; 1984

[3] World Health Organization. The Ottawa Charter for Health Promotion. Geneva: WHO; 1986

[4] Macdonald G, Davies J. Reflection and vision: Proving and improving the promotion of health. In: Macdonald G, Davies J, editors. Quality, Evidence and Effectiveness in Health Promotion: Striving for Certainties. London: Routledge; 1998. pp. 5-18

[5] Harrison D. Health promotion and politics. In: Bunton R, Macdonald G, editors. Health Promotion: Disciplines, Diversity and Developments. 2nd ed. London: Routledge; 2002. pp. 158-177

[6] Tones K. Why theorise? Ideology in health promotion. Health Education Journal. 1990;**49**(1):2-6

[7] Jones L. The politics of health promotion. In: Jones L, Sidell M, editors. The Challenge of Promoting Health: Exploration and Action. London: Macmillan; 1997. pp. 131-157

[8] MacDonald TH. Rethinking Health Promotion: A Global Approach. London: Routledge; 1998

[9] Victor C. Inequalities in health and health promotion. In: Pike S, Forster D, editors. Health Promotion for all. Edinburgh: Churchill Livingstone; 1995. pp. 157-170

[10] Webster C, French J. The circle of conflict: The history of the public health and health promotion movements. In: Adams L, Amos M, Munro J, editors.

Promoting Health: Politics and Practice. London: Sage; 2002. pp. 5-12

[11] Whitehead D. Health promotion and health education: Advancing the concepts. Journal of Advanced Nursing. 2004;**47**(3):311-320

[12] Caplan R, Holland R. Rethinking health education theory. Health Education Journal. 1990;**49**(1):10-12

[13] McLeroy KR, Bibeau D, Steckler A, Glanz K. An ecological perspective on health promotion programmes. Health Education Quarterly. 1988;**15**:351-375

[14] Sallis JF, Owen N. Ecological Models. In: Glanz K, Rimer BK, Lewis FM, editors. Health Behaviour and Health Education: Theory, Research and Practice. 2nd ed. San Francisco: John Wiley; 1997. pp. 403-424

[15] Stokols D. Establishing and maintaining healthy environments: Towards a social ecology of health promotion. The American Psychologist. 1992;**47**(1):6-22

[16] Hancock T. Health, human development and the community ecosystem: Three ecological models. Health Promotion International. 1993;**8**(1):41-47

[17] Janz N, Champion VL, Strecher VJ. The health belief model. In: Glanz K, Rimer BK, Lewis FM, editors. Health Behaviour and Health Education: Theory, Research and Practice. 3rd ed. San Francisco: Jossey-Bass; 2002. pp. 45-66

[18] Strecher VJ, Rosenstock IM. The health belief model. In: Glanz K, Rimer BK, Lewis FM, editors. Health Behaviour and Health Education: Theory, Research and Practice. 2nd ed. San Francisco: John Wiley; 1997. pp. 41-59

[19] Bartholomew LK, Parcel GS, Kok G, Gottlieb NH. Intervention Mapping: Designing Theory and Evidence-Based Health Promotion Programs. Mayfield: Mountain View, CA; 2001

[20] Parker EA, Israel BA, Brakefield-Caldwell W, Keeler GJ, Lewis TC, Ramirez E, et al. Community action against asthma: Explaining the partnership process of a community – based participatory research project. Journal of General Internal Medicine. 2003;**18**(7):558-567

[21] Parker E. Application of health promotion theories and models for environmental health. Health Education and Behaviour. 2004;**31**(4):491-509. DOI: 10.1177/1090198104265601

[22] Whitehead D. Incorporating socio-political health promotion activities in clinical practice. Journal of Clinical Nursing. 2003;**12**:668-677

[23] Edmondson R. Social capital: A strategy for enhancing health? Social Science & Medicine. 2003;**57**:1723-1733

[24] World Health Organization. Health Promotion: A Strategy for the African Region. Geneva: WHO; 2001

[25] Raphael D. The question of evidence in health promotion. Health Promotion International. 2000;**15**(4):356-367

[26] Wiggers J, Sanson-Fisher R. Evidence-based health promotion. In: Scott D, Weston R, editors. Evaluating Health Promotion. Cheltenham, UK: Stanley Thornes; 1998. pp. 31-49

[27] Seedhouse D. Health Promotion: Philosophy, Prejudice and Practice. New York: John Wiley; 1997

[28] Park P. What is participatory research? A theoretical and methodological perspective. In: Park P, Brydon-Miller M, Hall B, Jackson T, editors. Voices of Change: Participatory Research in the United States and Canada. West Port CT: Bergin and Garvey; 1993. pp. 1-20