The Collage of Functional Health Education for Effective Healthy Decisions and Health Promotion

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Preamble

On November 21, 2000, I was officially written by the former Vice Chancellor of this great University, Prof. Pita Ejiofor that I have been promoted to the rank of a Professor with effect from October 1, 1998. It was from this November 21, 2000 that I started occupying a permanent seat at the Senate of this University. We thank God for all these. It was from this date that I started thinking of my inaugural lecture. As a Professor of Health and Safety Education, there are reasonable number of areas from which one could make a choice. It
was actually a difficult task having to choose from a group of subject matters that people appeared to be very much conversant with and which will appeal to their interest to a greater level. This caused me a lot of anxiety. My levels of anxiety were heightened when in 2009 younger professors started presenting their inaugural lectures.

Ladies and Gentlemen, it took me some good number of years (twelve years to be precise) to settle down on this particular topic we are going to discuss today; which is "The Collage of Functional Health Education For Effective Healthy Decisions and Health Promotion". The topic may appear too strange and funny but, all the same its relevance to healthful living will never be over emphasized.

Mr. Vice Chancellor sir, this is the first inaugural lecture from the Department of Human Kinetics and Health Education and first from the Faculty of Education of this great University.

Introduction
Mr. Vice Chancellor, distinguished Ladies and Gentlemen, I therefore feel very honoured for this wonderful opportunity granted me to give this Inaugural Lecture to this great University, the University of the moment. I must feel more honoured and humbled since I stand before you today as the first occupant of an academic chair in the Department of Human Kinetics and Health Education and Faculty of Education of this great University to address our University Community in an Inaugural lecture; and the 8th occupant of the chair of Health Education from among the Professors of Health Education in Nigeria to present an Inaugural Lecture. I am talking of my senior Inaugural lecturers in Health Education like Professors C.O. Udoh and J.A. Ajala both of University of Ibadan, Professor J.O. Fawole of Obafemi Awolowo University, Ile-Ife; Professors I. Owie, G. Oshodi and A. Imogie all of University of Benin; and Professor, Teacher, R.U. Okafor of University of Nigeria, Nsukka. Mr Vice Chancellor, the rate of change and the tempo of development within Nigerian Universities and in Africa in general, are such as to make some Inaugural Lectures run the risk of being valedictory. I intend to show in the course of this lecture, that unless we gird up our loins with regard to our health knowledge, values, attitudes and practices, only the fortunate few will not altogether miss giving theirs.

The title of many chairs in this University are derived from the name of departments or from major subject areas within them as in this case. Where the subject is easy to define as in Statistics or Mathematics for instance, few people if any, harbour doubts over what the Professor is expected to know, do or teach. However, such eludes the holder of the title of Professor of Health Education, for as we will see later, the words "Health Education" can be interpreted in many ways.

In the first place the subject has so many synonyms: Hygiene, Health Science, Public Health Education, Community Health Education, Industrial Health Education, and so on depending on the setting in which it is done. To many, a Professor of Health Education is someone to be consulted in all matters pertaining to healthful living. Secondly, there are difficulties inherent in the definition of the words: Health and Education. Health fortunately has been given a wide interpretation for it covers everything from mental and social well
being of an individual to his physical soundness, adequate spiritual state, adequate occupation and environment. Education is a universal concept that differs from society to society. It is a normative word which implies that it is valued in every society and it is desirable and worthwhile. It is an instruction or training by which people learn to develop and use their mental, moral and physical powers. Ocho (1988) says it is that which makes a man eagerly pursue the ideal perfection of citizenship, and teaches him/her how rightly to be proficient in a job and to live healthfully in a society. By combining the two definitions, I hope you have now got a clearer picture of who or what is a Professor of Health Education.

The advantage of being a holder of such a title is of course, that one is absolutely free to choose to speak on any aspect within a public health sector when giving an Inaugural Lecture and, even to spend some time within the long one hour explaining to everyone exactly what it is that one does. This I intend to do with your permission before I go on to the subject matter of this lecture which is "The Collage of Functional Health Education For Effective Healthy Decisions and Health Promotion".

A health educator is that person who assists individuals, acting separately or collectively to make informed decisions regarding matters affecting their individual, family and community health for effective health promotion. The health educator must of necessity therefore, be exposed to many other disciplines including biological and physical sciences, basic social sciences, education and educational psychology, hygiene and public health, epidemiology, public administration, and principles and techniques of planning health services, among others. Political decisions often greatly influence for good or otherwise, the methods, modes and types of learning experiences that individuals and communities get. He should therefore be trained to understand the processes by which a group of people or government arrive at healthy decisions, and this is the essence of "Collage" in the topic of our discussion this morning.

A collage according to the New Webster's Dictionary of English Language (2004) is a picture made by gluing fragments of various materials in a composition. The Chambers Dictionary (1996) on the other hand defined collage as a picture made from scraps of papers and other odds and ends pasted up or any work or construction put together from assembled fragments". Longman Dictionary of Contemporary English (1996) and Hornby (2001) almost have similar explanation of this concept called "collage" and that is that it is "a picture made by sticking pictures, photographs, cloth, etc on to a surface. In this paper, therefore, we intend to discuss different learning experiences or content areas in health education as indicated by Okafor (1991 and 2001), and which after they have been understood by an individual, family or community help him/ her or them, take effective decisions for healthful living. That is, those learning experiences that make up the broad subject matter we call "Health Education". At the end of this discussion Mr Vice Chancellor, ladies and gentlemen, I would be very happy if I have achieved the following objectives. That is that we would be able to:

a. enjoy life more;
b. be more productive in our life's activities;
c. live at a higher level of existence; and
d. be interested in pursuing good health.

The reasons for the above objectives are that the greatest
future improvements in people's health will come from actions they take for themselves. Secondly, many health problems are actually self-inflicted. For instance, (a) lung cancer and various circulatory and respiratory ailments often result from an individual's choice to smoke cigarettes; (b) degeneration of circulatory and respiratory systems is often traced to a lifetime of relative physical inactivity; and (c) your decisions concerning personal care, drugs, sexual relations, and other health related matters may help or hinder you throughout your life.

Health Education
Health education is multi-dimensional in nature. It goes beyond definition, although a definition is important in order to prepare our minds for its proper understanding. Health education is both a subject matter and a process and according to Udoh (1996), it has a body of knowledge and a field of enquiry. It is health science, it is an applied science and it borrows from many fields including microbiology, epidemiology, parasitology, psychology, sociology, biology, preventive medicine, education, physical education, recreation, and dance and so on.

Health education is concerned with human beings: their emotions, their bodies, their intellect, their spirit and their total being. Health education is dedicated to helping people live more effectively. It has many determinants of wellness. Some of which are nutritional awareness, stress management, environmental sensitivity, movement and physical activity. Health education is first and foremost responsibility to self and secondly, responsibility for others. It is action 'now and here'. It is goal-based. That is, planning for now and future using the experiences of the past. According to Okafor (2000), the future of health education is based on the fact that it is capable of predicting the future health problems, needs and interest of the people, including their future health promotion and maintenance. Health education believes in intelligent risk-taking. That is, risks that are valuable and sensible and risks that are by choice rather than by chance.

Health education is all varieties of education: alcohol education, cancer education, AIDS education, family life education, human sexuality education, infectious disease education, environmental health education, consumer education, safety education, drug education, death education; emotional and mental health education, communicable and non communicable disease education, etc - all of which and many more individually and collectively represent the collage of a typical functional health education programme.

Definitions of Health Education
Health education has never been quite easy to define because it is open to various interpretations depending on what angle one is looking at it and, the health concept or understanding of whoever is putting forth the definition. It may appear simple and, because of its irregular nature, many people think that they know a lot about it, yet health education remains a formidable and interesting exercise. According to Nwana (2000) it is open to series of misconceptions and many people equate information about health to health education. However, one of the major aims of Health education is that it aims at influencing behaviour favourably and helping people to reach the stage of active conviction about matters relating to health. This is confronted with
many factors some of which are beyond the control of health education. A definition is a statement of conceptions held about an item or object (for example, Health Education). The statement expresses the individual's views or philosophy or belief about the item or object.

We shall examine a few of these definitions to help us appreciate the argument. Nwana (2000) cited the definitions of health education given by Wood (1926), Bauer (1947) Grout (1948) and Davies (1975) respectively as:

a. the sum total of experiences which favourably influence knowledge, attitudes and habits related to individual, family, community and racial health;

b. the translation of what is known about health into desirable individual and community behaviour patterns by means of educational process;

c. the sum total of our experiences and motivation, which add to health knowledge or influence health behaviour; and

d. the process of persuading people to accept those measures, which will improve their health and reject those which will have adverse effect on their health.

A critical analysis of these definitions of health education shows us that by implication, any experience, which does not culminate in positive behaviour, does not qualify to be regarded as health education; that health education recognizes the role of motivation in determining behaviour, and emphasizes on the transformation of health information/knowledge to health action. This goes to explain our philosophy in health education, that health education remains health information until it results to positive health action. Finally, from the definitions also, we understand that health education deals with many ways in which diseases can be prevented and the health of the members of the community improved.

Having seen all these definitions as given by some different authors in health education, we can now say that Health education can be regarded as that part of education - the responsibility of parents, the school, and indeed the whole community - which will help boys and girls as they grow up to minimize the risks associated with diseases and injuries resulting wholly or in part from ignorance, habits and ways of living, and give them a basis of understanding of the functions of the community health services so that they may be able to use intelligently and efficiently and play their parts in reaching wise decisions on their evolution as patterns of illness change. It has some objectives which guide the activities of health educators.

Objectives of Health Education

The objectives of health education can be summed up from the definitions we have discussed already. It is the translation of what is learned or known about the protection, promotion and maintenance of personal, family and community health into patterns of desirable attitude and behaviour. It aims at having a positive influence on the individual in such a way that such an individual can take care of his own health as well as play a part in promoting community health. Health education specifically aims at changing an individual's own health behaviour in such a way that will lead to the protection,
promotion and maintenance of his health. The focus according to Udoh, Amusa, Sohi and Agbede (1985) and Okafor (1993) is on what an individual thinks, how he feels and what he does in respect of his/her health.

In trying to achieve the objectives, we carry on health education activities in three different settings, namely: home health education, school health education and community/public health education.

Home health education is that type of health education which takes place within the home under the guidance of parents and other family members (Udoh, et al. 1985). The home is the pillar on which the society is built, and of all the social institutions it is the home that exerts the greatest influence on the individual. Therefore, the health education which goes on in the home is of utmost importance in the life of an individual, although not very scientific. In the area of health services, health educated parents ensure that they seek medical care and follow up treatment for the child when ill, have defects which are detected at school properly appraised and corrected; secure protective measures against communicable diseases through immunization. A child's living environment is important for his/her growth and development. Parents are therefore, according to Udoh (1996) expected to and should provide conducive environment for the child's optimum growth and development, by ensuring proper and adequate nutrition, encouraging adequate sleep, rest, relaxation and regular exercise as well as good personal hygiene.

School health education is that part of health education that takes place in the school or through the efforts organized and conducted by school staff. It takes place through individual health appraisal, counselling, informal health teaching in relation to daily experiences and formal or indirect health instruction. This appears to be the best setting for health education because trained health educators are involved and scientific facts are used.

Community/public health education is that part of health education which takes place in the community. It serves the community as a whole and provides special services to homes, schools, prisons, industries/factories, etc. This is carried out through the activities of health departments, voluntary health agencies, schools and youth groups and other community groups which reach out to young people and adults alike, using a variety of information dissemination approaches (Okafor, 1986).

Community/Public - wide health education most frequently takes the following forms;

a. Individual health counselling, which is carried out through face to face interviews, with officials of the health department such as physicians, dentists, nurses and many other types of health workers that provide much valuable health guidance in their contact with people.

b. Community Action Programme, where people in many communities are increasingly coming together to deal with problems of mutual concern. Health problems are often the focus of such community organization efforts, and as people study, plan and act on health matters, much education results.

c. Informal Health Education, which is the informal
communication among people is now being applied to fruition in health education.

In all these health education settings, the central aim is to apply fully the theories and models associated with healthy decisions and health behaviour. Accordingly, health behaviour is the central concern of health education and health promotion and usually the crucial criterion variable in practically all health education intervention activities (Owie, 2003). Many factors influence health behaviour and health decisions and some of them include how people think about themselves and their behaviour, their health knowledge, values, habits and social pressure.

Health behaviour can be grouped into three (Bruess & Richardson, 1989):

a. preventive health behaviour which occurs when any activity is undertaken by an individual who believes himself/herself to be susceptible does this for the sake of an illness condition;

b. illness health behaviour occurs when an individual who sees himself/herself as being sick, undertakes any action to define the state of his or her health status and finds adequate remedy; and

c. sick-role health behaviour which is that activity undertaken by a person who feels he or she is ill for the purpose of getting better.

The above explanations of health behaviour will help us understand the following theory associated with healthy decisions and health promotion, namely; Health belief model.

**THE HEALTH BELIEF MODEL (HBM)**

The Health Belief Model (HBM), developed in the 1950s to explain preventive health behaviours, focused on the relation of health behaviour to utilization of health services. Greatly indebted to Kurt Lewin, who believed that the world of perceivers determined their actions, HBM which has been recently revised to include general health motivation, distinguishes illness behaviour and sick-role behaviour from health behaviour. Illness behaviour is defined as any activity undertaken by persons who feel ill to discover what is wrong and what can be done about it. While sick-role behaviour is any activity undertaken by persons who consider themselves to be ill for the purpose of getting well. Health behaviour is any activity undertaken by persons who believe themselves to be healthy for the purpose of determining and preventing disease in any asymptomatic state.

Health behaviour is the central concern of health education and health promotion and usually the crucial criterion variable in practically all health education intervention assessments. Positive health behaviour changes in the normal direction are usually the ultimate concern in health education and health promotion endeavours. In most cases we use HBM to explain these. The model is interactive (i.e each step affects the other) and is based on four primary dimensions:

A. Perceived susceptibility
b. Perceived severity
c. Perceived benefits
d. Perceived barriers.

**Perceived Susceptibility**

This is a person's subjective perception of the risk of contracting a particular health condition (Rosenstock, Stretcher & Becker, 1994). It is clear that individuals vary widely in their perception of susceptibility of
contracting an adverse health condition. There are three levels of this:

(a) persons at the low end of the continuum deny the possibility of contracting any disease condition;
(b) those at the middle admit to a reasonable extent the possibility of disease susceptibility; and
(c) those at the high extreme of the continuum feel strongly that there is real danger and that with wrong decision they will contact a given adverse disease condition.

In health education, for adequate healthy decision of an individual according to Glanz, Lewis and Rimer (1997) efforts should be made to help people not to underestimate their own susceptibility to any disease condition, but to see themselves in the level of high susceptibility. If this happens people will be in a position to avoid contracting disease conditions. For instance, a man who believes or perceives cancer to be contagious will feel just as endangered by contact with a cancer patient as if the patient has a contagious disease. Conversely, a person who for some reasons perceived himself immune to tuberculosis (TB) will not feel threatened by prolonged and intimate contact with an active TB patient although, in reality, he/she does endanger his/her health by such contact.

Perceived Severity
This according to Kasi and Coob (1966) is the individual's feeling concerning the seriousness of contracting an illness or leaving it untreated. This includes the difficulties the illness will create. This may be in the form of both clinical and social consequences (pain, hospitalization, financial problem, problems for the family and relations and prospects for future conditions). The combination of perceived susceptibility and perceived severity constitute what Galli (1980) referred to as a health threat, and forms the first phase of the HBM model. In health education, the individual's perception of the seriousness of the threat is an important motivator for a positive healthy decision and pattern of healthy behaviour.

In life, there are innumerable things by which a man is really threatened, but he feels threatened by just only some of them. But, even when he perceives himself threatened by particular possible events according to Hochbaum (1970), he does not necessarily think about them constantly. The perception of the threats usually is latent, that is to say that the threat is there, but is below the threshold of awareness. Under the impact of special events this can be triggered to awareness by a stimulus that could be internal (e.g. a symptom) or external (e.g. news of the experience of a friend with a serious health problem).

Latent perception of a threat sensitizes a person to relevant stimuli. Thus, a person who feels latently threatened by cancer is more prone to notice cancer-like signs/symptoms than one who does not feel especially vulnerable to the disease. At this point, the threatened person is most likely to experience a desire to protect himself against the threat. But in order to do anything about it, he must perceive some actions that he believes will provide him with such protection and that he sees it as one that he is able to take.

Perceived Benefits
This concept is also regarded as the perceived effectiveness of the various available health strategies one has designed for reducing the threat of illness or
benefits in reducing the perceived threat from the health problem. After an individual has perceived the susceptibility of a disease and recognized its seriousness, the next step is to take action(s) towards the prevention of the disease or towards dealing with the problem. The individual, according to Owie (2003) must believe that the perceived action must actually do some good for him or her to comply.

The direction of action that a person chooses according to Glanz et al. (1997) will be influenced by his/her belief regarding the action and is highly dependent on knowledge and awareness. Health education is therefore highly necessary to help this individual take a healthy decision.

Sometimes, the action that a person perceives as effective and available may be easy and convenient. But on the other hand, it may be inconvenient, unpleasant, expensive, painful or otherwise very undesirable. If such negative traits seem to outweigh the presumed benefits to his health, he may choose some other less unpleasant actions or may not do anything.

Another factor to be considered here is some individuals' sense of "urgency" as distinct from a sense of "importance". The sense of importance means simply that a person believes it to be important for him to take a particular action, the sense of urgency means that he also believes the action to be needed immediately.

A man may, for instance notice a particular symptom, which he recognizes as one that requires medical attention. At the same time, he may not feel any reason for alarm or for seeking medical advice. Thus he/she may postpone the indicated action until the symptom becomes urgent. For instance if pain increases. The further in the future a threat to one's health lies, the less urgent it tends to appear even though it may be regarded as important. A typical example of this is the case when a young smoker considers the possibility of getting cancer ten or twenty years hence. Health education intervention tries as much as possible to help people regard any threat to health as urgent and one that requires immediate and adequate attention.

**Perceived Barriers**

Perceived barriers refer to the perceived negative aspect of the recommended course of action which may act as impediments to full appreciation of the indicated health behaviour. Sometimes, actions do not take place even though individuals may believe that the benefits of the action are effective. This may be due to barriers/undesirable consequences. The perception of undesirable consequences may encompass any direct physical effect, such as discomfort or pain, or effect on other aspects of one's life, such as inability to work, disfiguration, costs of treatment, disruption of valued activities, or interference with one's long-term goals and ambitions.

In health education according to Simon-Morton and Gottued (1995), efforts are made to help recipients make healthy decisions through some form of persuasive communications directed towards increasing the salience of beliefs about severity of and susceptibility to health problems; and the benefits of the recommended treatment or actions while minimizing barriers.

The HBM has been extensively used as a theoretical
framework for teaching and conducting researches in the areas of health education and preventive health behaviour. As a result of this, the HBM has been significantly expanded to take care of several confounding variables using such other theories as: Cognitive dissonance, Locus of control, Self-efficacy, Learned helplessness and Precede Model. Adequate understanding and appreciation of one or a combination of these theories through adequate functional health education programme will help people make effective healthy decisions and so promote their health.

Cognitive Dissonance
Cognitive dissonance is a theory that describes rationalizing behaviour. Dissonance occurs whenever people hold two inconsistent ideas, beliefs, opinions or attitudes. Since dissonance is uncomfortable, people strive to reduce the conflict in the easiest way.

As an example of this theory in action, Price, Galli and Slenker (1985), consider what happens when smokers are faced with facts indicating that smoking causes cancer. They will become motivated to change either their attitudes about smoking or their behaviour. It is obvious that the first choice is easier. Smokers can decide that the statistics are not true for some reasons. They may look for peer support among friends who smoke. They may conclude that filters are very effective in trapping the elements that cause cancer. They may adopt the style of treating the head of the cigarette with a chemical - menthol, in order to dilute the chemical that causes cancer. They may also accept the facts but conclude that a short and happy life is better than one without cigarettes.

To support choice and reduce dissonance, people seek evidence to confirm their decisions. The more they are committed to a course of action, the more resistant they will be to information that threatens their course. An effective health education programme should create dissonance related to contraindicated health behaviours.

Locus of Control
Locus of control also has an impact on health decisions. It suggests that people are motivated to explain and appreciate the cause of certain things, especially in situations that are relatively not clear. If people believe that their behaviour reduces the chances of developing a health problem, they are said to have an internal locus of control. If on the other hand, they believe that whether or not they develop the health problem is out of their control, they are said to have an external locus of control. Those with an internal locus of control are more likely to take responsibilities for their health decisions as well as the results of such health decisions.

Health locus of control may be affected by different variables, like the value placed on health, economic status, health knowledge and level of education.

Self-Efficacy
Self-efficacy refers to one's belief in the ability to do a specific behaviour. Self-efficacy theory suggests that people's belief in their abilities to perform specific behaviours according to Lawrence and McLeroy (1986) influence the following:

a. The choice of behaviour and the situations that will be avoided or attempted, such as attempts to reduce drug, alcohol or cigarette use.

b. The effort to spend in attempting a specific task.
More energy is often devoted to a task when it is perceived that it will be successful, such as taking effective medication for a particular illness.

c. How long a person will persist even when facing difficulties such as maintaining a balanced diet/adequate dietary programme.

d. Emotional reactions such as anxiety, since negative emotions may be aroused when an individual is confronted with the threat of failure.

In health education, one of the goals is to make people self-efficient. People are encouraged to know how to do a behaviour and want to do it. While locus of control applies in a general way, self-efficacy is linked to a specific behaviour. It is a better predictor of behaviour because it is more specific in terms of behaviour, setting and time.

Learned Helplessness

Learned helplessness refers to emotional, behavioural and cognitive problems that result from being exposed to uncontrollable event. Natural catastrophes, concentration camps, and even assaults might contribute to learned helplessness. Some people feel that the traditional male or female role have sometimes resulted in learned helplessness. For example, expecting a man or woman to limit skill development to those skills considered socially appropriate for his or her gender may result in learned helplessness for the broader range of skills required for living. Food faddism or taboos in a particular community may contribute to learned helplessness. Clearly, either men or women have the potential to develop a full range of skills if not limited by social expectations. Low self-image/esteem might prevent someone from using refusal skills and result in experimentation with chemical substances and unprotected sexual intercourse. In health education therefore, efforts are made to help people develop adequate self-esteem (Okafor, 2000).

Precede Model

Precede Model is another model that has implications in behaviour change and one that helps us in our health education activities. As seen in Greene et al. (1980) according to Udoh (1996), it has three categories or factors - predisposing, enabling and reinforcing factors (Table 1).

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Source: Udoh (1996:7)  
The greatest influence in the model we know is that from
those identified under the re-inforcing factors, because of the influence or support for or non-approval of a specific health behaviour. For instance, a behaviour is not likely to continue if family support or peer pressure is negative or a significant person abhors such a behaviour. The reverse is the case if a given behaviour earns the approval of significant others. However, both the predisposing and enabling factors contribute in influencing behaviour change or otherwise. In health education, adequate use of the theories we have just discussed will contribute to adequate healthy decision and health of the people.

THE CONCEPT OF HEALTH

Health is a term derived from Anglo-saxon word which means a condition, state or quality of the whole individual which enables him carry on his daily activities which are either obligatory or non-obligatory (Udoh, 1999). Historically, the meaning of health is not entirely new. Early perception of health according to Udoh is one which sees it from purely simplistic and unidimensional perspective, as well as from a physical point of view. Health could be seen as that quality of life which enables one to live most and serve best. It is that thing that makes you feel that now is the best time of the year. To some it is that state that makes one throw up his hands in the morning and declare, "I feel great".

Health could mean any of the following: having stamina to work; good body built derived from physical exercises; the capability of spending long periods solving a problem; the ability to stay on the job to complete a given task; normal functioning of the cells, organs, and systems of the body; a most priceless possession to one who has lost his health.

The World Health Organization (WHO) in 1948 defined health as "a state of complete, physical, mental and social well-being, and not merely the absence of disease or infirmity". This definition that was introduced by WHO in 1948 used to be the most widely accepted and quoted definition of health. Today, it is being so critically and severely criticized on the grounds that there is no such thing as "complete state of physical, mental and social well-being".

Authorities in the fields of health and health education however agree that health has physical, mental and social dimensions. Completeness of health they contend is an Utopia which everyone aspires for but never attains. Yet the inability to attain completeness of health does not necessarily mean that health does not exist in a person. This is explained by Hoyman (1975) in Udoh (1999) as a "moving target" on a continuum. Hoyman visualizes health as a range, extending from zero health (which signifies death) to optimal health. In other words, individuals find themselves somewhere along this health continuum as illustrated in the figure I below, depending on their health status as determined by the factors that influence human health.

Figure I: Wellness-Illness Continuum
Mental health is the capacity to cope with life's circumstances, to grow emotionally, to develop to our fullest potential, and to expand in awareness and consciousness (Bruess et al. 1989). It can be maintained by keeping your mind active through life-long learning, engaging in thoughtful discussions with friends and reading (Powers et al. 2006). Maintaining good intellectual health can improve one's quality of life by increasing his/her ability to define and solve problems. Further, continuous learning and thinking can provide one with a sense of fulfillment that accompanies an active mind.

Emotional health is related to mental health, and is the ability to express emotions comfortably and appropriately. This might include choosing not to express emotions in certain situations. Emotional health includes your social skills and interpersonal relationship; your level of self-esteem and your ability to cope with the routine stress of daily living. The cornerstone of emotional health is emotional stability, which describes how well you deal with the day-to-day stresses of personal interactions and physical environment.

Emotions can be physically exhausting and create considerable stress; however according to Okafor et al. (1998) are also desirable and useful. Emotions make us human, make our lives more interesting and help us to function more effectively in our environment. Somebody can easily assess his or her emotional wellness with the test items in Table 2, called an Emotional Wellness Assessment Inventory.
18-21 points: You are probably fairly happy, but could develop more effective means of needs fulfillment. You may have some doubts about your identity and are possibly unsure of your value as a person.

17 points or less: You appear to have many unfulfilled needs.

Spiritual health is an important component of overall health (Bensley, 1991); and is significant in health-related decision making (Goodloe & Arreola, 1992). Optimal spiritual health includes the ability to discover and express your purpose in life; to experience love, joy, peace, and fulfillment; and to help yourself and others achieve full potential.

Occupational health includes feelings of comfort and accomplishment related to one's daily task. It is a function of daily tasks. For instance, you might assess this component of health by answering such questions as: Do I feel a sense of accomplishment from my daily task?, and am I basically happy with the way I spend most of my occupational time?

Environmental health is concerned with those factors that can negatively or positively influence our ability to achieve total wellness. For instance, air pollution and water contamination are the two most important environmental factors that can harm physical health. Polluted air with particulate matters and other contaminants can lead to a variety of respiratory disorders (e.g. asthma). Water that contains bacteria can lead to infections. Also, drinking water that contains carcinogens (cancer-producing agents) can increase the risk of certain types of cancers (e.g. stomach, colon and

In table 2 you have the opportunity to evaluate your level of emotional wellness as it relates to your self-image and need fulfillment. Circle the number that most closely matches your reaction to each statement.

**Interpretation**

22-24 points: You are enjoying positive emotional wellness. You have a fine sense of your own identity, well developed self-esteem, effective ways of fulfilling your needs and you are enjoying life.
rectal cancer). Other examples of environmental problems that can negatively impact health are the safety of our food supply, over exposure to ultraviolet radiation and other household factors. From the above views, achieving total wellness requires learning about the environment and protecting yourself against environmental hazards that threaten your health and well-being.

**Social health** is defined as the development and maintenance of meaningful interpersonal relationships. This results in the creation of a support network of friends and family (Powers et al. 2006). Good social health results in feeling of confidence in social interactions and provides you with a feeling of emotional security. Certain factors are necessary for social health. These are called social determinants of health.

Social determinants of health according to WHO (2003) are the economic and social conditions under which people live which determine their health. Virtually all major diseases are primarily determined by a network of interacting exposures that increase or decrease the risk for the disease. While medical care can prolong survival and improve prognosis after some serious diseases, more important for the health of the population as a whole are the social and economic conditions that make people ill and in need of medical care in the first place.

Raphael (2008) reinforces this concept by saying that social determinants of health are the economic and social conditions that shape the health of individuals, communities and jurisdictions as a whole. They are the primary determinants of whether individuals stay healthy or become ill. They determine the extent to which a person possesses the physical, social, and personal resources to identify and achieve personal aspirations, satisfy needs and cope with the environment. Finally, social determinants of health are about the quantity and quality of a variety of resources that the society makes available to its members.

The scope of social determinants of health as stated by WHO (1986), Health Canada (1998), Marmot and Wilkinson (2001), Centres for Disease Control and Prevention (2005) and Raphael (2008) include: peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, equity, social status, social support network, employment and working conditions, physical and social environment, biology and genetic traits, lifestyle options, coping skills, healthy child development, gender, culture, health services and transportation.

**Physical health** is not only freedom from disease but includes all aspects of physical fitness as well. Physical fitness can positively affect your health by reducing your risk of disease and improving your quality of life. The physical fitness categories as stated by Powers et al. (2006) include cardio-respiratory fitness, muscular strength, muscular endurance, flexibility and body composition.

Although the specifics of exercise training programmes should be tailored to the individual, the general principles of physical fitness are the same for everyone. It is left for the person to take that healthy decision. These principles include: Overload, progression, specificity, recuperation and reversibility.
The overload principle is a key component of all conditioning programmes. In order to improve physical fitness as explained by Powers and Howley (2004), the body or the specific muscle must be stressed. For instance, for a skeletal muscle to increase in strength, it must work against a heavier load than normal. We achieve an overload by increasing the intensity of exercise or by increasing the duration of exercise. Overload can also be applied to flexibility, by increasing the range of motion at a joint by either stretching the muscle to a longer length than normal or holding the stretch for a longer time.

Principle of progression is an extension of overload principle. It states that overload should be increased gradually during the course of a physical fitness programme. It is important that the overload should not be increased too slowly or too rapidly if optimum fitness improvement is to result. Progression that is too slow will result in limited improvement in physical fitness, too rapidly may result in chronic fatigue and injury.

Principle of specificity of exercise refers to the fact that exercise training is specific to those muscles involved in the activity. Specificity also applies to the types of adaptations that occur in the muscle.

Principle of Recuperation explains the fact that because the principle of overload requires exercise stress to improve physical fitness, it follows that exercise training places stress on the body and the body needs rest. During the recovery period between exercise training sessions, the body adapts to the exercise stress by increasing endurance or becoming stronger. Therefore, a period of rest is essential for achieving maximal benefit from exercise.

Reversibility of training effect refers to loss of physical fitness due to inactivity. Although rest periods between exercise sessions are necessary for maximal benefit from exercise, long intervals between workouts can result in a reduction in fitness levels (Coyle, Martin, Sinacore, Toyner, Hagberg & Holloszy, 1984). Maintenance of physical fitness for normal health requires regular exercise sessions because, physical fitness cannot be stored.

Determinants of Normal Health
The modern concept of health is that which allows us to explain it as a condition which permits optimal functioning of an individual, and which enables him to live most and to serve best in his personal and social milieu (Okafor, 2000). Okafor, explains this condition as a normal health. It is a phenomenon which involves keeping the body (soma) and mind (the psyche) at the highest level, in terms of physical, mental and social. The issue of variability of health illustrated by health - illness continuum explains the fact that there are gradations of health and that everyone not affected by disease or infirmity is not equally healthy. This shows that health is not a condition, but an adjustment. It is not a state but a process through which human beings adjust to their environment.

According to Dubos (1959), health fundamentally is a function of adjustment. Dubos explained that under natural conditions, organisms that survived were always effectively adjusted to their environment. Experience has shown that man is always adjusting to his environment, and makes steady progress toward highest level of health, he will discover it is a goal (highest level of health) which can NEVER really be achieved. In other
Heredity as a factor of health. 
Heredity determines the health status of people. People inherit certain diseases from their parents e.g. Tay-Sack disease, Sickle-cell disease, Down's syndrome, Bloom's syndrome, Colour blindness, etc. Some people are short while others are tall, some fair-skinned while others have dark skin, some have albino skin and hairs, while others have dark hairs. These and many more are evidences of inherited traits from our parents. We can also inherit some degrees of health conditions and some predisposing factors to certain diseases from our parents. All these factors either positively or negatively influence our health.

Environment as a factor of health.
Environment in the postnatal state, is regarded as anything outside the body of an individual. Every person tries to interact with and adjust to his environment which is in the form of physical, social or biological factors.

Physical factors: These include such things as weather, climate, housing, soil, water and food supply; air, etc which can affect our health for better or for worse.

Social factors: These are the interactions which take place between and among people. When an individual interacts with another person, such an individual is influencing the other person just as that other person is also influencing him/her. In this way people are constantly exposed to the beliefs, attitudes, ideas, ideals, values of and customs of other families, friends and communities. These social forces in a direct or in an indirect way affect all aspects of man's well-being either positively or negatively.

### Table 3: Determinants of Normal Health

<table>
<thead>
<tr>
<th>Main Factors</th>
<th>Sub-Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heredity</td>
<td>• Inherited diseases&lt;br&gt;• Predisposing factors to diseases.&lt;br&gt;• Shortness&lt;br&gt;• Tallness&lt;br&gt;• etc.</td>
</tr>
<tr>
<td>Environment</td>
<td>• Physical, e.g. wealth, climate, housing, soil, etc.&lt;br&gt;• Social e.g. Exposure to others' beliefs, attitudes, ideas, values and customs.&lt;br&gt;• Biological, e.g. Germs, plans, insects, animals and other people.</td>
</tr>
<tr>
<td>Behaviour/Lifestyle</td>
<td>• Positive behaviour&lt;br&gt;• Negative behaviour&lt;br&gt;• Knowledge of the body&lt;br&gt;• Application of knowledge</td>
</tr>
<tr>
<td>Health Care resources</td>
<td>• Physical plants, facilities&lt;br&gt;• Personnel (all cadre)&lt;br&gt;• Availability or Non availability of drugs.</td>
</tr>
</tbody>
</table>
Biological factors: These are living things such as germs, plants, insects, animals and even people themselves. Some germs are helpful to us while others can cause diseases and death. Some plants provide us with essential food nutrients while others are poisonous and can cause diseases and death. Some animals can be very helpful in promoting our well-being, while others can also be the cause of our illness or death by transmitting to others the disease they have; for instance in the case of hereditary diseases. However, other people are also instrumental to ensuring that we enjoy good health such as when a mother provides good food and takes adequate care of the children when they are ill, or the father providing clothings and good housing for the family.

Behavioural/lifestyle factors:
Our behaviour is considered the most important of all the factors in relation to our health, more important than the hereditary and environmental factors earlier discussed. One can make the best of his life by using his behaviours to modify his hereditary defects. He can also eliminate or reduce the limitations imposed on him through such defects. Also through our behaviours we can change our environment or adapt to it in such a way that will increase our opportunity for living safely and healthfully. Behaviour as a factor for maintenance of good health is closely linked with the acquisition of scientific knowledge in relation to our bodies and the application of such knowledge we have acquired.

In relation to the basic knowledge of the body, we need to have adequate knowledge of the organs, systems and their functions. In relation to this, we need to: think of the choice of food we eat; complications of over-weight, digestion and elimination of the food we have eaten; think of what to do to put our body to task; consider the importance of works and exercises; have the knowledge of how to restore the energy we have used, in terms of rest, sleep and recreation; understand to some extent how to cope with some of the environmental hazards - pollutions, contaminated foods among others.

Connected with the knowledge of the body parts is the application of the scientific knowledge we have acquired to our everyday life. For example we can use the knowledge we have acquired to improve the intelligent quotient (IQ) of a group which is hereditary or to improve our environment.

Health Care

Health care delivery as opined by Bryant (1998) in Onuzulike (2004) is all the formal and non-formal activities which help in the provision of health services for a given population. Health care delivery as a determinant of health encompasses, such considerations as availability of health care resources, accessibility of health care facilities, adequacy and quantity of health care providers and government commitment and priorities (Udoh, 1996). Health care resources include hospitals' or clinics; consumables as well as drugs and equipment.

The quality and adequacy of health care providers according to Udoh (1996) have significant impact on health care delivery. The problem of inadequate health facilities and other resources are often compounded by the problems of inadequate number and lack of qualified medical and paramedical health personnel. The nature of the impact which the above sub-factors exert on health
Care delivery is a reflection of governments' commitment to health as well as the priority it enjoys in relation to other government activities (Udoh, 1996). Adequate health education programme will ensure that individuals become aware of the impact of these determinants of health so as to enable them make adequate decisions and take necessary action within individual jurisdictions and cooperatively with community members and or with the government to protect and promote their health and well-being.

Somebody who has gone through a collage of a functional health education programme, should be a health educated person, should develop favourable attitudes to the knowledge he/she has acquired and should be able to put the acquired knowledge into practice for effective health promotion. That person should live as a normal healthy person with specific indicators.

**Indicators of Normal Health**

A thorough inventory of an individual's exact health status would require a clinical examination by a physician, plus a battery of laboratory tests (Okafor, 2002). Such inventory according to Okafor should be made at the early stage of ones life, and thereafter at regular intervals or for special occasions. However, since part of the aims of this lecture is to help an individual promote his own health and for practical purposes, a person who is obligated to direct his own programme of health promotion needs some observable health landmarks to guide him/her. By evaluating these outward characteristics collectively the person has a day-to-day inventory or a template of his general pattern of health. It is necessary to point out that these indicators will be interpreted in relative terms. They serve as sufficient guide in his programme of self-improvement and can indicate any significant decline in health status. Most importantly, they point out the significance of physical vitality and social adjustment as attributes of positive health. The indicators are shown in Fig III.

![Figure III: Indicators of Normal Health](image-url)

**Social adjustment:** No person is as well adjusted as he/she would want to be, nor is it necessary to be perfectly adjusted socially in order to attain the normal level of health. A sincere interest in people, expressed through interest in them as personalities and in their abilities and accomplishments, is fundamental to social adjustment. The confidence and ease of the socially well-adjusted person is the result of applying and expressing this interest in day-to-day social experience.

**Adequate temperament:** The individual should have adequate emotional stability. He needs to have a temperament of congeniality and poise in order to meet...
the frustrations and crises of life. The well-integrated person may occasionally experience some disintegrations but will be able to mobilize his resources and recover rather quickly from the disturbing experiences.

Planned and purposeful daily living: To live effectively and enjoyably, one needs to have a realistic philosophy of the ultimate purpose of life. The person needs an orderly, organized plan of daily living based upon immediate, worth-while goals. Consistent attainment of these goals yields the personal gratification so essential for a higher level of mental and emotional well-being.

Adequate sleep and rest: Regularity in sleep is both an indication of normal health and a factor contributing to normal health. Following the usual night’s sleep, a person should be adequately rested to start the day to maximum efficiency. Some persons have a constitutional make-up which is slow in accelerating and one that is slow in rising to normal. For this, health educators recommend warm bath which will elevate body temperature and speed up the general body function.

Some may show occasional indications of inadequate rest, but chronic fatigue indicates that an individual has an inadequate level of health. In this case a physician should be consulted in order to locate the basic causes.

Constant body weight: Little variations in weight are normal and to be expected, but pronounced variation is abnormal. The normal body tends to attain a balance, or homeostasis in all its functions and conditions including weight. Stable body weight is an indication of general constitutional stability which is a valuable asset. Pronounced variation in weight is not a normal state and merits the immediate attention of a physician.

Feeling of buoyancy: In chronic fatigue or in illness, the body feels heavy and is like an anchor. The feeling of weightiness also accompanies the ageing process. In contrast, normal person has a pronounced feeling and air of buoyancy. The person feels light and has a minimum of body weight. In our local language, we refer to it as "bounce". The normal healthy person feels as though he carries virtually no weight, as though he has little attraction.

Adequate vitality: An individual with normal health has sufficient vitality to meet with the normal demands of everyday living. Great muscular strength is not necessary, but the person should have sufficient muscular energy to carry on the customaries of life. More important than strength outside is the physiological condition and endurance of the person. Physiological fitness (outside the scope of this lecture) in which the various body functions are carried on harmoniously and efficiently is far more to be desired than the physical fitness expressed merely in terms of strength.

General ease and relaxation: To be relaxed and at ease is an indication of wholesome adjustment to the immediate situation and to life in general. In everyday life, there will be occasions when tensions are created, but a normal healthy individual recovers rather quickly and soon displaces tenseness with ease and relaxation. A person who is unable to relax or is constantly tensed up is in need of adjustment. Whether the tenseness is due to
physical, mental, emotional, 'occupational, social and spiritual factors, the cause must be determined and eliminated if the individual is to attain an acceptable level of well-being.

**Unaware of bodily existence:** A healthy individual is not aware of his bodily existence unless it is called to his attention. When an organ or any part of the body becomes diseased or disordered, a person is then likely to become aware of the existence of that organ. A person who has to be reminded of a particular part of his body, doubtless, possesses a high level of physical well-being.

**Absence of diseases or disabilities:** A first essential of normal health is absence of diseases and defects which promote effectiveness and enjoyment in living. The presence of even mild illness and minor defect can have an appreciable adverse effect upon health. Continuing through several years, a minor ailment may have a cumulative effect which will lower a person's health to a level below normal. Some defects may not be disabling. For example, a loss of hearing in one ear may not be disabling if hearing in the other ear is normal, or if a corrective device gives the individual a normal end result. A defect therefore would not be classed as disabling.

**Wholesome appetite:** A steady, wholesome appetite is customarily an indication of wholesome health. People in poor health usually have a capricious appetite. This poor appetite continues the downward spiral to an even poorer level of health. Although a wholesome appetite does not assure a balanced diet, nevertheless, there are at least a good probability that a person with adequate appetite will have a reasonably well-balanced diet.

Adequate health education, plus a wholesome appetite can be the formula for a balanced diet and adequate nutrition.

Mr. Vice Chancellor, ladies and gentlemen, I have so far explained to you the meaning of this important concept called Health Education, the collage that make up this important area of learning, its objectives and a group of theories we use as our basic principles in explaining these component parts of health education to enable individuals make healthy decisions. I have also given you a brief sketch of the meaning of health; its component parts, determinants and indicators. I have therefore set the stage from which to launch onto the next bowl of our discuss this afternoon - health promotion.

**Meaning of Health Promotion**
Health promotion has been defined by the World Health Organization's 2005 Bangkok Charter for Health Promotion in a Globalized World as the process of enabling people to increase control over their health and its determinants, and thereby improve their health (WHO, 2005, Aug 11). Health promotion according to Minkler (1989) can be defined as the science and art of helping people change their lifestyle to move towards a state of optimal health. The WHO Regional Office for Europe also defined health promotion as the process of enabling people to increase control over and to improve their health.

The primary means of health promotion occur through the development of healthy public policy that addresses the pre-requisites of health such as income, education, housing, food security, employment and quality working conditions. Most of the time, there is a tendency among
public health officials and governments to reduce health promotion to health education that focuses on changing behavioral risk factors.

Health promotion aims at informing, influencing and assisting both individuals and organizations to accept more responsibility and be more active in matters affecting all aspects of human health. It seeks the development of adequate community and individual measures which can help people develop lifestyles that can maintain and enhance their state of well-being. These measures for adequate lifestyle are what make up the functional health education programme.

In addition to methods to change lifestyles, the WHO Regional Office advocated legislation, fiscal measures, organizational change, community development and spontaneous local activities against hazards as health promotion methods. Also included in the methods of health promotion are: self-care, the actions people take to help each other cope and healthy environment. Apart from the health promotion methods which can be found mostly in a functional health education programme, there are some five strategies which have been identified as essential for health promotion. These strategies are in line with the role of private sector in health promotion. They include: building healthy public policy, creating supportive environment, strengthening community action, developing personal skills by providing information and re-orienting health services to be reciprocal (that is, beyond its responsibility for providing clinical and curative services).

The concept of Health Promotion was also defined at the landmark First Global Conference on Health Promotion in Ottawa in 1986 as consisting of five elements:


b. Creation of supportive environment for health.

c. Strengthening of community action.

d. Development of personal skills.

e. Restoration of health services.

These five elements are explained in Fig IV in three basic components. The first component is health education with individuals and communities. The second involves reorientation of health services to improve their accessibility, acceptability and appropriateness; and the third is advocacy to influence policy makers to adopt healthy public policies, enact/enforce laws that promote health and consumer rights.
From all indications, the trend expected in the practice of health education is health promotion. Part of Jakarta Declaration (1997) makes it clear that health promotion acts on the factors that determine health status through investment and actions which create the greatest population health gain, reduce inequalities, ensure human rights and build social capital. These could be done in communities and different worksites/places.

**Worksite Health Promotion.**
Health promotion can be performed in various locations. Among the settings that have received special attention are the community, health care facilities, schools and other worksites (Tones & Tilford, 2001). Worksite health promotion, also known by terms such as "workplace health promotion has been defined as the combined efforts of employers, employees and society to improve the health and well-being of people at work. WHO states that the workplace has been established as one of the priority settings for health promotion because it influences physical, mental, economic, social and spiritual well-being and offers an ideal setting and infrastructure to support the promotion of health of a large population (Engbers, Van Poppel, Chin & Van Mechelen 2005, July).

Worksite health promotion programmes (also called, workplace health promotion programmes, worksite wellness programmes or workplace wellness programmes) include exercise, nutrition, smoking cessation and stress management; and are in line with personal health promotion.

**Worksite health promotion has the following advantages:**
- decrease in sick leave absenteeism;
- decrease in health cost;
- decrease in worker's compensation costs and disability management claim costs;
- significant effect on worker's ability and his overall well-being;
- reduces depression and anxiety among workers;
- helps to assess employees' health needs and tailoring programmes to meet these needs; and
- promoting self-care and targeting several health issues simultaneously.

**Personal Health Promotion**
According to Okafor (2005) personal health promotion is expressed in the effort of an individual or group to safeguard, maintain and improve his/her own health; or in terms of organizations or government to improve healthy principles. Personal health promotion is not time consuming for a person with a basic understanding of health and health education, and who has established a regimen of living which incorporates recognized principles of healthful living. Along this line, all the activities of the school and community in the area of health education are geared towards health promotion. Most of the activities of Ministry of Health are geared towards health promotion. The National Drug Law Enforcement Agency (NDLEA), National Agency for Food, Drugs Administration and Control (NAFDAC), the Federal Road Safety Commission (FRSC), Power Holding Company of Nigeria (PHCN), Consumer Protection Council (CPC) and so many others have activities either directly or indirectly that have implications for personal health promotion.
In all, a health promoting activity of a person or unit must aim at achieving personal healthy life style for the person or the total population by creating or developing supportive environment conducive for promotion of health. An individual wishing to enjoy adequate state of health may wish to adopt the following health principles of personal health promotion as suggested by Anderson and Langton (1961) and Okafor (2005), namely:

a. Taking a regular inventory of the present health status through periodic health examinations.

b. Caring for body functions.

c. Avoiding products harmful to health.

d. Providing essential nutrition and vitality for the digestive system through scientifically established dietary practices.

e. Adapting physical activities to ones capacities and needs.

f. Adjusting the pattern of living to avoid extreme fatigue

g. Providing adequate relaxation, rest and sleep in the daily programme.

h. Preventing infections or immediately attending to those that occur.

i. Adapting to physical hazards through safety consciousness adequate to anticipate hazardous conditions and practices.

j. Developing a positive, mature mental, emotional and social adjustment.

k. Adapting effectively to frustration.

l. Adjusting to the dynamics of group action.

m. Using available health resources appropriately and at the appropriate times.

Conclusion

Mr. Vice Chancellor, ladies and gentlemen, thank you very much for giving me your attention this far. For the past one hour or more I have been talking to you about some concepts - health, health education and health promotion, which importance is not well appreciated in Nigeria. It is true that many people do not know most of the things they need to know about reducing personal risks that compromise health, injury and death, and many people do not act on what they know. There is therefore the need for both transmission of accurate health related information and active promotion of health behaviour change through functional health education programme. By implication, health education should be a core subject in primary and secondary schools and part of it should be a requirement for graduation in all tertiary institutions. Our discussion today is unique for many of us. Many of us might be hearing and learning for the first time this important concept called health education and the components that make it up. We have also been informed about the relationship between a functional health education programme and healthy decisions and health promotion. Health education has as its major goal, empowering people to take positive steps to improve their own health and well-being. The emphasis should now shift significantly from school based health education to community based, where health education attainment would probably not be judged by the traditional paper and pencil tests, but by the extent to which it contributes to increased meaning, understanding, control and quality of life of the population.
ACKNOWLEDGEMENTS

I would want to first of all appreciate my late uncle-in-law and my master at that time, late Mr. Felix Okeke, who in 1963 planting season revealed to me how he had convinced my parents that I should be given secondary education. I am also very grateful to my parents, late Mr. and Mrs. Michael Okafor Ezisi for accepting this suggestion. May their souls rest in perfect peace.

Let me also thank some special lecturers of mine whose contributions are very special to me and who taught and encouraged me to out-do others in doing good. The first in the list is Prof. (Mrs) O.C. Nwana who supervised my M.Ed work and who prepared me for research activities that helped me to reach this height. Next is my major supervisor in my Ph.D programme, Prof. James A. Ajala, then of the University of Ibadan. His fatherly advice and the materials he gave me helped me to complete my Ph.D programme in thirty months. I will also not forget Prof. C.O. Udoh, a father and my academic mentor in some special ways. Prof. Udoh was my second Ph.D supervisor who in spite of his special academic advice, gave me a second key to his office and advised that I should respectfully use his materials at any time I felt necessary. Prof., may God bless you abundantly for me.

I will also want to appreciate my colleagues in the department, Professors S.O. Umedum, O.M. Abone, A.I. Ogbalu, G.O. Umeasiegbu, O.C.N. Okonkwo and others including my HOD Dr. E.C. Agbanusi for the nice social environment we enjoy in the department. It has been very wonderful working together since October 1, 1990. The contributions of my postgraduate students (Past and present) can never be missed. They had always responded to calls that contributed to the quality of this inaugural lecture.

This inaugural lecture is all about my family, and I want to appreciate the members in some special ways. For one thing, each and everyone of them contributed in making it possible for me to prepare this lecture. The most important in the list are Chinyelu my wife, and our children: Chioma (Mrs Nzekwe), Amalachukwu, Ogochukwu, Chukwueloka and Makuachukwu. The newly added members, Mr Okey Nzekwe (our son-in-law), Ketoechukwu and Bless God (our grand sons) are also appreciated. Included in this precious family are my siblings, who in some special ways contributed to my progress in life. They are Mrs Roseline Okeke, Kanayochukwu, Pius and Linus and all the members of their respective families.

It is not possible to mention everybody that has contributed in one way or another to this lecture, but I should not forget to show my appreciation to the Vice Chancellor, Prof. B.C.E Egboka and members of the University Management for giving me the opportunity to present this inaugural lecture. To the Chairman of Inaugural Lecture Committee, I love you and thank you for all your efforts in making this lecture possible; and please, I sincerely request you to extend my appreciation to other members of the Committee. I also appreciate the good work of my computer operator, Mrs Juliet Ifeyinwa Ikpeamachi, who type-set the original manuscript of this lecture.

Last but not the least, I thank God Almighty, for it is to Him I owe my life, my successful life in elementary and secondary schools and that of the Universities, most importantly for all that I have achieved as an academic and a teacher.

Ladies and gentlemen, I thank you all for being such a wonderful audience.

Prof. Jerome O. Okafor
REFERENCES


APPENDIX A

11. EDUCATION INSTITUTIONS ATTENDED WITH DATES
c. University of Nigeria, Nsukka - 1975 - 1979
e. University of Ibadan - Sept. 1984 - May 1987

12. EDUCATIONAL QUALIFICATIONS WITH DATES
b. Teacher’s Grade II - 1973
c. B. Sc. (Hons), Health and Physical education - 1979
d. M. Ed Health Education - 1982
e. Ph.D Health Education - 1987

13. MEMBERSHIP OF PROFESSIONAL BODIES
a. Member, Nigeria School Health Association (NSHA) 1998 to date
b. State Secretary of NSHA 1992 to 1997
c. Member, Nigeria Association for Physical, Health Education and Recreation (NAPHER) 1995 to date.
d. Member Nigeria Association of Health Education Teachers (NAHE) 1992 to date.
e. Fellow Nigerian School Health Association (FSHA) from October, 2001
f. Member Nigeria Academy of Education (NAE)
g. Fellow Nigerian Association of Health Educators (FNAHE) from July, 2011.

14a. TEACHING AND WORK EXPERIENCE
i. Classroom Teacher 1973 to 1979 (4 years of study leave in the University included)
14b. WORK EXPERIENCE IN THE UNIVERSITY - 1990 TO DATE

i. Head of Department of Health and Physical Education, Nnamdi Azikiwe University, Awka Anambra State, Nigeria 1994-1996
ii. Sub-Dean, Acting Dean Faculty of Education, Unizik (Oct, 1998-Feb. 1999)
iii. Director Sandwich Unit, UNIZIK (Feb. 1999 to 2001)
v. Director Sandwich Unit (2003 to 2004)

vii. Dean, Faculty of Education, NAU, Awka, 2006 to 2008
viii. Director, Sandwich Unit, 2009 To-Date

14c CONTRIBUTION WITH IN THE UNIVERSITY:

a. Examination Officer- Faculty of education, Nnamdi Azikiwe University, Awka, Anambra State Nigeria 1996-1998

C. Member Faculty of Education Research and Publication Committee, 1993/94
d. Member, Departmental Tender's Board 1993/94
e. Consulting editor, Oriental Journal of Education Research Nnamdi Azikiwe University, Awka, Anambra State, Nigeria 1994 to date

14d. CONTRIBUTIONS OUTSIDE THE UNIVERSITY:

b. External examiner to Enugu State University of Science and Technology, Enugu State/Nigeria 1995 to date
d. External Examiner to University of Nigeria, Nsukka - 1995 to date
e. Consulting Editor, Katsina Ala Journal of Physical, Health Education, Recreation and Dance (KAJOPHERED - 1996 to date

h. Member, Committee on the case of the Diversion of Electrical Fittings Purchased for the Auditorium - 1996
i. Committee on Unauthorised Conduct of Examination - Dr E.M. Katchy January- February 1997
k. Has graduated Twenty (20) Masters candidates, and is currently supervising ten Masters and five Ph.D Candidates.

j. Chairman University Scholarship Committee 2002 to 2004

k. Member University Management & Estimate committee (2001 to 2004).


j. Consulting editor, Journal of Women In Colleges of Education (JOWICE) 1996 to date


l. External Examiner Postgraduate programme in Health Education, UNN - 2003 to Date

m. External Examiner Postgraduate programme in Health Education, Ebonyi State University Abakaliki, 2003 to Date

n. External Examiner Postgraduate programme in health Education, University of Benin, Benin City 2002 to Date


p. External Examiner, Postgraduate Programme in Health Education, Ambrose ALI University, Ekpoma, Edo State. {2006 to Date}


r. Eternal Examiner, Postgraduate Programme in Health Education, DELTA STATE UNIVERSITY, ABRAKA, DELTA STATE. 2008 to Date.


t. External Examiner, Post graduate Programmes, University of Port-Harcourt, 2009 To-Date

u. Consultant For The 2010 UBEC/ASUBEB Teacher Professional Development Programme

BOOKS (Details Of Publications)


BOOK CHAPTERS


**JOURNAL ARTICLES**


16. **Okafor Jerome O.** (1986) Environmental Health Problems of the University of Ibadan as Perceived by the University Senior Students. *Journal of Science education*, 2 (1), 66-82


55. **Nwankwo, B O & Okafor, J O (2009).** Effectiveness of Insecticide-Treated Bednets (ITNs). In Malaria Prevention Among Children Aged 6 Months to 5 Years in a Rural community in Imo State, Nigeria. *International Journal of Tropical Medicine* 4(1), 41-49.


APPENDIX ‘B’

DETAILS OF CONFERENCE/ACADEMIC SEMINARS/PAPERS


