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From Health Education to Health Promotion: The Need for Workplace Health Promotion

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Introduction

I would like to commence this presentation by expressing my heartfelt gratitude to the patron, ex-officio and the entire executive members of the Health Promotion Research Association of Nigeria (HEPRAN) for finding me worthy to be the second lead paper presenter in this epoch-making event: the 16th national conference of the Association. Health Promotion in the workplace is a glaring need that is staring at Health Educators in Nigeria. Virtually all workplaces require Health Promotion but a group needs to sensitize workplaces and take responsibility for how this course could be advanced. This is the focus of this conference: to bring Workplace Health Promotion in Nigeria to the limelight through research. Nevertheless, the need for Health Promotion is apt in Health Education as we take a cue at the evolutionary trend of the discipline to aptly define our relevance in the development of Health Promotion.

Consolidation of Health Education

A history is a past event that is relevant to the present; it is made by man, so is the evolution of Health Education to Health Promotion. Man's quest for disease prevention evolved the theories of disease. The presence of disease is a threat to health. Man battled with the cure of diseases for years till the era of disease prevention which emerged to address the subject of health. This quest set humanity thinking of health and disease prevention.

Five evolutionary theories of disease emerged commencing with the *religious theory*. This theory maintains that disease is a consequence of man's poor relationship with the Creator of the Universe or Infinite Intelligence. Education for health in this era was focussed on morality. As the era of the religious theory was phasing out, the *demonic theory* of the disease crept in. This theory proffered that supernatural powers were responsible for man's predicament in the upsurge of disease. Such forces imposed ill health on man to debilitate him. Consequently, education for health shifted gradually from morality to appeasement of supernatural powers. Within these two eras, the ordained were solely responsible for education for health.

The swooping epidemics of the 17th century in Europe introduced *the miasmatic theory of disease* which birthed the concepts of contagion, poisonous vapour and pestilential air. Hence the *miasmatic theory* prevailed. It introduced the isolation of the sick and quarantine as measures of prevention of diseases. This episode redefined the concept of disease prevention from the imperceptible to the perceptible, from the supernatural to the environment. Man's concept of health evolved into man's ability to dwell in a healthy environment devoid of putrefied air. This era featured the agents of transmission of knowledge of prevention of disease from *the ordained to community agents*.

Exploration of the environment stirred up the discovery that a specific organism caused a specific disease. This shifted man's view from the macro view of the environment to microorganisms. This was the era of the *ecological theory of disease.* Many scientific discoveries were released as to specific diseases and their causative agents. Resource persons for disease prevention set in motion the teaching of hygiene in schools, communities, and the public. A pool of hygienists flooded the schools to exert their influence on the health of school children and the public (Charles, 1959, Ejifugha, 1999).

The *social-ecological era* introduced lifestyle or personal behaviour as a causative agent. Some lifestyles are risk factors and have the same potency to cause diseases as any micro-organism. Within this era emerged the quest for Health Education as a discipline to address the knowledge of numerous health matters including lifestyle (Emeharole, 1987). Nevertheless, the religious and demonic theories of disease still stand. This explains why some diseases that defy medical treatment find solutions in the hands of the ordained. The biomedical upholds the ecological theory of disease; the Sanitarians maintain the miasmatic theory, while Health Educators are still the advocates of the social-ecological theory.

Many definitions of Health Education whether formal, informal, or non-formal, *all have a common denominator: the acquisition of health knowledge, attitude, practice, and skills (KAPS)* for the attainment of personal, family, and community health. The discipline of Health Education emerged in 1918 (Lussier, 1984, and Means, 1975) expanding its boundaries and producing numerous literature in health knowledge, attitude, and practices but literature in health skills is still at infancy. Since Health Education came into Nigeria, the country has been mass-producing health educators as well as literature in the field.

The Concept of Health

The creation of the World Health Organization (WHO) as a world body tasked with the responsibility of health matters refocussed emphases on disease prevention to the concept of health. This transformed the concept of health for all nations. The Organization emphasized that the health of all people is fundamental to the attainment of peace and security and it is solely dependent on the fuller cooperation of individuals and States. The introduction of an individual's responsibilities to health was an emerging phenomenon because historically health maintenance and disease prevention were the affairs of the State (Hutlinger and Mandell, 2002).

The biopathological, ecological, biographical, and communitarian models of health compartmentalized the concept of health (Beettie, 1993). The biopathologicals and the ecologicals were the advocates of physical health. The biographical advocated for mental health while the communitarians confined themselves to social health. These models seemed to have been collapsed into the World Health Concept of Health. WHO's definition of health as 'a complete state of physical, mental, and social wellbeing and not merely the absence of disease or infirmity' provides an ideal state of health. The WHO's concept of health placed the bulk of responsibility on States which battled over the years to face the task of producing healthy individuals for economic growth. In 1998, WHO emerged with *individual's responsibility towards health to cooperate with States* in ameliorating health problems (WHO, 1998). This approach required individuals, families, groups, health care professionals, communities, and nations to develop collaborative efforts which promote the partnership that motivates all people to make an *informed decision* about health and health care including other processes.

Health Promotion: a paradigm shift

Ottawa conference of 1986 gave a paradigm shift from Health Education to Health Promotion. The Ottawa Charter defined *Health Promotion as 'a process of enabling people to gain control over and improve their own health'*. (https/fifforwork.org/blog/what-is-health-promotion accessed 29/09/2019). This development brought many States in motion to embrace the new development in health matters. A shift from Health Education to Health Promotion was predicated upon *the knowledge – action gap on health matters* which existed in the pre-Ottawa Charter version of Public Health. The old public health system could not provide the framework that could direct health care interventions to achieve the desired public health policy, community empowerment, and sustained change in health behaviour (Legge, 1991 in Hutlinger and Mandell, 2002).

The National Policy on Health Promotion confirmed that Health Promotion is broader than Health Education. There has been growing realization that Health Education can influence health knowledge which in its own does not result in a behaviour change. Good enough, Health Education is still one of the three major keys that drive Health Promotion; the other two are advocacy and service orientation. The Nigerian National Policy on Health Promotion (2006*)* called for the need for specialists in Health Promotion who will be charged with the responsibility to receive special training in Health Promotion, whose task is to act as resource persons for the planning, evaluation, and support of Health Promotion.

The global conference in Health Promotion in Bangkok, Thailand, 2005 further articulated the concept of Health Promotion as "*a process of enabling people to increase control over their health and its determinants and thereby improve their health"* (Nigerian National Policy on Health Promotion, 2006). The Policy stated the determinants of health to encompass biology and genetics, individual behaviour, social and physical environment, and health services. It explicitly stated that the resources for Health Promotion are human, technical, and financial. Hutlinger and Mandell (2002) expounded the determinants of health to include the determinants and pre-requisites outside the health care realms such as adequate income, employment, housing, food, education, and safe social and physical environments for health development (WHO 1998; Tsouros, 1996 in Hutlinger and Mandell, 2002).

With these factors influencing health, Health Promotion moves beyond the change in individual health behaviour to positive changes in many aspects of social and environmental factors that influence health.

Workplace Health Promotion

A workplace normally has physical and human entities; the physical aspect of it consists of the physical environment and facilities. The human aspect of it consists of an organization which is a purposeful social unit comprising personnel functions and physical factors and a system of getting work done. Worksite health promotion harnesses the creation of a supportive work environment to drive worksite health promotion programmes such as exercise, nutrition, cessation of smoking, and stress management. Wellness programmes are based on the belief that unhealthy lifestyles can be changed with the right support structure. According to the National Policy on Health Promotion, one of the five key elements of health promotion is to create supportive environments. Others are the development of healthy public policy, strengthening of community action; development of personal skills,

and re-orientation of health services. Workplace health promotion should take advantage of the supportive environment created by the workplace to address programmes that enhance changing patterns of life, work, and leisure.

Work and leisure are sources of optimal health

The steps for workplace health education include:

(a). Promote a healthy culture at work explaining how lifestyle choices affect health and wellbeing.
(b). Allow workers to participate in and consult with workplace initiatives.
(c). Offer training to staff on various subjects related to their health.
(e). Support a flexible working arrangement. (http-fitforwork.org/blog/.2019, 29-09).

Workplace health promotion is defined as the combined efforts of the employers, employees, and society to improve the health of the employees. Health in the workplace is produced by two major factors: *personal resources* of the employers which they bring to the workplace and what the employers do to employees in terms of organization of work in the physical and psychological sense (Shain, 2004, accessed 29/09/2019).

Personal resources of the employers encompass their health practices, belief, attitude, values, hereditary, endowment, self-efficacy, resilience, quality and density of the social support *of the individual*. All these are affected by work and non-work factors. The organization of work in terms of physical and psycho-social work environment makes heavy demand on the personal resources of the individual employee. Management decisions direct the organization of work.

These decisions are influenced *by the management theory* which managers adopt. By inclination to Scientific Management theory or Human Relations theory, some managers are extremists in the applications of the principles of these theories which make heavy demands on the personal resources of the individuals they employed; hence the need for Health Promotion in the Workplace. Shain (2004) observed that literature is more replete on personal health practices and their effects on productivity than on the effects of organization of work on the personal resources of the individual. Literature on the psycho-social aspects of the organization of work is still very scarce.

Aldana (2004) updated in hwww.welssteps.com/blog/2019/01/04 clearly stated seven top reasons for workplace Health Promotion. Workplace Health Promotion programme improves employees' health behaviours; it reduces elevated health risk; reduces health care cost; improves productivity; decreases absenteeism; improves employees recruitment and retention, and builds and helps sustain high employee morale. Nevertheless, all these merits of workplace health promotion focus on the employees and not the employer; at the same time, the employees are the target group and clients of workplace health promotion. Workplace Health Promotion, as a very viable field of endeavour for health educators, calls for the application of the principles of adult learning in Heath Promotion. Additionally, workplace it provides a ready non- formal setting for health education to thrive which health educators should take advantage of.

Conclusion and Recommendations

The paper has articulated the significance of Workplace Health Promotion in the evolutionary trend of Health Education. The era of emphases on school health education, public health education and acquisition of health knowledge for change in health behaviour is gradually fading away. Health Educators must steadfastly capture the opportunity they have in Health Promotion to carve out a niche for themselves in the discipline. These advances should be made in the key elements of Health Promotion: development of personal health skills, community empowerment, creating conducive workplace health promotion, and possibly advocacy. In other words, research efforts must be geared towards these areas and likewise, production of manpower in Health Promotion should be articulated and accelerated. Obviously organization of work induces stress on employees and invariably affects family life. On the other hand, domestic stress influences productivity in the workplace. The areas of research interest for health educators in Health Promotion should encompass:

1. Poor organization of work has the inherent negative influence on productivity. Conflict management and conflict resolution are a *sine qua non* in every workplace. The worksite is an organizational setting for the implementation of conflict resolution skills between employers and employees or among employees. Conflict resolution skills are effectively practised by a neutral professional like the health educator.
2. Organizational- based health promotion is gradually evolving. This is an area of research and manpower development. It guarantees a setting for non-formal health education.

3. Since the organization of work and its influence on the psycho-social health of the employees is still at its infancy, researchers in Health Promotion should plunge into this area to produce an abundance of literature.
4. The extending boundaries of determinants of health call for intensive research work since they constitute the pillars of health promotion.

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