4-CIRCLE BASE TRIANGULAR MODEL IN AGEING AND DEATH EDUCATION

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A. Introduction

It is my pleasure and privilege to be here today to give this 45th inaugural lecture of our dear University, the only University of Nigeria. This lecture has to be inaugural because I have not been able to give one since I became professor some nine years ago, and an action (even the very wrong one) is ever better than inaction. Since my whole idea of inaugural lecture is to share with the world around me the thrust of that my academic journey which placed me in the professorial brackets, the apex of this career of ours and to point at the path I shall pass in the coming years of my academic journey to the **END.** Incidentally, I am squarely at the ends, the end of two important processes in life – ageing and dying. Both of them begin at conception and pull through the other phases of human life before they finally terminate at old age and death respectively.

Taking a look at any of these ends is what is called 'vision' and since this vision will always stare you in the face you are compelled to fashion out ways of realizing the vision. These ways of realizing the vision is what is called 'mission'. This is why people at the ends live their ends daily and they are most concerned about the beginning and

what transpires between the beginning and the end because at the end itself those who neglected the earlier stages face frustration and irreversibility. In other words, those at the ends do not take any stage of life for granted since eventual end is predicated upon the earlier stages that lead to the end. All this while, ladies and gentlemen I have been at the ends, so I have no other option of choice than to come up with a model which is basically aimed at preparing one for some kind of 'good evening' achievable through adoption or acquisition of healthy lifestyles.

In this lecture, therefore, we shall try to discuss a few popular lifestyles which one could develop or adopt through proper application of the 4-circle base triangular model. The two ends, ageing and death, shall also been discussed in some greater detail with a view to helping us generate our ageing-based and death-based ideas which will metamorphose into lifestyles of the healthy type. Let us now take these four parts of my lecture; lifestyles, 4-circle base triangular model, ageing education and death education one after another.

B. Lifestyles

It is a known fact now that the major causes of early death have shifted from communicable diseases to chronic lifestyle-related conditions. Incidentally, positive alteration of lifestyle is known to result in reduced risk for non-communicable diseases and associated conditions, and people with poor health habits have twice the relative risk of death of those with good health habits. This is why now, more than any other time in history; efforts are being made

to promote healthy lifestyles among youths in particular, in order to help them have a ‘good morning’ and people in other human age brackets in general for their ‘good afternoon’ and a ‘good evening’. Eight lifestyle equations or options are available to every one of us and the eight of them have been arranged in a special order with the best or most desirable equation on top and down in that descending order to the worst option. Below are the options:

1)	GM(Good Morning)	-	GA (Good Afternoon)	-	GE (Good Evening)	– Fantastic!
2)	BM	-	GA	-	GE	
3)	GM	-	BA	-	GE	
4)	BM	-	BA	-	GE (Miraculous)	
5)	GM	-	GA	-	BE	
6)	BM	-	GA	-	BE	
7)	GM	-	BA	-	BE	
8)	BM(Bad Morning)	-	BA(Bad Afternoon)	-	BE(Bad Evening)	– Terrible!

The sad aspect of these equations is that the option chosen by one does not affect only the person making the choice, but also affects both members of the immediate family and the society as a whole. Let us, for instance, consider the difference between options two and three. In option two the individual had a bad morning when he or she was most dependent, but as youth and early adulthood he or she had a good afternoon. This good afternoon usually helps to create a good morning for his or her offspring both of who are most likely to join hands together to make a good evening for their parent and a good afternoon for their children In equation three he or she had a good morning but had a bad afternoon which destroyed

his or her children. Though his or her evening is miraculously good, the most likely thing is that the evening is bad where it turns out good especially here in Nigeria it is an uphill task. One is at liberty to consider each equation very deeply.

In about two decades now, I have been considering these equations and the result is a shift in paradigm which made me devote my academic efforts to teaching, research and writing about the various human lifestyles, the healthy ones in particular, which actually deserve the attention of every health educator. All through this period, I have tried to nurture a growing passion for helping people acquire, adopt or develop healthy lifestyles. I see it an area I will continue to explore for the rest of my earthly life as an academic.

Though all people will be ill at some time in life, but the target of every health educator is to educate about health in such a way that the days of illness are reduced to the barest minimum and the number of healthy days each of us experiences optimally increased. Most interestingly, lifestyles and behaviours are in our control, and if we make changes and adhere to them, good things will happen. The health of every human person is definitely not static, and cannot be preserved in the box, stored on a shelf or given to other persons. Thus, it remains ever true that the health one had yesterday no longer exists and the health one aspires to have next week, next month or next year is not guaranteed, but what one does today will help determine the quality of his or her future health. Regardless of one's present age and state of health, therefore, it is possible for one to still achieve a higher level of wellness

by acquiring the skills for developing and integrating healthy lifestyles in one's style of living.

Okafor (2007) selected twelve of these healthy lifestyles and had severally discussed them, but for emphasis and the zeal to satisfy my passion I have opted here again to briefly build them into this lecture. The healthy lifestyles among others are listed here now with the first three as 'the top three' and top in deed. The rest, 4 – 12 have only been presented in a simple alphabetical order and not in any order of importance. They are:

(1) participating in physical activity regularly,
(2) eating properly,
(3) managing stress,
(4) adopting good personal health behaviours,
(5) adopting good safety habits,
(6) avoiding destructive habits,
(7) being a skilled consumer,
(8) learning first aid,
(9) practising healthful sex,
(10) protecting the environment,
(11) seeking and complying with medical advice, and
(12) time-management,

Participating in Physical Activity Regularly

Participating in physical activity regularly is habit-forming, but the result of the habit so formed is ever positive, not negative. Thus, participating in physical activity regularly even to the level of addiction is a positive behaviour. Some of the major benefits of participating in

physical activity include: increased cardiovascular fitness and health; less body fat and greater lean body mass, improved flexibility, reduced effect of secondary ageing, improved appearance, bone development (greater peak bone density and less chance of osteoporosis), reduced cancer risk, improved strength and muscular endurance, reduced diabetes risk, reduction in mental tension, opportunity for social interaction, resistance to fatigue, extended life, decrease in dysfunctional years, aids some people who have arthritis, asthma, and chronic pain. We shall come back to this lifestyle later in a fairly more detailed form under the ageing education section of this lecture.

Eating Properly

Good eating habits have a substantial impact on health and quality of human life. Presently, five of the ten leading causes of death (e.g., coronary heart disease, kidney diseases, cancer, stroke, and adult-onset diabetes) are nutrition related. If alcohol consumption was considered a dietary behaviour, then accidents, suicide, and cirrhosis should be counted among the leading causes of death that could be prevented by eating properly. Three cardinal points of necessity in eating properly, borrowing from the dietary guidelines for Americans, remain imperative and they are: aiming for fitness (e.g., aiming for a healthy weight) as you eat; building a healthy base (e.g., choosing a variety of grains, fruits and vegetables daily, and keeping food safe to eat) and choosing sensibly (e.g., eating food with less salt, saturated fat and cholesterol) what to eat. These cardinal points Okafor (2005) reported are made

most difficult if not impossible to attain by people's dispositions towards food myths, taboos, and beliefs.

Managing Stress

Stress, experienced by all people, regardless of culture, significantly influences the development of illness such as cancer, cardiovascular disease, and eating disorders. Being unable to control stress effectively is also linked to an increased incidence of violence. On the other hand, Okafor and Okafor (1998) asserted that learning and practising stress management skills promote wellness.

Adopting Good Personal Health Behaviours

Many of the healthy lifestyles discussed in this lecture are good personal health habits, but this sub-heading has been purposefully isolated to bring out the fact that commonsense is truly not common, and that there are many personal health behaviours which adults and youths or adolescents fail to adopt because they seem elementary, childish, and common. Unfortunately such simple and elementary personal health behaviours which are important to optimum health do not have competent health teachers to handle them (Okafor, 1998a). Some of such behaviours include: engaging in personal and group prayers, attending catechism and religious lessons, proper sleeping habits, good posture, regular brushing and flossing of the teeth, care of ears, eyes, and skin, proper inoculation for disease prevention and so on.

Adopting Good Safety Habits

Accidents are a major cause of death in Nigeria even

though we cannot statistically account for the specific number of deaths caused by them. In addition to causing death, they result in varying disabilities and problems that are capable of detracting from good health and wellness. Okafor (1993b) stressed the fact that not all accidents can be prevented, but it is possible to adopt habits such as regular use of seat belts, proper maintenance of play and work equipment, proper maintenance of cars, motorcycles, bicycles and others that can greatly reduce the risk of accidents, injuries and deaths. Young ones should not engage in experimental driving or driving parents' vehicles without their permission and approval.

In one Nigerian university, there was a rule prohibiting students from cooking in their hostels. As is usually the case, many students did not have any regard for the rule and the hostel staff didn't help matters. The students then went ahead with pleasure to cook in their hostels. For over ten years no mishap occurred. Situations were normal, but in the 14th year of existence of that particular hostel there occurred fire outbreak. Shouts, screams and cries in varying degrees left all the people around helpless. While some were running towards the burning hostel others were running farther away from it. Those who ran to the scene found themselves helpless and only ended up becoming ordinary observers. They, in the absence of the fire fighters and non-availability of fire extinguisher watched the fire as it consumed the hostel. Victims were rushed to the hospital and about four of them finally died.

One of the cars belonging to a university staff used for rushing the victims on the way unexpectedly caught fire. This driver who had no fire extinguisher forgot he was

carrying a victim so rushed out of his car with shouts for help. Meanwhile, the dying victim lay helpless in the car unable to get up to help save her dear life. People who rushed to the scene collected sand and green leaves and threw them on the burning car. Fortunately, the owner of the second vehicle conveying the victims had a functional cylinder of fire extinguisher which he pulled out and ran to the vehicle in front and 1st, 2nd and 3rd flushes of the implement put off the flame. Mark you, it is not impossible that the driver without fire extinguisher had before now bribed the road traffic officials who probably 'set him free' as many times as he was caught for not having one.

Avoiding Destructive Habits

The use and abuse of tobacco, alcohol, other drugs and substance, are among the most destructive habits. The unfortunate aspect of these habits (usually formed through peer influence, social acceptance; desire to be 'mature' 'independent' and to be like their role models or the adverts that are appealing) is that once they are adopted, they are exceptionally difficult to break or eliminate. Fortunately, they belong to the lifestyles or health behaviour over which one has personal control even though breaking the habits may take the assistance of others who are prepared to handle such dispositions as "something must kill somebody," "my father smoked all his life and never died young," "I don't intend to inherit the earth," and so on.

Being a Skilled Consumer

Each individual has available to him or her three key elements to consume and they are information, product and

service. Okafor (1999) reported that the unskilled consumer is gullible and purchases elements that are ineffective and often dangerous. This is most serious in Nigeria now, where quacks and producers of fake goods are everywhere. What is needed is the investigative skill particularly for health products and service of all kinds.

Learning First Aid

It is a known fact that many deaths could be prevented if those at the site of emergencies were able to administer first aid. It follows that whether one is a health personnel or not he or she needs to be familiar with cardiopulmonary resuscitation (CPR), the Heimlich manoeuvre for assisting a person who is choking, first aid for minor injuries, poisoning, control of bleeding and other important procedures. At the primary level of education here in Nigeria, the Federal Ministry of Education and UNICEF has provided a guide to the introduction of first aid though before then Okafor and Uzoalor (1993) had produced the needed materials for first aid at the secondary school level.

Practising Healthful Sex

Healthful sex is sexual intercourse had by two legally authorized male and female partners capable of taking responsibilities without committing abortion for the outcome of their intercourse. It follows that one who has no legal partner should live without sex. The physical and social consequences of not keeping to a legal partner Mba and Okafor (2003) identified as calamitous. This is why it is always safest to practise and live abstinence, after all the nearer one is to sex the sexier he or she becomes. Good

enough, the key to prevention of the most common sexually transmitted infections (STIs) is healthful sex (Okafor, 1991).

Protecting the Environment

The damage done to our Nigerian environment is yet to be felt and suffered by us. It seems the Nigerian public is not concerned a bit about the environment. If our environment had a mouth it would have raised alarm for safety. Okafor (1997b) then presented death as a stimulus and Okafor (2000a) was later compelled to ask if those responsible for helping the people of this country were teaching or cheating health. Honestly, the need to take an immediate and drastic action to protect our environment still remains crucial. Some of such actions include: learning to dispose refuse and sewage, avoiding noise pollution and so on.

Seeking and Complying with Medical Advice

Some people purposely avoid seeking the advice of a physician because of ignorance or the fear that something may be wrong and discovered. This is unhealthy. The healthy lifestyle here is not to delay treatment, for a stitch in time saves nine; take regular preventive medical exams (i.e., for women especially after 40 years regular self-exam for breast cancer and for men regular testicular exam and a prostate test); be familiar with the symptoms of the most common medical problems in our culture; seek medical advice if symptoms are present; comply with the medical advice, and if in doubt with the advice given seek a second opinion. It is always safest to avoid quacks or charlatans

(Chuku, Kanu, Okafor, & Adikwu, 1996; Okafor, 1999).

Time-management

One of the most denied, irredeemable, irreducible, irreplaceable, and irreversible commodities to which most people would say "I don't have" is time. No matter the weather or circumstance, time for each day remains 24 hours and has never waited for anybody. This is why it is most important to learn to use your God-given time. Although no single best approach has been developed for managing time, most experts suggest the following: make a list of your priorities analyzing what you value in life, and eliminating unnecessary activities; keep a daily record of how you actually spend your time; make a schedule on a daily basis accounting for every minute of your day, then strive to conclude activities that you have started, and reassess your schedule from time to time and adjust accordingly.

Concluding this section of the lecture, it seems to me most appropriate to ask our people when we shall wake up to our responsibility of adopting healthy lifestyles. Though all factors that influence our health and wellness are not under our control and people who do all of the right things still have health problems, still the best way to make a difference in our own health and wellness is to take control of the things over which we have control, and healthy lifestyle adherence is under our control. Paying attention to the healthy lifestyles can always contribute to our well-being. Regardless of our present state of health, we can still achieve a higher level of wellness by integrating these components in our style of living (Okafor, 1997d). In

order to achieve this, we have to adopt these healthy lifestyles through adoption or adaptation of the 4-circle base triangular model for life is not an illness for which we seek a cure, but a journey to be enjoyed.

C. 4-circle Base Triangular Model

This our time is the age of psycho-technology, a time when we will begin to unleash the amazing powers and inner abilities that we are all born with. Just like the saying that there is nothing we have that was not given to us, every attitude of ours is learnt, habits formed, and lifestyle developed or acquired. Naturally, each of us exists as the only one of his or her kind in the entire world, so you are, here and now, the only you on earth. This may be why we are full of our individual differences. Thus, it is not surprising that each of us has some personal convictions about his or her environment and the safety therein. While one is concerned about some aspects, some others are unconcerned about the same aspects the other is passionate about making the existence of many models possible (Okafor, 1996). Ideas are also like that, because each of us has his or her ideas not necessarily shared by others or even by the work place safety profession as to what is important and good for his health and what is of little importance or of dubious value. Each person will do certain things and will not bother to do other things which are presumed either to promote or to endanger health and safety. The question then is: “How do we acquire these healthy lifestyles?”

I present to you this my 4-circle base triangular model which provides the avenue for developing each of

the much needed healthy lifestyles.

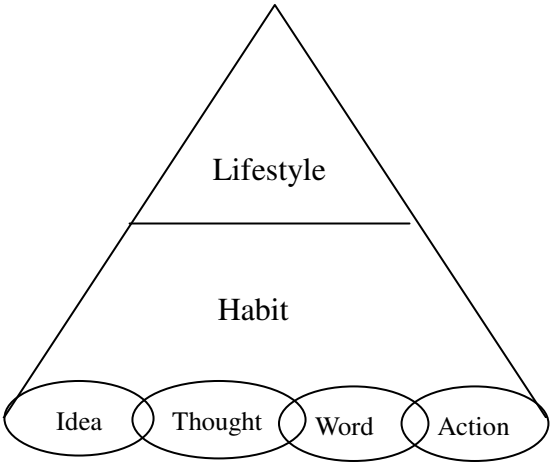

Fig One: *4-circle Base Triangular Model*

The model is a triangle which has four interlocked or chain linked circles of **idea, thought, word,** and **action** as its base with two sides formed half way with habits and finally completed with the desired lifestyle which in itself is a full pyramid. Left alone that upper pyramid would exist without the four circles and habits. Ideas, it is said, rule the world and every single action or invention begins as an idea. Inventing electric light, for instance, came to Thomas Edison, as an idea. Fortunately, he did not suffocate the idea, rather he moved it into the first circle through the two other circles to the action circle. In each case Thomas failed and failed as many as 700 times. For him, however, failure did not exist in his dictionary, but only an attitude not

actually an action or outcome. It was in this frame of positive mind that he said:

> I have not failed 700 times. I have not failed once. I have succeeded in proving that those 700 ways will not work. When I've eliminated all the ways that will not work, I will find the way that will work.

When his idea came he gave it the highest degree of positive thought. Both his word and action were also positive. It is an action practised several times that develops into a habit and such a habit if lived translates into a lifestyle. The target, of course, is to give the model its triangular shape or complete the pyramid, and the completing component is 'lifestyle'.

The truth is that several ideas came and has continued to come our way like waves. Generally, the ideas terminate in the 'idea' circle of the model with no definition of a new possibility and no break from the past, thus not answering resignation, hopelessness and despair with empowering thought and interpretations needed between 'idea' and 'action'.

Many ideas have been so suffocated or dismissed that the second circle, 'thought' never existed. We are thus left in our usual way of thinking, business as usual, and our problems continue to live with us. In the words of Albert Einstein "Our current problems cannot be solved with the same level of thinking which created them." It becomes imperative that we must think outside the box.

'Word' proceeds from 'thought' and where the thought that should be new is terminated then 'word' must proceed, but this time from our old thought leaving us with no commitment at all. Certainly, there is hesitancy and the chance to draw back until one is committed. This means that 'action' won't also be taken. If in the contrary we toe the positive side of the model then it goes on like that until lifestyle apexes the pyramid.

The more important task now is that of applying the model on ageing and death education in particular and on the other fifteen broad areas (Federal Ministry of Education and UNICEF, 2008) of Health Education in general. In Nigeria, ageing and death (purely for convenience) are always taken together as if there was a special important relationship between the two. No such relationship exists that must bind the two together. It was just that ageing education and death education emerged as missing dimensions of Health Education (Okafor, 1992) at the same time and the best way to accommodate the two separate issues in the already existing Health Education curricula at all levels of education in Nigeria was to grant them a marriage of convenience.

This explanation is important because death respects no age brackets and can pick its victim from any bracket of its choice. It is a known fact that very aged ones live their active lives when death comes to pick a baby in the womb or a national youth corps member in his or her place of primary assignment and we can go on and on to list other brackets where death can smoothly show its existence. In both the primary and secondary Health Education curricula this marriage of convenience is also retained. In this section

of the lecture, therefore, ageing and death education shall be taken one after another with a view to applying the 4-circle base triangular model on each of them.

D. Ageing Education

Ageing education became a conspicuous vital component of Health Education in the late 80s to address the public health challenge and an important development issue 'Population ageing,' requiring an urgent action. Population ageing simply means increased and larger number of the older individuals relative and absolute to the population of the people in a specific setting. It is this paradigm shift from a 'young population' to a 'population ageing' that gave rise to ageing education.

Population ageing can be traced to family planning particularly in Europe and Americas, where family planning was so abused that it became almost only birth control with very severe emphasis placed on number of children. In China, for instance, number of children per family dropped dramatically from 5.5 in 1970 to the current 1.8 level which is below 2.1 replacement level following their "one-child-per family" policy. In Brazil the drop was from 5.1 to 2.2 narrowly attaining the replacement level and in India it was from 5.9 to 3.1. Okafor (2001) then posited that population ageing can rightly be attributed to two demographic factors of fertility and mortality.

As for mortality WHO (1997) reported that average life expectancy in the developing world in the early 1950s was 41, in 1990 it rose to 62 years, and in 2020 it shall reach 70 years. Already in over 20 developing countries including Argentina, China, Malaysia, Mexico, and

Thailand it has already exceeded the age of 70. WHO added that the number of people aged 60 and above is rising world wide, and projected that by 2020, more than 1000 million of the people in the word will be over 60 years old and two third will be living in the developing countries.

This rise in life expectancy can further be traced to decline in premature mortality from many infections and chronic diseases during the last century, and sanitation, housing, nutrition, and in medical innovations, including vaccination and the discovery of antibiotics. With this rise in life expectancy number of children who reach adulthood and adults who reach old age keep increasing. The import of this phenomenon is that more and more people will be entering the age when the risk of developing certain chronic and debilitating disease is significantly higher, and that what was an extraordinary achievement of the 20th century now turns the great challenge for the century which is ensuring that all of them enjoy optimal health and wellness. The target then is to provide ageing education that is capable of helping people enjoy active ageing. Kalache (1999) defined 'active ageing' as "the process of optimizing opportunities for physical, social, spiritual and mental well-being at later life in order to extend healthy life expectancy" (p.299). Messages and activities are the two main operative terms for ageing actively which we will give attention.

Messages of Active Ageing

Active ageing has three key messages (WHO, 1999) which we need to internalize namely:

i. accept and get people to accept to accelerate ageing and to know that ageing is good for all of us, and that the alternative, premature death, is bad for individuals and societies alike;

ii. the society is for all such that active ageing remains the key for continuing contribution to society portraying all dimensions (physical, social, mental & spiritual) of being graceful, and

iii. intergenerational solidarity be instituted with no marginalization of older persons just in tune with the United Nations International 1999 Year of Older Persons, "Towards a society for all ages."

Activities of Active Ageing

WHO (1999) grouped these activities into five categories – attitudes, environment, lifestyle, social dimensions, and diseases and discrimination.

i. Attitudes.

WHO isolated six major myths which help to fashion the attitudes of people.

a) ***Myth:*** "Older people are all the same."
Fact: The fact is that the longer people live, the more diverse the elderly population becomes.

b) ***Myth:*** "Men and women age in the same way."
Fact: In reality there are very significant differences.

c) ***Myth:*** "Older people are frail."

Fact: Surprisingly, the vast majority of the older people remain physically fit far into later life.

d) ***Myth:*** "Older people have nothing to contribute."

Fact: In reality, the contributions of older people are difficult to quantify, but their net contribution to their families and communities is large.

e) ***Myth:*** "Older people are an economic burden."

Fact: In reality, this burden is caused, to a large extent, by older people being excluded from paid work, despite their willingness and ability to continue.

f) ***Myth:*** "Most old people live in developed countries.

Fact: The fact is that 355 million of the world's 580 million older people live in developing countries.

Later WHO (2002), Gatz (2004) and Nelson (2005) expressed concern for wellness of rising number of people aged 60 years and above which led to spanning the spectrum of attitude from a pessimistic view that equates age and ageing with ill health and increasing financial burden on the welfare state, to a focus on active ageing. Our attitude towards ageing has been so negative that people who pray for long life receive it, but reject the features of the answered prayer which include: graying and loss of hair fought or suppressed with dye or by physically

pulling them out and regular clearing of the entire hair in order to make it impossible to observe the bald portion of the head. Others include loss of teeth replaced with artificial ones, wrinkling of skin suppressed with plastic surgery, and so on.

In the face of this negative attitude, retirement is seen as a monster or a terror which must also be fought but because ageing is a process, one is compelled to retire even after all forms of falsification of age. The person who physically manifests his or her negative attitude towards ageing according to Ney (2005), Perek-Bialas, Ruzik, and Vicova (2006) and Walker (2006) keeps pushing forward the new economic status and the fact that retirement marks a major change in the second half of life. Planning ahead which is more crucial can hardly be executed by one consumed by fear of ageing. Attitudes fall within the second circle of the model.

ii) Environment.

Our life course begins before birth, that is, from conception. Foetal – foetuses undernourished in the womb grow up to be adults more likely to suffer from a variety of diseases including coronary heart disease and diabetes. They also age faster than people who receive good nutrition during early life. Childhood – malnutrition in childhood, particularly during the first year of life; childhood infections such as polio and rheumatic fever; exposure to accidents and injuries all make chronic and sometimes disabling diseases more likely in adult life.

iii) Lifestyle.

It is most appropriate here to draw attention to the healthy lifestyles already discussed. Most importantly are the top three ones on the list: participating in physical activity regularly, eating properly, and managing stress. Adding to what we had earlier discussed on this lifestyle, it is important to state that the elderly needs exercises which will help them to: maintain the flexibility of the joints, improve blood circulation, increase breathing ability, maintain the strength of muscles necessary to keep the spine in proper form, maintain the usefulness of all moving parts of the body, and keep the heart in shape.

Though it is good to make the elderly feel less elderly without necessarily being glued to the ageing stereotype, and engage in physical activities it should be borne in mind that exercise and overexertion are two different things. Overexertion is bad for the young and even worse for the elderly. The purpose of exercise is to get rid of muscle pain, not to increase it, create relaxation, not anxiety; train the lungs not to exhaust them, and improve circulation, not to tax the heart. This is why it is most unhealthy for the elderly who, for example, is a tennis player to engage in any form of competition, even to play one game on the court. Tennis has here been used as an example which one should apply to all other forms of physical activities one engages in.

The elderly, therefore, should bear these ground rules in mind as they engage in exercises. I repeat, in ordinary physical activities and not in games and contests. The rules are:

1) do the exercises regularly, daily if you can or 3-4 times weekly. It's a matter of building up your capabilities, not to put them to a test, so be recreational with no single element of competition;
2) don't rush. Start slowly, do things at your own pace, feeling comfortable doing each of them. You may allow yourself 15 minutes to an hour to do your exercises;
3) a little heart pounding and panting after an exercise is normal as long as it doesn't continue for longer than a couple of minutes following the exercise;
4) exercises are best done two times each day; on arising in the morning and before going to sleep for the night. The morning exercises can begin while still in bed (lying position exercises) and they go along well with 'morning stretching';
5) the morning ones take the stiffness out of the joints and the sleepiness out of the muscles, while the evening exercises put a little fatigue into the muscles which enhances relaxation and helps set the stage for a restful and sound sleep, and
6) as much as you're physically able, try well-selected exercises choosing the ones you prefer (either for fun or because they help you most) and do them according to your schedule.

Better physical fitness is necessary to improve survival and the quality of life in ageing people. This way, they can look and feel well, carry out their daily duties and enjoy their different forms of activities and meet unusual or emergency demands. At least one aspect of ageing, the

decline of efficiency, can be inhibited by 25 years and more, provided there is systematic and lasting application of suitable physical training. Although there is no proof that exercise extends life, there is sufficient evidence that physical fitness can improve changes of ageing.

The second top healthy lifestyle, eating properly, as earlier stated has a substantial impact on health and quality of human life. Share with me the level of ignorance of old. When we were children our parents rated children who ate meat as potential thieves and bad boys. The girls hadn't the opportunity of eating meat at all except the little given to them by the mothers. Old people then took almost all the meat served in the family. One lump of meat was given to us which we shared yet nutritionally speaking those who had no much need for protein consumed the protein in larger quantity while those of us who needed it only tested to comfirm its taste. The sad aspect of this old practice is that it still lives with us. In many homes and functions, younger ones are still receiving the same treatment of meat denial while old people waste very precious protein needed by children and punish their liver with large quantities of meat. Something needs to be done about this unhealthy lifestyle.

The third top healthy lifestyle, managing stress, places a special demand on us because our lives can never be stress-free. This is why it is desirable that we approach life with a positive perspective capable of providing us with a sense of hope and anticipation, as well as an understanding that life will never be without stress. Without here now delving into the specific stress management techniques such as progressive muscle relaxation, meditation, and

cognitive behaviour training it is necessary to adopt a realistic perception of our today's fast-paced world. Some of the perceptions are:

1) accept that no human person is perfect, so be always prepared to tolerate mistakes;
2) take control of your own future, by accomplishing all your goals;
3) anticipate problems and refuse to be surprised by any trouble;
4) think success, visualize success and act success without disregarding possibility of failure;
5) reject negative thought patterns;
6) live each day well, combining activity, contemplation, and a sense of cheerfulness with the many things of each day;
7) accept the unchangeable, since you have no direct control over the event, and
8) look for spiritual guidance, not leaving out your prayer for whatever reason.

iv) Social Dimensions

This involves social integration and security which requires each of us to stay peacefully in his or her family, community, club or religious organization, and being aware of and speaking out against ageism (i.e., negative or pejorative image of and attitudes towards an individual simply because he or she is old). The other two aspects of social dimensions are that you continue to educate yourself and all your children, and to see how you handle your retirement.

Let us briefly discuss only the last aspect of the social dimensions, handling your retirement. There are two main categories of retirees namely: retirees in good evening (reorganizers, focused retirees, disengaged retirees, & adventurers) and retirees in bad evening (succourers, apathetic retirees, & disintegrated retirees) yielding seven types of retirees. Those in good evening are generally characterized by high satisfaction in life, open to new experiences, possessing good cognitive abilities and see themselves as competent, and achievement-oriented. Those in bad evening are very other people dependent, seem to have little interest in what goes on around them, and they show gross psychological disorganization.

Reorganizers are those who engage in a wide variety of activities such as business at retirement, engagement in community, political and religious affairs. They show a great deal of success in any venture they engage in at retirement. The **focused retirees** are those who remain active, but selectively so. Retirees who are focused may just opt for politics and nothing else no matter the pressure. They only go into activities that give them joy and in which they are almost always assured. The **disengaged retirees** are those who retire happily with a high level of satisfaction except that they demonstrate involvement in little or no activities at all. They withdraw from role commitments and watch and enjoy the world. The **adventurers** remain ambitious and achievement-oriented. They work hard in order to still obtain satisfaction from life. They try to maintain their health and youthful physical appearance.

Succourers are retirees whose joy and happiness at old age are dependent on other people. With a meaningful support they are active and seem to adjust to ageing, but in the absence of support they become sad and inactive. The **apathetic retirees** are primarily passive with little or no interaction with others. Nothing that goes on around them makes sense. If you buy bread they ask for biscuit and if you buy meat they ask for fish. They are very difficult to satisfy. The **disintegrated retirees** are those who are virtually impossible. The only thing they can do by way of interaction is to keep those around them unhappy no matter the degree of benevolence shown them. In most other countries outside Africa they only maintained in institutions, where specialized health workers provide the care needed by them.

In all these, Nwagu and Okafor (2008) hold that the type of retiree one becomes is consequent upon one's long standing lifestyle. This is why we cannot do without acquiring different healthy lifestyles at every level of our existence here on earth and adopting specialized groups approach to educating our elderly ones (Okafor, 1998b). Before we leave this section may I suggest some ten things you need to do before you retirement.

- Develop an optimistic view of ageing.
- Understand and live out the implications of primary and secondary ageing.
- Develop and insist on several healthy lifestyles of your choice.
- Invest on human beings while you age without thinking it is insurance.

- Get rid of your debts before retirement.
- Start saving today no matter how little it may seem.
- Don't allow your fear of retirement to change your birthday.
- Visit your home town regularly so you don't retire into it a stranger.
- Ensure you know or have the house you will retire into.
- Prepare your retirement budget.

iii) Diseases and Discrimination

- Ensure necessary lifestyle adjustments
- Make use of available prevention programmes
  - ✓ Screening blood pressure
  - ✓ Blood sugar
  - ✓ Eye sight
  - ✓ Diabetes
  - ✓ Weight control
  - ✓ Vaccination
  - ✓ Cholesterol test
- See your doctor at regular intervals and be at home with the preventive aspects of communicable diseases (Okafor, 1990).

Be aware of and speak out against gender discrimination and prejudice (avoid gender stereotype)

D. Death Education

There can be no meaningful development of healthy lifestyle in this area of Health education without first and

foremost discussing a few major components of death education. The discussion in this section is aimed at providing the spectrum for applying the model. Five such areas to be discussed in this section are: meaning of death and death education, need for death education, death attitudes, and grief.

Meaning of Death and Death Education

Death has three levels: physical, psychological and social, as delineated by Kalish (1986). Physical death is either clinical or biological. Clinical death is an all-or-none proposition in which the individual is either declared functioning or not functioning, that is, cessation of life. In biological death, the individual dies in parts such as having a 'brain death' while the other body organs are still reasonably healthy.

The second level is the psychological death in which one is aware of self or the world around. With regard to AIDS it is stigmatization or isolation. Whereas physical death is irreversible, psychological death is reversible. Lastly, one can be socially alive or dead to oneself, but whether one has attained a social death depends on the ways in which others perceive him or her. When one for all practical purposes, is perceived as dead or non-existent, he or she is socially dead for that person. Social death according to Kastenbaum (1991) may also occur before the end of biological life, when the dying person experiences limited contact, muted voices and averted eyes as in the case of AIDS.

In other words, the last two levels of death may be rightly classified as dying which is a process of attaining

the state that is death. Cessation of life is neither in psychological death nor social death. Any such process that terminates in death is referred to as apparent-dying. In all these levels of death or types of dying the health arenas attempt protection, promotion and maintenance. Every prevention effort is therefore aimed at either stopping death or managing dying through death education. This prevention is the goal of education even though prevention is predicated upon prediction, and most people are not good predictors of human behaviour.

Okafor (1994-95) reported that for the first time in the formal development of teacher education in Nigeria, the National Universities Commission (NUC) in 1990 introduced education about death in the Health Education programme of Nigerian universities. Before then, it has not been known that there is any other level in the Nigerian educational system where death education was offered. Motivated by the challenging stride of the NUC, we embarked on empirical investigations into death-related phenomena. As a beginning death educator, I attempted to start education about death in my home. This I did by giving the youngest of my sons an Igbo name, Onwubundu, meaning 'death is life.' The name faced and has continued to face a lot of resistance or generate surprise simply because it contradicts most of the existing death-related Igbo names. The name, Onwubundu, has long been abbreviated to 'Bundu,' and with some people to 'Bundus' which means "…is life." This is done to make sure that death (Onwu), the prefix of that name, is not mentioned at all. Greater part of these attacks and disagreement took place in and around the home, and the mother of this child

was clearly seen to have been in the best position to kill or uphold the name.

Okafor (1993a) has pointed out that education is not confined to the limited time frame of the classroom and that any preparation for understanding and dealing with the experience of death and dying ought to begin in the home. Hardt (1979) also submits that if the issue is really to be faced that the place for the two "taboo" subjects – sex education and death education – as they are called, is the home since both are basically parental responsibilities.

Okafor (1993a) then asserted that throughout history, women have occupied the central place between life and death in the Nigerian Home. They understand and fulfil their gender roles in several other aspects of life, but not as concerns death and dying. Nigerian women are not alone in this propensity for death avoidance. Men in the Nigerian culture also exhibit the same death avoidance characteristic as women. Here in Nigeria, therefore, it may not be improper to assert that the subject of death has remained a taboo. It is not surprising that most parents are presently not capable of talking even with themselves about death, let alone talking with their young ones.

Fortunately, death education has in recent times successfully found its way not only into health education curricula of Nigerian universities as part of minimum standards set by the National Universities Commission (NUC) for award of a Bachelor of Science (B.Sc.) honours degree in Health Education, but also at both primary and secondary school levels of Health Education. Before then death and death-related phenomena it must be said were swept under school and departmental carpets with the hope

that death may be forgotten. Unfortunately, death would always intrude by forcing its head out of the carpet, thus instilling untold fears and anxieties in students (Okafor, 1994-95) non-students (Okafor, 1997a) in several unexplored sites (Okafor, 2000b; Okafor, 2002) alike..

Such a carpet that hides death is now being removed at virtually all levels, exposing death as a hidden explosive and even joining the world in internationalizing death education (Crase, 1993). Obviously, death is an integral part of our lives, so the mask that hides it must be removed. This can only be done by engaging in death education fundamentally at home where 'teachable moments' and 'nurturing moments' abound, and later on in school. It is interesting to report that Nigerian schools and colleges have presently a good number of literature or curricula addressing the topic of managing death, or developing death attitudes with a view to acquiring positive preparatory experiences since part of adventure into life is understanding death (Okafor, 1994b).

This supports the recommendation of Okafor (1993a) that as a multi-disciplinary subject area, death education should be treated as such at all levels of the nation's educational system to enable many people to realize that we must communicate about death. For about two decades now, the thrust of my academic effort has been to present the usefulness of death education or its rationale some of which require to be shared with you in this lecture.

The Usefulness of Death Education

In the past, most Nigerian people died in their homes, a situation that offered several people death experience.

The story is different today because dying at home is now associated with poverty on the part of the bereaved family. People therefore struggle to remove even their apparently dying relations to nearby hospitals to avoid having them die in the home. Even when the dying relation has died, his or her corpse is usually stolen away by his or her people to a nearby hospital from which the corpse is publicly conveyed home. This situation which calls for death education in the home agrees with conditions described by such scholars as Hardt (1979) and Crase and Crase (1984).

It seems that here in Nigeria and in most other African countries, even though there may not be much supporting statistical evidence, that our children survive more (reduced infant mortality), pregnant mothers also survive more (reduced maternal mortality) in this era of National Programme on Immunization (NPI), and in fact more people now live longer. That supported Nakajima's (1991) assertion that increased progress made by many developing countries in combating infectious diseases and malnutrition had improved the length and quality of life for their people. This implies more death and crisis experienced by people and greater need for death education even among our children (Okafor, 1992). As a result, death needs to be prepared for to avoid the consequences of ill-prepared death. Riley (1980) explained that his professional experience as a priest involved him in hundreds of ill-prepared deaths that actually hurt and separated families when it could have healed and unified them.

Nigerian society is rapidly losing the culturally organized resources to cope with grief and bereavement, especially now that it hides under the cloak of development

or civilization that destabilizes the former simpler resources inherent in the extended family system and strong church ties. Many towns and communities now make bylaws regarding grieving and mourning, and in fact slash the weeks (particularly to native weeks of four days each).

Okafor (1997d) stated that the African environment, to which Nigeria belongs, like any other, is a multi-environment system in which any changes in the structure or condition of any one of the major components affects the others. It is the rate at which our Nigerian nation adjusts to her physical environment that determines her level of development. We have continued to face changes in the Nigerian social environment which show revolutions in communication, transportation, and public health as a result of scientific and technological developments. Unfortunately, however, we Nigerians also have created an environment in which we are capable of destroying ourselves. As a result, the social environment is now dangerous to all of us, and it appears that our social organization and behaviour patterns are becoming quite inadequate for dealing effectively with these new relationships we have created.

The saving grace is that some aspects of Nigerian cultural practices refused to be changed or modernized. A good example of such practices is seen in the strong ties that hold a typical Nigerian to his or her home town and people. Even in the face of urbanization and one of its apparent problems: that of attracting people from rural areas to urban cities, the individual's strong loyalty to his or her people persists. People not only migrate from rural areas to urban areas within the nation, but also migrate

from Africa to Europe, America, and other parts of the world. No matter where this migration lands a typical Nigerian, he or she still remains part and parcel of his or her home town and related communities here in Nigeria. What this means is that the death of such a person or that of the wife, husband or children in whatever part of the world they live is the concern of his or her people back home. Such a death represents a threat not only to the immediate family, but also the entire community.

A typical Nigerian in Europe, America, or any other part of the world normally referred to as an 'abroad person,' pays his or her local dues and makes all his or her financial contributions back home in absentia. He or she participates in solving family or community problems particularly those involving finance. If, for instance, an 'abroad person' fails to make payments from their current location, the family usually keeps paying on his or her behalf as long as this individual has not been declared dead. They also receive on behalf of the 'abroad person' all benefits due to him or her at home. Almost everybody in the hometown, related or neighbouring communities, care to know how the 'abroad person' is doing. People are concerned about progress or failure. Sometimes, the "abroad person" sends a few items home to be distributed to relations or pays visits to home.

In the event of the death of such a person, all hometown people suffer the bereavement. This death definitely involves not only people from the hometown, but also relations from the mother's family, families from where brothers, uncles or cousins married, and families to which sisters are married. The extended relationship is even

much wider than this, and these several communities remain interdependent as they are part and parcel of most activities concerning their deceased one. Death, they would say has robbed them of their beloved relation, and so they converge in the deceased's home in their different dance and non-dance groups to pay their last respect. Members of the University of Nigeria community provide a practical example of the point being discussed because when once a member of the community dies or is bereaved almost everybody is touched and all roads lead to the compound of the bereaved here in Nsukka and later to their hometown for the burial rites and to sympathize with the bereaved family. This practice can rightly be described as a lifestyle of the community.

Death education in the Nigerian home is, therefore, necessary particularly in the present era of modernization, development, or civilization to help forestall the loss of our culturally organized resources to cope with grief and bereavement. Stillion (1985) has made it clear that negative emotions and desires concerning the deceased that are not expressed adequately may cause the bereaved persons to turn these emotions against themselves.

Another important factor that makes death education essential is that people engage in varying forms of suicide and homicide, even though it is culturally an abomination or against the law to do so. A mother's knowledge of death education may therefore strengthen the ability of members of her home to deal with fears and guilt which lead to less suicide and other self-destructive behaviours.

Furthermore, Nigerian people have learned to produce posters of deceased relations and to pay for radio and

television obituary announcements. They have also brought these media instruments right into the homes and children are continuously exposed to the various death experiences carried by the media. Absence of death education at home in the face of these advancements will definitely cause more harm than good. One basic premise that should be clear is that there can be no question as to whether death education should occur in our homes in particular and society in general. Death education is occurring and will continue to occur in our homes and beyond regardless of our desires because it is not only a study of an integral aspect of the life we lead, but also a preventive mental healthcare need.

Kastenbaum (1991) advanced an assumption that by studying death people somehow reduce their fears and anxiety. Hence, when confronted with challenges in life positive attitudes, relief and feelings definitely come into play. It is, therefore, possible to develop the ability to relate probably more positively to dying patients and their families. Such ability would make health teachers appear more caring as professionals. Besides, death education removes the inhibition by the language or ethics of death thereby helping to destroy the taboos and unrestricting learning. We made a collection of 102 posters conveying obituary, and the interesting aspect of these posters is that only one out of the lot carried or mentioned the word, ‘death’. All the others were such euphemisms as ‘exit,’ ‘call,’ ‘return,’ ‘transition,’ ‘sleep’ and so on.

Again, death education is likely to be a broader, more worried, more dynamic, and far more interesting subject matter than one might first think. This is so because

in a death education class three categories of people may be present: healthy people, grieving or bereaved people, and ill or dying persons. The healthy students are ready to receive an introduction to subject of death while bereaved person wish to be educated to find solace in their experiences of life or grief. As for the dying persons they desire to learn how they can aid themselves and their families as they cope with illness and anticipated death.

Okafor (1995) examined the social dimension of exposing some of the undergraduates in Nigerian universities to death education needs to be mentioned here because the lot of the Nigerian society may be improved. Contemporary health educators often encourage learners to examine the way they relate to others. Sound exposure to death may prod students to lay down their defence and pick the courage to relate more psychologically intimate with others. In this way, better communication and interaction among members of the society may ensue, and aggression reduced to the barest minimum.

Nichols and Doka (2009) argue that our place on the health-disease continuum at any given time is mostly determined by this ecologic interplay. This interplay is thus regarded in two contexts: the elements of the biophysical environment that are detrimental to human health and safety, and actions (please don't let me list them) within this environment that themselves threaten our health and well-being. It is out of conflicts likely to arise from this dynamic complex of interactions that our health is jeopardized and we meet our death. To address this problem, Nigerians need to be educated about the health risks associated with the threat of imminent, irreversible

danger resulting from our mismanagement of the environment. My argument in the present comment is that the prospect of such death could stimulate Nigerians to reexamine the implications of our behaviour for promotion of health and wellness.

The Nigerian environment has several deathogenic (death-causing) factors that arise in the absence of lifegenic (life-enhancing) ones. These seemingly all-too-rare lifegenic factors are meaningful education, employment, love and friendship relationships, financial security, access to quality healthcare, opportunity for self-actualization, enjoyable recreation and play, artistic and creative expression, and opportunity to achieve spiritual goals, maximize health, and have sound purpose and meaning in life. One goal of this comment is to sensitize health education specialists and other related professionals to the need for optimal health through recognition of the presence of death-engendering factors in the Nigerian environment.

It is worth remembering that horrendous deaths are caused by people and can be eliminated by people if only we put our collective minds and wills to it. Thus, it is necessary to draw attention to the presence of death in the environment, no matter how tightly we may close our eyes, and to motivate us to act to eliminate or minimize horrendous deaths.

Death, which in some cases may be preceded by dying, is an age long fact of life. Nobody exists today that is not younger than death, and no family here in Nigeria can claim ignorance of the existence of death. Yet in today's Nigerian society, people find it morbid to discuss and think of their own death. By not discussing death, people place it

in the closet hoping it will not become a reality they will have to face. Incidentally, there is every assurance of life and death no matter the stand people take. If the taboo nature of death persists, it will only perpetuate traditional myths and erroneous conceptions. Reisler,Jr (1977) holds that the absence of factual knowledge does not only stimulate the development of myths and misconceptions, but also results in suppression of feelings. Death education for adolescents is most likely to motivate the rest of the society to clarify its values about death and dying.

Is it not surprising that though death, of all human experiences, has the greatest overwhelming implications, yet we keep a glaring distance away from it? The tabooness of the subject of death is so great, alarming and pitiable that in the Nigerian society of the last decade in the 20th century, it is still impolite and embarrassing to mention death. How dare you ask your friend how he or she hopes to die? In my death education class I ask students to do a list of members of their nuclear family and then ask them to arrange the names in the order they would want them to die. Many refuse to do the arrangement because the idea or practice of imagining one's own death is impossible and fearful.

The present stand of most Nigerians pervades all our agencies of socialization. In the home, parents shield their young from the events of death and dying. The churches and mosques tend to centre on the theological aspect of the subject if and when they do. Treatments of death-related issues in the popular media are at best unrealistic and the schools which Ulin (1977) maintains seem to be the logical and perhaps the only feasible locus for this kind of learning experience also avoid death and dying education. It is not

surprising, therefore, that today's youths may be growing up with a confused and unnatural image of death.

Incidentally, death education has emerged as an attempt to fill the void created by the tradition of silence about death and by the many social and cultural changes of the 20th century. With these changes, death has been taken almost out of the family structure and now being replaced by paid 'outsiders,' a factor which O'Brien (1979) stated has presented several mental problems. Some of these problems he adds have resulted in child runaways, suicide, and breakdown of religious beliefs which have forced changes in individual life patterns.

The psychological health of students, for instance, is certainly not enhanced by avoidance of the feelings associated with death and death-related topics. The silence of avoidance and absence of factual knowledge only perpetuate traditional myths, erroneous conceptions and suppression of feelings. Incidentally, death education encourages the sharing of thoughts and experiences to the extent that its participants become adults and teachers that are responsive, perceptive, and sensitive to the needs and attitudes of people.

Fortunately, the emergence of death education deals a blow on avoidance of the issues of death and dying which is common practice in the Nigerian society. Avoidance of death may also be seen from an ecological perspective as avoidance of the value of life and destroyed. Death is then envisioned as a lifelong process that provides a paradigm against which individuals can examine their own and other's life-shortening actions such as smoking, drug abuse, reckless driving and pollution.

Another aspect that needs to be discussed is the fact that the theme and concept of death relate importantly to every thread of adolescent development. The adolescent's emerging neuropsychological organization and abilities for conceptual and systematic thinking provide the necessary cognitive equipment for a full grasp of death (Hankoff, 1975). The lack of appropriate and valid death education can have a deleterious effect on such a developing personality.

Furthermore, participants in a death education course may be so healthfully socialized that they attain a mature appreciation of both happy and sad realities of life. It is these student-teachers that constitute our future hope, and we cannot expect them to cope effectively with that future if they were denied death-related learning opportunities, the experiences to develop the skills, and to draw upon the insights that such coping requires. According to Corr (1992), "The moral is that healthy children will not fear life if their elders have integrity enough not fear death" (p.350).

In the required Health Education, students themselves are seen as the first line of defence in helping their peers cope with crisis. Since students need to retain psychological equilibrium, they are expected to learn to cope with such crises as death of or separation from a loved one, and his own imminent death. In this way students may learn to feel that they are members of a community responsible for the health and safety of one another.

For the student to be able to start this crisis intervention, he would have been exposed to such a Health education that makes the understanding of one's eventual death a legitimate concern. Whether at home or in school,

children need adults to be responsive, perceptive and sensitive to their moods and attitudes. This need is more so in secondary school students, for whom role models are still influential.

Health education as a strong field needs its controversial areas, old and new, and gain in strength by improving its coverage of these considering, too, the assertion of Russell, Goldsmith, and Jose (1982) that most controversies have a heavy component of ignorance. One good thing is that such a controversial area when included in the curriculum may according to Ulin (1977) help to energize the already existing curriculum. On the premise that death is an integral part of life, and that every aspect of life has to do with health, it seems the schools have no choice but to include death and dying education in their curricula. This view agrees with that of Prichard and Epting (1991-92) that there is the need for a broadening of research interests with children into the area of death threat.

Kubler-Rose (1981) postulated that we are born with only two natural fears, one of falling and one of loud noises. All other fears are unnatural and passed on from fearful adults to children. When children reach age 3 or 4, in addition to the fear of separation comes a fear of mutilation. This is when they begin to see death in their environment. Most children raised in a family of love and faith and in an environment that accept death as part of life respond naturally and without fear to their own death.

Pollock and Oberteuffer (1974) concurred that attitudes are learned and that is why a great many of them are firmly held by the time the child comes to school, still they can be modified by latter learning. In other words, the

philosophical and religious belief of parents and teachers define their reactions to death and dying, and thus their interpretations shared with children (Crase and Crase, 1976). Teachers according to Fodor and Dalis (1981) specifically can and indeed do greatly influence the direction of students' attitudes. Teachers' attitudes, their approach to the subject, what they say or do not say, and what they do or do not do influence and therefore will shape student attitudes. Hardt (1979), therefore, submitted that these attitudes are not only measurable, but that just by talking about various aspects of death and dying, attitudes can be improved.

Okafor (1997e) opined that our survival in this country requires us to develop an attitude that regards humanity as part of nature instead of adopting an attitude of environmental apartheid. A few common Nigerian expressions may help to reflect the antagonistic attitude of Nigerian cultures toward the environment. Some of such attitudinal statements are "Germs have no power in the African belly," "Man conquers the environment," "Man subdues nature," and "Man pushes back the frontier." With this type of attitude, the environment remains a threat and an enemy that cannot be cherished, protected, and conserved.

Another reason is that death education makes for a greater appreciation of life, right now and day-to-day (Russell et al., 1982). Apparently, understanding of death-related phenomena, like sexuality is being recognized as an area intimately related to man's ability to live a worthwhile and happy life. Weisman and Hackett (1961) have written that how one has lived can determine how he

will die, and that conversely, how one views his imminent death can affect his style of living. Leviton (1969) concludes that the study of man's ability to cope with his own imminent death and the death of others is a valid area of concern for health educators.

In fact, it is right to contend that death and dying education is as much a health entity as sex education and both have as their goal the desire to help individuals come to terms with their own feelings, attitudes, and body. For one to live a constructive life, one must be at peace with the fact of his or her own eventual death. Happily, death is being pulled out of its present closet by integrating education about it into the existing secondary and primary school Health education. Death and dying education will definitely help students confront their feelings about death without causing excessive stress.

As it is increasingly realized that how one views his own imminent death and that of others is closely associated with one's personal health and sense of well-being, some theorize that the fear of death is the basis for and underlies all other fears and anxieties. It is necessary therefore that Nigerian students should be educated about death more so through Health Science so that they may grow up with a minimum of death-related anxieties.

It is likely that attitude towards death and dying have a greater daily psychological effect on students than even health educators care to know or imagine. Incidentally, sexuality, family-life, and other dimensions of education are much more integrated parts of the secondary school health education than are death and dying. Nevertheless, several scholars including Irwin and Melbin-Helberg (1992)

hold that in most published studies addressing the effects of death education courses, the major finding has been that death education generally has a positive effect on participants.

Russell et al. (1982) submit that at this time it probably is true that the majority of learners, youngsters and adults, tend to think of death as a negative, "unhealthy" topic. Death education, particularly under the health education canopy is therefore bound to overcome this perception and implant a more positive one.

In many Nigerian communities, death rites and ceremonies are being revised or modernized, probably to reduce costs or meet current changes in cultural issues and trends. Such changes, according to Bordewich (1988) were indications death, although handled rather poorly, should have been better handled. These same changes prompted Okafor (1993b) to contend Nigerian society was rapidly losing its culturally organized resources to cope with grief and bereavement under the cloak of development, civilization, or modernization. It becomes a necessary and welcome innovation that Nigerians, in different settings are exposed to some form of formal education about death.

Crase and Crase (1979) argue that death education aims at providing appropriate information on cost and other issues surrounding death to consumers. Is it surprising that people borrow to give 'befitting' burial or memorial part of which is to build, paint or renovate a house, buying very expensive coffin and so on. This may help them in making intelligent decisions before a death forces such decisions. Managing estates and utilizing written wills are also units usually incorporated in death and dying education.

In fact, a death-educated and active Nigerian population is the best means for ensuring national health, and good death education and environmental education can contribute effectively to the desired goal. Obviously, the ultimate success of scholarly advocacy of this goal would be action in varying quarters and at different levels, resulting in a heroic confrontation with death and a positive response to its stimulus to improve the Nigerian environment.

If any aspect of human life needs to be included in a Health Education Curriculum, it should be death education among others. On the part of students currently treated to death education, it is hoped that the course if properly handled will aid their psychological development, minimize their negative reactions, familiarize them with, the needs and issues surrounding death and dying, reveal their responsibility to maintain life, and prepare them for building a better future even in Nigeria.

Death Attitudes

The simple meaning of attitude in the context of death is the way one thinks and feels about death, and the way one behaves towards death. Even when the way you think and feel may be camouflaged or faked, the way you behave towards death may reveal how you think and feel about death. It is possible for you to devalue, or even deny it for a time, but it is impossible to elude it or avoid it. This is so because if you don't experience death yourself then you are a survivor especially in our Nigerian culture in which extended family is still the practice. The ties are on. One other definition of attitude is that by Kalish (1981) in which

he stated that attitude is a relatively enduring tendency to think, feel, and behave in a consistently favourable or unfavourable fashion towards a concrete or abstract thing (including person) or idea. Thus, one who has unpleasant images of what his or her own dying will be like, when he or she feels that the death of a loved one would create immense problems for him or her, or when he or she tells a friend that he or she cannot accompany him or her to a brother's funeral is expressing a death attitude.

The terms death attitudes, death threat, death fear, death concern, and death anxieties according to thanatologists such as Wass and Myers (1982), Kalish (1981), Koestenbaum (1971), Hoelter and Hoelter (1980) and others are often used interchangeably in the thanatological literature. Wass and Myers (1982), however, expressed the important distinctions which some of the expressions enjoy in psychological theories. 'Fear' typically refers to a known specific object or event of which one is afraid while 'anxiety' is a state of felt impending danger or threat, this is unconscious. In fear the source is identifiable while in anxiety the source is unknown. 'Attitude' has already been seen to refer to an affective or cognitive orientation, either positive or negative, towards an object or event.

Two persons who say they fear death may not have the same content of death fear. Death anxiety or fear is according to Leming and Dickinson (1985) a multidimensional concept based on four foci as follows: death of self, deaths of significant others, process of dying, and state of being dead. It follows that the content of death fear will be influenced by whose death the individual is

considering. Take death of self, and we see that the fear will border on the way one's death or dying will affect others. It is also possible to privately worry about how others may treat you at death or when you are dying.

In the case of deaths of significant others, the individual's concern may border on financial, emotional and social problems likely to be created by the death of a significant other. In the state of being dead our fear may be that of how your body will be handled or you not being able to come nearer a corpse let alone touching or sighting it at lying in state. When people file past a decorated corpse in the casket those whose fear hinges on this category throw their faces in the opposite direction of the corpse or cast their faces downward refusing to raise it up until they get to a position where they can no longer sight the corpse. The fourth and the last of these four foci is the process of ding which causes greater concern tan the event of death itself.

Kalish (1981) and Head (2004) contended that the death attitude that receives the most attention, and deservedly so – is the fear of death. He suggested further that it is difficult to know when we consider death, whether the source is known or not. This precisely is why death fear and death anxiety are used almost interchangeably. He emphasized death fear as the acclaimed most popular of death attitudes by identifying the consequences of death being feared and the positive outcomes of fear of death. The consequences are: losses, dread of extinction, dread of entering the human and facing the possibility of judgment, punishment and retribution, separation and abandonment, fear and anxiety about one's dying process, and the fear and anxiety about

the death and dying process of loved ones.

Death fear has about eight dimensions.

(1) Fear of ding which deals with the specific act of dying rather than with any related consequences accompanying death.

(2) Fear of the dead which simply pertains to people or animals that have died.

(3) Fear of being destroyed which relates to human destruction of one's body immediately following death.

(4) Fear of significant others which concerns fear of significant others dying as well as fear associated with the effects one's death may have on significant others.

(5) Fear of the unknown which deals with ambiguity of death and the ultimate question of existence.

(6) Fear of conscious death which deals with living our horrors associated with the immediate processes subsequent to death whereby the pronouncement of death is not accepted to be final termination of consciousness.

(7) Fear of the body after death which is associated with concern for bodily qualities after death.

(8) Fear of premature death which is based on the temporal element of life and concerns the failure to achieve goals and experiences before death.

Though some values are attached to fear of death, most possible attitudes towards death such as not being afraid of death, accepting death, being open to one's feelings concerning death, all at the opposite end of the continuum from fear of death, have been relatively ignored in research

as well as empirical and theoretical writings. This practice confirmed the assertion of Feifel (1969) that people unconsciously behave as immortal because they do not believe in their own death, yet they are not spared by grief.

Grief

Grief is simply a person's emotional response to the event of loss, and this event of loss is ***bereavement*** while the process we take to incorporate the experience of this loss into our lives is ***mourning***. Interestingly enough no human person exists who can boast of not experiencing grief. Even our Lord Jesus Christ did when He wept for Lazarus who was only a friend. In our time, it is a fact that the majority of people need some social context for healing of their grief to occur. Wolfelt (1993) would posit that bereaved persons need the opportunity to express their grief outside of themselves in a caring environment. It is this caring environment we try to both provide and destroy. The tragedy is that we have learnt to destroy our safe environment for mourning by giving shame-based messages to bereaved people which make a man's cry for the loss of a spouse or some other close relation a shameful thing and the cry of a woman for the loss of a mother expression of hopelessness and poverty (Okafor, 2004). Such a death is in most cases welcome and a time to 'declare surplus' for people to come around and feast with the bereaved for the loss of a mother. At burials and funerals we foolishly distribute souvenirs to people, a practice we cannot understand its wisdom even as I speak to you here. Our women folk have gone into making different sets of dresses for a parent's burial, funeral and

memorial.

Whitfield (2006) explained that generally speaking, most people now try to avoid experiences of pain and feelings of loss, yet it is only in gathering the courage to express our emotions of grief that we become able to heal. Wolfelt (1993) identified as many as eleven unique patterns by which persons repress or "move away" from the expression of their grief, and they are: the chemical abuser, the crusader, the displacer, the eater, the minimizer, the postponer, the replacer, the shopper, the somaticizer, the traveler, and the worker. These various patterns of avoiding grief response are not mutually exclusive. It follows that some people experience a combination of these patterns while others maintain one primary mode of avoidance. The specific combination of patterns (or primary mode used most often) will depend on one's personal history, societal influences, and basic personality. It should be acknowledged that a vital part of surviving acute grief is avoidance.

Some of the avoidance patterns outlined below are temporary means of survival and coping. It is when these patterns become rigid and fixed in place that they are observed as creating fall-out consequences for the mourner. The destructive effect of the adopted pattern is typically directly proportional to the degree of avoidance. However, prolonged avoidance, whatever the degree, will always be destructive. In moving away from our feelings of grief, that is, in repressing, denying or deadening our feelings, we ultimately become destructive to ourselves. Our refusal to do the "work of mourning" destroys much of our capacity to enjoy life, living, and loving. After all, how can we relate

to ourselves or others if we don't feel? Moving away from grief results is moving away from us and other people. Let us briefly discuss each of these avoidance patterns.

The chemical abuser.

The chemical abuser is the person who uses alcohol and/or other drugs to avoid the work of mourning. Interestingly, this behavior is often reinforced with comments like, "Here, take this, it will make you feel better," even when it is common knowledge that chemical abuse is among the most dangerous of avoidance patterns. In reality this pattern is capable of causing disruptive sleep patterns, worsening mood states, and increasing agitation. Chemical abuse is known for becoming a destructive pattern of behavior that blocks the work of mourning for years into the future.

The crusader.

Alston and Alston (2009) describe the crusader as the person who converts his or her grief into over-dedication or premature involvement with a cause and the problem of premature over-involvement in a cause, no matter the degree of importance of the cause inhibit and delay one's own work of mourning. The crusader in this case is one who becomes passionate about certain things.

The displacer.

The person who displaces his or her grief feelings in other directions is the displacer. In the burial of the father of one of our students we attended, the most elderly brother stopped that our student right in front of every sympathizer

and ordered her to return the bottles she was bringing to us to the store without delay and desist from 'lavishing' things. It afforded me a 'teachable moment' and her classmates who were in our group reminded her of the characteristics of a displacer. It didn't them time to classify him and rightly for that matter. They reminded her that while some awareness may be present, displacing usually occurs with total unconsciousness. This intent to shift grief away from its source to a less threatening person, place or situation, has left many families disperse in enmity after the funerals if they all manage to get to the end.

Gray (2005) hold that some persons who adopt the displacer orientation become bitter toward life in general. Others Rosenblatt and Wallace (2005) assert displace the bitter unconscious expression of their grief inward, becoming full of self-hatred and experiencing debilitating depression. So, while at times this person displaces his or her grief in interactions with other people, at other times, he or she believes that other people dislike him or her, once again projecting unhappiness from the inside to the outside.

The eater.

The eater who unconsciously, tries to fill a void from the emptiness felt inside his or her body is the person who has continual cravings for food. Experience suggests that the craving is often experienced as a compulsion, and the person feels powerless to stop eating even when the weight gain is observed. In fact, the eater may observe that he or she is continuing to gain weight, yet he or she is not able to change the behaviour. This way they compound their problems with physical and emotional problems associated

with weight gain. Incidentally, stress denied often stimulates hunger centres in the brain (Jordan & Neimeyer, 2008).

The minimizer.

The minimizer is the person who responds to society's message to quickly 'get over' one's grief, and not cry like one who has no hope. He is aware of feelings of grief, but, when felt, works to minimize the feelings by diluting them through a variety of rationalizations. However, internally, the repressed feelings of grief build and results in emotional strain. The unfortunate thing is that the more the minimizer works to convince self that the feelings of grief have been 'overcome,' the more crippled he or she becomes in allowing for emotional expression which finally result in the evolution of a destructive, vicious cycle.

The postponer.

The postponer is the bereaved person who believes it is safer for him or her to delay the expression of grief with hope that the grief will over time go away. Incidentally, it does not go away rather it builds up within the mourners and typically comes out in a variety of undesirable ways. This person unaware that through expression comes healing, continues to postpone. He or she may feel that if the grief doesn't vanish, at least there may come a point in time when it will be safest to experience the pain. Unfortunately, no such time ever comes yet postponing is frequently an automatic unconscious process.

The replacer.

Replacement pattern is seen in the widower who immediately names another wife after the death of his wife. People generally say that he had no atom of love for the late wife not knowing that the replacer has often loved very much, and out of the need to overcome the pain of confronting feelings related to the loss, moves into this avoidance pattern of replacement. Unfortunately, there is little, if any, conscious awareness for this person of how his or her replacement efforts are really a means of avoiding the work of his or her grief.

The shopper.

The shopper is the person who spends money in efforts to avoid the work of mourning. This pattern is often referred to as 'retail therapy.' This pattern only provides short-term relief which disappears with time. Unfortunately, some bereaved persons get themselves into serious financial problems of spending beyond their resources. The outstanding debt plunges the shopper into secondary grief especially when those being owed start coming around to demand repayment.

The somaticizer.

The somaticizer is the person who converts his or her feelings of grief into physical symptoms, with no organic findings. Unfortunately many people in grief unconsciously take on the 'sick role' so that people don't pull away and leave them abandoned. Corr, Nabe and Corr (2008) posited that in this state of illness the somaticizer may become so completely preoccupied with bodily involvement and

sickness that they have little or no energy to relate to others and to do the work of their mourning. It is, however, important to note that this somaticizer avoidance pattern as presented here is different from the person who experiences real physical illness during the mourning process. It is not abnormal to show some degree of physical illness during the mourning process. It follows that we would never want to automatically assume that a bereaved person is converting every emotion of his or hers into physical symptoms. We must therefore be guided by a general medical examination.

The traveller or mover.

The traveller or the mover is the person who stays on the move to avoid the work of mourning. What he or she achieves is to leave his or her grief behind. Some bereaved persons don't just travel, but prematurely move their place of residence, thus creating secondary losses such as previous support systems and comforting routines. Paradoxically, the traveler, or mover, may begin to miss what was left behind, the very things that he or she was trying to escape.

The worker.

The worker is the person who begins to over invest in work to the point where no time is available to think or feel about the loss. Interestingly enough, the worker is often following advice of well-wishers who encourage him or her to 'keep busy.' Let me share with you a typical example of a recent funeral of a man's wife I attended. This widower on the burial day of the wife was busy carrying chairs,

taking plates to the kitchen, carrying crates of drinks and serving people different kinds of food item even after some of us his friends had advised him in the contrary. As the chief mourner he was expected to be seated in a particular place arranged for him and his key family members, but he kept so busy working almost all the hours of day that one could hardly find him on that his seat. Paradoxically, this our bereaved friend who threw himself into work ultimately hurt more when he tries to compulsively hurt less. In the contrary, the Nigerian Nri widows (Okafor, 2004) are compulsorily confined to a place and not allowed to engage in any type of work at all.

Consequences of grief avoidance.

Among some of the more common consequences of adopting grief avoidance patterns are the following:

- Deterioration in relationship with friends and family;
- Symptoms of chronic physical illness, either real or imagined;
- Symptoms of chronic depression, sleeping difficulties, and low self-esteem;
- Symptoms of chronic anxiety, agitation, restlessness, and difficulty concentrating.

Encouraging healing grief expression.

One major problem is that we don't understand grief so we in our impatience with grief expect a bereaved person to 'be back to normal' in the shortest possible time. We refuse to allow tears particularly the men suffer in silence and presenting ourselves 'strong' yet Wolfelt (1993) found that

lack of expression of outward mourning as brought about the evolution of the 'silent mourner.' Balk (2008) and Worden (2002) posited that even those persons who want to be supportive cannot identify the mourner. However, the typical Nsukka mourner is wonderful because he or she uses wrapper to announce bereavement of particular type. Unfortunately, we fail to acknowledge the continuing need for support and understanding of the bereaved. Just ask: how many of us still stay around a bereaved person a month or more after burial and funeral rites?

Healthy mourning which has always been based on an assumption that feelings are best accepted and expressed. Besides, we have to understand that confronting one's grief and the pain inherent in the experience is not always an easy task, and that people who continue to express grief should not be viewed as 'weak,' 'poor,' 'ignorant,' self-pitying,' or 'mad,' since grief is not something to be overcome rather than experienced.

E. Summary and Conclusion

In this lecture, I have tried to take you through the three main aspects of my Health education effort which are: my lifestyle based model, ageing education and death education. The 4-circle base triangular model which has two pyramids a smaller one which completes the larger pyramid. The smaller pyramid constituting lifestyles which when chopped off the bigger pyramid exists with an ordinary base attracting the attention of beginning mathematicians and actually not a health educator. This smaller pyramid provides the completeness of the larger

one which seizes to be a pyramid when once the smaller one is chopped. The bigger pyramid has four circles of idea, thought, word and action forming its base and the sides of the bigger pyramid that join it to the smaller one is for habits. All elements of death or ageing start with idea when methodically handled translate into lifestyles. Twelve healthy lifestyles were discussed as necessary conditions for managing dying or ageing, and living with death.

In discussing ageing, three messages and five activities necessary for active ageing were taken. The activities received a more detailed attention than messages because of the need for each person to understand and be able to participate in the activities which will finally help in determining whether one enjoys a good evening or a bad one. Death education which is my main thrust received quite a good attention. The different levels of death and the meaning of death education formed its first part. Three other parts of death education: the need for death education, attitudes towards death and grief were discussed in a fairly detailed form making useful provision for the application of the model as appropriate.

In conclusion, the development of the 4-circle base triangular model can be said to be my gift to Health education not just here in Nigeria but any where in the globe where people are taught health and led through behaviour change or modification. The mask hiding death all this while is aggressively being removed in our circle but this effort needs to go beyond our circle to other walks of life. Besides, the fear posed to many by ageing is also being addressed in such a way that people will no longer see gray hair and other features associated with old age as

threatening, but to see gray hair as golden and not rejecting the other features in preference to youthfulness. Since it is now a known fact that the emphasis placed on youth in Nigeria is clearly becoming excessive and emotionally unhealthy, our future research shall be devoted to these aspects of shortcoming with a view to making our society not associate health, beauty, sexual attractiveness, strength and vitality, employment, long-range goals, hopes and dreams with youth.

Appreciation

Mr Vice-Chancellor, Sir, kindly permit me to end this lecture with some words of appreciation and thanksgiving to my fellow humans who made God visible to me in this life and helped to describe the path that led me to this my present status. I thank God who inspired these people and gave them the wisdom and heart that performed the miracle of my life. The first human person I would want to appreciate is my loving father, Late Chief Lawrence Igwenagu Brown Okafor (LIB Okafor) a principled man. Let me recall that as a Biafran soldier I smoked Indian hemp and all other 'smokeable substances' and couldn't stop smoking when the war ended in 1970. I was to go back to school for my School Certificate examination but there was no penny any where to do this. I then went into business, opened "a bunk" where I sold Indian hemp (oja or gay), cigarette, and illicit gin (kinkana). The business grew so much that I could have a supply of four cement bag of Indian hemp, two drums of kinkana and actually became a Nigerian Tobacco Company (NTC) distributor receiving

four cartons of cigarette in a single weekly supply. My gay business became so big that I started cultivating my own Indian hemp garden.

I became such a rich young man then that my father asked me to go back to school in 1971 and I refused. It is my father's decree of 1971 that makes me shout in the very depth of my heart: Thank you father for saving me. He decreed, "You have only one week to go back to school or cease to be my son, leave my house and never bear my name anywhere you go. I will from today regard you as my dead son and your funeral will be fixed to place in 6 months' time." This Decree pulled me back to school and here I am now a Professor. De Law I wish you were alive to see what your Decree did in my life.

Let me thank some specific lecturers of mine whose contributions were not just the general ones expected of most lecturers. One of them is, Professor Simon Umedum of Nnamdi Azikiwe University, Awka, my supervisor in the first degree who laid my research foundation with our quasi experimental design. Professor G.B.I. Onuoha, my Ph.D supervisor, who allowed me into his bedroom several times from where we discussed my file to his sitting room. Professors F.A. Amuchie, and S.U. Anyanwu who made my Ph.D and my professorship possible. Professor T.A. Ume, my Faculty Dean, who joined hands together with Professor (Mrs) Lizzy Anyakoha, my Seminar Chairman, to save me during my Ph.D seminar. I must thank Professor (Mrs) O.C. Nwana who came to Nsugbe about three times to pull me into the Department as a Lecturer and since I came over has always been a mother.

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I sincerely dedicate this inaugural lecture to my family, a family of love and one heart. The gratifying thing is that each member of my family is a gift of love, and at the head of this love is my dear wife, Agnes Ebelechukwu Okafor, who received the shock of beginning death education in the family. Your large heart is God given and I thank God that we started the journey together, and pray Him to be with us while we continue on the journey through your Ph.D to your professorship. Don't forget that I have always insisted on you answering when I call you Dr(Mrs) Okafor. You know that as soon you get your Ph.D I will start addressing you as Professor (Mrs) Teacher.

May I thank Oba Francis Tabansi (Akunwafo), Oba G.A.D. Tabansi (Nwawelugo), and Dimonyia Umuoji for helping me financially at the very points of need in my academic journey. I thank God for the gift of ASUU as a body, for I would have been drained into Trinidad and Tobago if not for your efforts oneness and solidarity in our past struggles. Members of AAA and NPU Nsukka branch you mean a lot to me and I thank you.

It is not possible to mention everybody so let me end

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I thank you for listening

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