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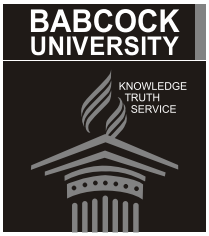

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INAUGURAL LECTURE

THE MINISTRY IN THE MINISTRY OF PUBLIC HEALTH PROMOTION: *Contending with Principalities and Powers*

by

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Preamble

It is with great humility that I stand here today, before this well constituted audience, to deliver the 14th Inaugural Lecture, seven years after my assessment and subsequent appointment, as a University Professor. Mr. President/Vice Chancellor Sir, you have invited me before this honorable audience to justify how my teaching, research and community service of 23 years have contributed to addressing public health promotion needs, locally, nationally and globally. It is such a great privilege. Thank you for the honor.

Mr. President/Vice Chancellor Sir, I am here to address you on the topic, *The Ministry in the Ministry of Public Health Promotion: Contending with Principalities and Powers.* Considering the literal meaning of my middle name, Nwadibia, "son of a native doctor", I am tempted to invoke the

"powers**"** of the oracular deities to contend with persons, politicians, personalities, policymakers, proprietors, personnel and professionals working against Public Health. However, as Nwadibia, "son of God of Heaven and Earth [the greatest Healer]", I will rather approach this lecture from the perspective of a Christian scholar, teacher, researcher, advocate, administrator, and preacher.

My parents' early encounter with the Seventh-day Adventists prepared me for the career in which I am most excited about today. I learnt from them, at an early age, that "cleanliness is next to Godliness", and that "prevention is better than cure." As a young boy, I observed the tenacity with which my parents espoused the biblical teachings on diet, personal and public hygiene, sanitation, marriage and family, relationship matters, and spirituality. As a young boy, I observed health workers visit my mother severally at home when she gave birth to my siblings. As a young boy, I witnessed the wole-woles (sanitary inspectors) visit and inspect homes and public toilets, market places, abattoirs, schools, etc, to protect public health. That early exposure to issues related to health and wellbeing scuttled my peer-influenced drive to have become a lawyer. Indeed, God wins!!!!!

By divine providence, I enrolled in the Health Sciences program of Andrews University in 1986, where I became intoxicated with the doctrine of prevention. The Community Practicum classes and subsequent exposure to community health practice further ignited my passion and compassion for Public Health, particularly in the area of Health Promotion.

My Master of Community Health (MCH) classes in Primary Health Care exposed me to local, national and international health priorities and targets, and the urgent need for health promotion focus. I got to understand how personal and corporate interests, even among public health scientists and practitioners tend to undermine public health goals. Mr. President/Vice Chancellor Sir, it is against this backdrop

that I anchor my lecture on *The Ministry in the Ministry of Public Health Promotion: Contending with Principalities and Powers*. The outline of my lecture is as follows:

- Introduction
- Public Health Promotion in Nigeria: Haunted by our Historical Past
- Nigeria's Health System: Overwhelmed by the Present Realities
- Balancing Health and Health Care in Nigeria
- Principalities and Powers against Public Health Promotion: Interests and Intrigues
- Summary of my research contributions to the profession of Public Health Promotion
- Summary of my contributions to Babcock University and other institutions
- Recommendations
- Acknowledgments
- Conclusion

INTRODUCTION

The Creator, God, desires, “above all things that [we] prosper in health” (3 John 2 - KJV), and Virgil (2016) asserts that, “the greatest wealth is health”. Erasmus (2016) affirms that, “prevention is better than cure”, and Franklin (2016) opines that, “an ounce of prevention is worth a pound of cure”.

The above quotes and many more, illustrate the obvious importance of health promotion, which, in this lecture, refers to the ministry in the ministry of health. Health promotion is a preventive approach, defined as a process of enabling people to increase control over the determinants of health and thereby improve their health; recognizing that health “is not solely the responsibility of the health department [Ministry of Health] but of all people, governments, industries, social institutions, communities, families and friends” (New Brunswick Department of Health and Wellness, 2003). It employs machineries of "legislative action, educational measures, health service activities, media coverage, and individual counseling to initiate changes in behaviour" (Brundtland, 2016). Therefore, health promotion

is a ministry that is community-oriented and population-based.

The word “ministry” in the ministry of health is a Christian religious term from the Latin word 'ministerium', meaning 'the work or vocation of a minister of religion', first used in the 14th century (http://www.merriam-webster.com/dictionary/ministry). It refers to “meeting people where they are at and taking them to where God wants them to be.” (Jrbriggs.com, 2016). Thus, it is relational, that is, vertical (God-centred) and horizontal (people-oriented). It is an all-encompassing ministry.

As we would see later in this lecture, public health promotion has its origin from the bible. No wonder the term 'ministry' is often attached to health. The ministry of health is expected to promote God's wellness agenda by establishing a health system that is not only curative or medical but also preventive, promotive, protective, rehabilitative, and spiritual; thereby taking the public “to where God wants them to be.” It is a God-given responsibility, and hence the need “to address the entire range of conditions and factors that determine health [and] the complex interactions among them" (Public Health Agency of Canada, 2016).

The World Health Organization (1948) defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”, suggesting that the ministry of health extends beyond curative care. The ministry of public health promotion suggests that “health status indicators [are] influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services” (Public Health Agency of Canada, 2016). Health is a universal concept and a fundamental human right. The underlying principles and values are social justice and equity, access (availability, affordability, acceptability, and appropriateness), cost effectiveness, efficiency and accountability, partnership and collaboration (Braveman, Kumanyika, Fielding, LaVeist, Borrell, Manderscheid, and Troutman, 2011).

PUBLIC HEALTH PROMOTION IN NIGERIA: HAUNTED BY THE HISTORICAL PAST

Looking back in time, it can reasonably be confirmed as follows (Egwu, 1996):

1. Nigeria's health system is an offshoot of the British colonial model, which is clinically-designed, hospital-based, doctor-centred, patient-oriented, urban-focused and curative in nature.
2. In essence, Nigeria's health system is preventive-phobic in nature.
3. There was limited focus on the ministry of prevention [health promotion]. The closest to health promotion were school health programs and services and environmental sanitation.
4. The earlier national development plans focused on building of hospitals, health centres, including training of physicians and much later nurses, and far later "Dispensers" and "Public Health Officers", with limited qualifications.
5. Until recently, the highest qualification for a Public Health Officer was a Diploma.
6. Only physicians had a full degree and were seen as champions in the ministry of health. Other health professions were degraded; hence, part of the acrimony we find in our health system today. The struggle for the survival of the other health and health care professionals is part of the huge lingering problems that have bedeviled our entire health system.

NIGERIA'S HEALTH SYSTEM: OVERWHELMED BY THE PRESENT REALITIES

Fifty six years after independence, Nigeria's health system suffers from poor infrastructural development, inadequate government funding, absence of integrated system for

disease prevention and surveillance, unimpressive health indicators (Anyika, 2014); lack of coordination, fragmentation of services, dearth of resources, inadequate and decaying infrastructure, inequity in resource distribution, lack of clarity of roles and responsibilities among levels of government, and poor leadership (Welcome, 2011), including poor health literacy (Adekoya-Cole, Akinmokun, Enweluzo, Badmus, and Alabi, 2015), which is a major risk factor for other health problems, such as HIV and other sexually transmitted infections, unwanted pregnancies, maternal mortality (World Health Organization, 2016), and many others.

Nigeria's poor health status indicators call for the ministry in the ministry of health promotion. Life expectancy at birth in Nigeria is estimated at 53 years (World Population Data, 2016). Records from the 2013 Demographic Health Surveys show that total fertility rate for women aged 15-49 was 5.5 births per woman, under-five mortality rate 128, maternal mortality ratio 576, children underweight, 28.7%, and children under 5 who slept under an insecticide-treated net (ITN) were 16.7% (USAID, 2016).

Poor environmental sanitation continues to contribute to the disease burden. The number of Nigerians using improved sanitation facilities, as at 2015, was below 40% (World Health Organization, 2016) (Table 1).

		Table 1: Population using improved sanitation facilities (%)	
		Rural	**Urban**
Nigeria	2015	25.4	32.8
	2000	33.1	35.8
	1990	38.2	37.7

Source: Global Health Observatory Data.
http://apps.who.int/gho/data/node.main.46?lang=en

According to UNICEF Nigeria (2016), about 70 million and 110 million Nigerians lack access to potable water and improved sanitation respectively, while about 28.5% practiced open defecation leading to diarrhoea, and other diseases. Many Nigerian communities do not have access to safe toilet and hand-washing facilities.

Common causes of illness in Nigeria are preventable and avoidable disease conditions, which require preventive approaches such as access to clean water, environmental sanitation, education on personal hygiene, etc. The continuous focus on vaccine-preventable diseases (hepatitis B, measles, polio, diphtheria, pertussis, chickenpox, etc), and not on prevention generally, is worrisome.

A bulk of the federal health budget meant for the Ministry of Health is often shared among 33,303 General Hospitals, 20,278 primary health centres and posts, 59 Teaching Hospitals and Federal Medical Centres, with little or nothing left for public health promotion. In fact, the present hospital-based, curative care model tend to create a disease-focused economy (Hyman, 2012). As a result, donors and Nigerians in diaspora tend to be more interested in organizing short term, unsustainable, holiday-driven, medical outreach programs in Nigerian communities, rather than a more far-reaching health outreach activities that empower communities to practice healthful living.

The minimum standard for health is clearly articulated in the Alma-Ata document (WHO/UNICEF, 1978). Unfortunately, today, emphasis is more on treatment of diseases and injuries, which currently serves just a few, rather than prevention, which focuses on the provision of basic health information, food and proper nutrition, safe water and basic sanitation, maternal and child health (including family planning), immunization against the major infectious diseases, mental health, oral health, etc.

BALANCING HEALTH AND HEALTH CARE IN NIGERIA

The height, depth, length and width of the health problems in Nigeria are huge and extend beyond physical, to include, biological, social, mental and spiritual domains. No wonder the mission of Nigeria's Federal Ministry of Health, as clearly articulated, is "to develop and implement policies that strengthen the national health system for effective, efficient, accessible and affordable delivery of health services [not health care services] in partnership with other stakeholders" (Federal Ministry of Health, 2016). From this definition, health is perceived to be a system made up of other components. However, in practice, it appears the Ministry of Health is 'majoring on the minor', by focusing on health [care] policies and health [care] services that tend to strengthen the colonially-masterminded health [care] system at the expense of the entire health system, which includes public health.

By definition, Public Health is: *"a science and art of preventing disease, prolonging life and promoting health and efficiency through organized community effort for (a) the sanitation of the environment; (b) the control of communicable infections; (c) the education of the individual in personal hygiene; (d) the organization of the medical and nursing services for the early diagnosis and preventive treatment of diseases; and (e) the development of the social machinery to insure everyone a standard of living adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize his birth-right of health and longevity"* (Winslow, 1920).

The above definition is loaded with both preventive and curative services, with health promotion strategy particularly emphasized in (c) and (e). Indeed, Public health is the pivot on which health (beyond disease and infirmity) is delivered to population groups, rather than individuals; a ministry in the ministry of health that should include "the capacity of people to adapt to, respond to, or control life's challenges and changes" (Frankish et al., 1996). Public health is focused on the people, addresses health determinants and the way they

interact; it is evidence-based, applies multifaceted strategies in addressing needs, promotes intersectoral collaboration, accountability and public involvement (Public Health Agency of Canada, 2016). No wonder in many countries, the "Ministry of Health" is better defined as "Ministry of Public Health," for instance, Guyana, Afghanistan, Qatar, Cameroun, Ecuador, Lebanon, Cuba, Haiti, Kenya and Bangladesh. Such countries have the tendency to strike a healthier balance between population-level health and individualized curative care.

Many people in this honorable audience, over the years, have been made to believe that public health is a branch or subspecialty of medicine. From the definition above, Public Health is, indeed, the grandfather of the health system enterprise that should be allowed to drive the entire health system, for the public good. The public health field is so vast, and driven by not only Health Promotion, but also Epidemiology, Biostatistics, Nutrition, Environmental Health, Global Health, Maternal and Child Health, etc, as well as the health care disciplines, which include Medicine, Nursing, Medical Laboratory Science, Pharmacy, and other sectors. While each segment tends to operate independently, public health aims to integrate all at the population level for effective delivery of public health services.

The profession of public health can be classified into two major areas of specialization the "software" and "hardware" areas. The software area of specialization includes Health Promotion, while the hardware areas of specialization include Epidemiology, Biostatistics, Nutrition, Environmental Health, Global Health, etc. The hardware areas of specialization complement the software area. For example, the ingredients of Health Promotion, which are, health education, service improvement and advocacy, rely heavily on resources from the hardware areas, to perform its core functions, which are, to strengthen community action, create healthy policies, reorient health services, develop personal skills and create supportive environment for people to make healthy choices.

To effectively achieve these core functions, a God-centered, mission-driven, people-oriented, health education, service improvement and advocacy, is very important (Figure 1)

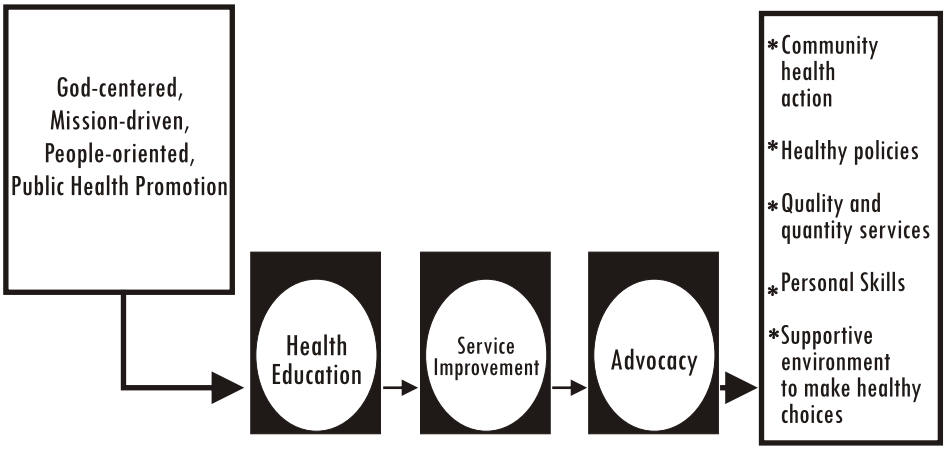

Fig.1: The ministry in the ministry of Public Health Promotion model

PRINCIPALITIES AND POWERS WORKING AGAINST THE MINISTRY IN THE MINISTRY OF PUBLIC HEALTH: INTERESTS AND INTRIGUES

Let us note that "we wrestle not against flesh and blood but against principalities and powers in high places" (Ephesians 6:12, King James Version). According to Lippman (2005): *"The selling of sickness seems to follow a familiar pattern. A drug company identifies a wedge condition, set of symptoms or 'risk factors'; hires a PR firm to come up with a "disease" name, ideally something catchy with a pronounceable acronym (e.g., SAD); develops a drug or adapts an existing one to tout as a 'fix' for this new medical problem; and begins massive marketing to physicians and the public. The media pick up the story, suggesting that this 'new' disease is greatly undiagnosed or undertreated. Drug sales soar. Voila! Another pharmaceutical blockbuster is born".*

The above quotes and many more tend to pinpoint the crux of the matter. Principalities and powers against health promotion include persons, politicians, personalities, policymakers, proprietors, personnel, etc who:

1. Support "the neo-conservative free market ideologies", or promote market orientation of neo-liberal globalization, that is, more for a few, and a few for more; thereby, creating health inequity (Starfield, 2011; Bambra et al, 2015).
2. Support the bastardization of the local government tier of government which forms the basic unit, as well as the platform for the delivery of preventive ministry.
3. Divert resources to disease-management and care subsystem at the expense of population-based, health-oriented system.
4. Focus on single diseases and selective interventions, and not on comprehensive health, including health determinants.
5. Promote consumption and unrestricted advertising of soda (soft drinks) and processed food, sugar-laden foods, fast and fatty foods, tobacco and alcohol use, and medicinal and beauty products, etc, rather than intensive protective lifestyle measures.
6. Draw examples from "inequitable societies in the industrialized world" rather than from countries that promote equity-focused health agenda.
7. Withdraw all needed support to curb the menace of environmental pollution.
8. Promote unregulated health marketing on the internet (Rodrigues, 2000).
9. Take over power and responsibility for health from individuals to powerful elite (Bambra et al, 2015); whereas in public health promotion, responsibility and authority are transferred from the professionals to the people.
10. Hire unqualified personnel "to teach mainline and core public health courses and to supervise thesis and projects" (Abanobi, 2016).
11. Generally promote curative medicine at the expense of prevention.

While health promotion professionals have done a lot to support and strengthen community action, help create healthy policies, and reorient health services, it has been a herculean task to help create supportive environment for people to make healthy choices. As examples:

- Health promotion professionals advocate for tobacco-free environment, yet new tobacco companies are licensed by government to boost tax revenue.
- Rather than support health promotion professionals to promote healthy lifestyle centres across communities, more hospitals and clinics are built without adequate support.
- Health promotion professionals promote the need for safe water, yet community taps are dry.
- Health promotion professionals promote the need for proper nutrition, but our cities are being taken over by desperate fast food companies.
- Health promotion professionals promote environmental sanitation, and yet no designated refuse dumping sites in most communities.
- Health promotion professionals advocate for healthy policies, yet no effective enforcement mechanisms for existing ones.

SUMMARY OF MY RESEARCH CONTRIBUTIONS TO THE PROFESSION OF PUBLIC HEALTH PROMOTION

Mr. President/Vice Chancellor Sir, my research contributions to the ministry of public health promotion are outlined below. In other words, these are ways I have contended with principalities and powers to contribute to the advancement of health promotion.

1. Perspectives on the Biblico-Historical Foundations of Public Health

One of the challenges in our health system is the lack of understanding of the basis for the ministry in the ministry of health. Aja (2002), affirmed that Public Health is as old as the Bible, thereby establishing the connection between biblical history of public health and contemporary perspectives. My paper noted that biblical history is important in understanding the origin of disease and illness, and provides the basis for restoring human health from a state of incompleteness to "a state of complete physical, mental and social wellbeing" (World Health Organization, 1948). The foundation for healthful living is rooted in the Bible. For example, alcohol, one of the killer drugs globally, is condemned in the Bible. Aja (1998), advocated for the "touch not, taste not, handle not" principle. Another example is the scourge of HIV/AIDS, which continues to ravage our world, particularly in sub- Saharan Africa. Aja (1997), maintained that rather than focus on short term "puppet human sexophilosophical strategies", a bible-based, morally-justified, abstinence approach is likely to achieve greater results in the long run. In many settings, masturbation is celebrated. Aja et al (2014), reaffirmed the bible principle of self-control; a position which almost affected my membership of one of the organizations I belong to. Undoubtedly, Bible history provides a clear understanding of the root of human health problems and what the ultimate solutions are, including the need for public health promotion. Building on the works of Effa (2005), McKnight & Kretzmann (1996), Nwaorgu (2005), Pinneh (2005), Aja et al (2009a) identified 'hidden' religious health promotion assets needed to prevent and control HIV/AIDS. The findings indicated that the expertise of church members who are health professionals would help engage [religious bodies] in HIV/AIDS prevention activities. Aja et al (2009b), further explored the importance churches attached to health assets. Table 2 showcases the results.

Table 2: Importance ratings of assets for the prevention and control of HIV/AIDS

Spiritual asset
Faith that God is able to heal those who have HIV/AIDS*
Compassion for those affected
Preaching on HIV/AIDS
Compassion for those infected
Prayer for people who have HIV/AIDS
Health education asset
General education about health for members*
Members who are health professionals (doctors, nurses, health workers)
HIV/AIDS education for members
HIV/AIDS posters
HIV/AIDS booklets/brochures
Transportation to health programs
Church's HIV/AIDS action committee
Barbing salon for members (barber shop)
Capacity building asset
Projector/DVD/VCD*
Youth ministry on HIV/AIDS
Trained HIV/AIDS counselors
Scholarship for orphans
Job placement opportunities for members affected by HIV/AIDS
Men's ministry on HIV/AIDS
Women's ministry on HIV/AIDS
Church advocacy for people living with HIV/AIDS
Time for HIV/AIDS education during church services
Social asset
Visitation team for people who have HIV/AIDS*
Visitation team for families affected with HIV/AIDS
Food and clothing for families affected by HIV/AIDS
Food and clothing for those who have HIV/AIDS
Home outreach services
Financial asset
Special offerings taken for HIV/AIDS*
Financial support from non-members

**Highest ratings in the prevention and control of HIV/AIDS*

How the health needs of churches relate to the assets they hold, including the collective capacity of members to use needed resources to help address a wide range of health issues, including HIV/AIDS, that continues to challenge resource-constrained economies, including Nigeria, was

further explored. Aja et al (2011) revealed that churches with more resources were more likely to engage in more HIV/AIDS programs. Contrary to our expectation, churches that had health needs were also more likely to engage in HIV/AIDS programs, having been more aware of their needs.

2. Building Health Promotion Agenda into Nigeria's National Health Policy

Long before the approval of the National Health Policy on Health Promotion by the National Council on Health in 2006, and the official launching in January 2007 by the Federal Ministry of Health, Aja (2001a) had advocated for the integration of health promotion component into all health-related programs in Nigeria to bridge the gap between curative care and preventive/promotive programs.

3. Added Value to Qualitative Research in Health Promoton

The use of focus group discussions (FGD) in public health and social sciences qualitative research is common. It enables the researcher to look beyond numbers, and explore "in-depth the motivations, the feelings, the reactions of selected social groups towards a given subject or concept, by listening and analyzing their way of expressing themselves in discussion groups or with non-directive interviews" (European Commission, 2012). My team redesigned the FGD model into three pronged approach beginning with the open forum to the FGD and ending with the closing forumn (Fig.2).

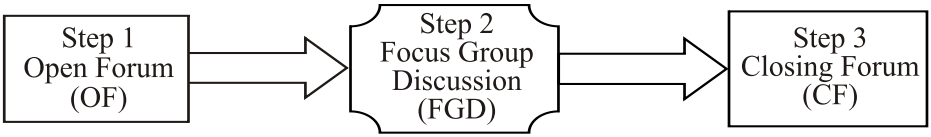

Figure 2: A three-step Forum Focus Group Discussion (FFGD) method (Aja, Modeste & Montgomery, 2012)

Our study revealed new data from the closing forum (Fig.3), that would have been lost if the traditional FGD had been used (Aja, Modeste & Montgomery, 2012).

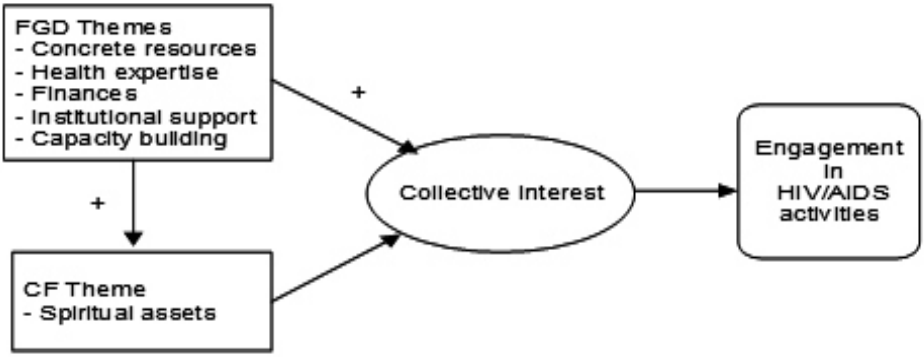

Figure 3: Focus group discussion and closing forum themes

4. Developing Behavior Change Communication Resources

a. ABC of Rational Use of Medicines: Communities need clear messages on health issues, presented in a simple, easy to read format. Aja (2002), articulated pertinent issues aimed at helping communities learn how to use medicines safely and effectively. The project was funded by the UK Department for International Development (DFID), through her support of the Networking for Rational Drug Use in Africa Project of the Health Action International (HAI) Europe Foundation, Amsterdam, The Netherlands.

b. ABC of Malaria Prevention and Control: Malaria continues to be the single biggest threat to millions of lives throughout Africa, particularly women and children. The bulk of existing information on the subject is not always readily accessible to non- medical people. It is often written and presented in a language that is not so easily understood by a vast majority of the community people who really need clear messages to make informed choices. Aja et al (2014a), compiled easy-to-read, key facts, on malaria prevention and control.

c. ABC of Women's Health: A Handbook for Girls: Girls need information on health issues confronting women. Aja et al (2014b), explored practical perspectives on issues related to sexual and reproductive health and rights of

girls. Topics covered include inter-generational relationships, teenage pregnancy, gender-based violence, risky sexual behavior, etc. Funding for the development and publication of the study was from the Global Health through Education, Training and Service (GHETS) Mini-Grant.

These materials are being used by community groups to promote health and well-being in Nigeria, India, South Africa, and other countries. Efforts are being made to translate these materials into French and Nigerian languages.

5. **Public Health Promotion Training and Capacity Building Resources on Women's Health**
   Health professions training, oftentimes, does not take into account critical health needs of vulnerable groups, particularly women and children. Aja (2006), presented the danger of irrational use of medicinal products by women, as one of the modules in the Women and Health Learning Package, a CD ROM resource for health professions education, produced by the Women and Health Taskforce and Global Health Through Education, Training and Service (GHETS). It is being used in the training of health professionals in some institutions in Nigeria, Mexico, South Africa, India, Sudan and other countries.

6. **Sexual and Reproductive Health Research and Research Capacity Strengthening in Africa**
   Strengthening research capacity is recognized as an approach to better health and development in low- and middle-income countries (LMICs). Especially, fields such as sexual and reproductive health (SRH), would require inter-disciplinary teams of researchers, equipped with a range of methodologies to achieve this. In November 2013, as part of the International Family Planning Conference in Addis Ababa, Ethiopia, a group of African researchers, of which I was a part, was invited by the World Health Organization (WHO) Department of Reproductive Health and Research, to discuss the gaps and strategies to improve sexual and reproductive health

research and research capacity strengthening in Africa. The three broad areas identified were addressing research gaps that are most relevant to policies and programs in SRH, carrying out high quality and collaborative research, and translating research findings into SRH policies and programs (Adanu, Mbizvo, Baguiya, Adam, Ademe, Ankomah, Aja, Ajuwon, Esimai, Ibrahim, Mogobe, Tuncalp, Chandra-Mouli, and Temmerman, 2015). As a result, in 2014, the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) formed 'the HRPAlliance' to enhance regional research networks and mentoring capacity.

7. Assessing Knowledge, Attitude and Practice of Family Planning in Rural Communities in Nigeria

Maternal and infant mortality rates, coupled with high population growth rate, are unacceptably high in Nigeria. The Nigerian government endorsed the promotion of reproductive health, including family planning, through maternal and child health services. Ohaozara Local Government Area (LGA) introduced a Five-Year Action Plan (FYAP) in 1989. To appraise the plan, Aja, Nwangwa & Egwu (1995), interviewed 600 persons stratified by geographical location and sex in three randomly selected autonomous communities to determine their knowledge, attitude and practice. The findings showed a high awareness level with a moderately positive attitude and generally low level of practice. We recommended a comprehensive reproductive health education, budgetary increase, evaluation of the FYAP, and program coordination.

8. Translating Research Evidence Into Action

Mr. President/Vice Chancellor Sir, it is not enough to conduct research. While health promotion research may be important in identifying the extent of public health problems, utilizing research evidence to address identified health problems is crucial (Aja, 2007). The following are some of my contributions in this area:

a. Developing Culturally-Oriented Strategies for Communicating Women's Health Issues: A Church-based Intervention

Local knowledge is powerful. Learning from local people can be fun. Women are important family care providers, and agents of health promotion. Recognizing these facts, Aja, Umahi & Allen-Alebiosu (2011), utilized culturally-oriented strategies to increase awareness on women's health issues, among church-based, women support groups, in Aba, Nigeria (Table 3).

Table 3: Summary of groups, Women and Health Learning Package (WHLP) modules, communication method(s) and application of communication strategy

Group	WHLP Module	Communication Method	Application
1	Adolescent Health	Dialogue	Focused on sex and HIV/AIDS and conveyed important lessons on abstinence, faithfulness, voluntary counselling and testing and Christian support. The dialogue involved two good friends: one was against indiscriminate sexual relationships while the other was in favour of a "free life" until she was confronted with the realities of HIV/AIDS. Then she remembered the discussions she had had with her friend on the devastating effects of HIV/AIDS and how it can be avoided.
2	Violence against Women	Drama	Portrayed forms of sexual abuse (a husband insisted on sexual pleasure even when it was not convenient for the women), physical abuse (beating, kicking and hitting) and verbal abuse
			(insults, name -calling and unreasonable demands). The group strongly highlighted o ne of the root causes of family violence in the Nigerian setting, which is undue demand from mother-in-laws for a boy -child in the family. The drama ended with a song, on the note that "the time has passed when women were regarded as nothing..."
3	Nutrition and Women's Health	Song and Storytelling	Emphasized that balanced diet (protein, carbohydrates, fats and oil, vitamins and minerals and water) helps protect against diseases and provides fresh blood leading to good antenatal and postnatal health, energy and vitality.

4	Use of Medicine by Women	Story	Portrayed a poor widow who could not afford to take her child to the hospital because she had no access to the health center due to lack of money and transportation. She relied on a fraud village doctor who prescribed "too many drugs" at affordable cost. The illness got worse and the child was eventually rushed to the hospital where he got well. While the song emphasized the importance of hospital care, the need for improvement on the social determinants of h ealth was also strongly highlighted.
5	Cervical Cancer	Quiz	The twelve questions centered on the causes and prevention of cervical cancer. The questions generated further discussions and questions within the groups, particularly during the feedback session.
6	Safe Motherhoo d	Poster	Illustrated the danger of having more children than one can care for and how this can enhance poverty and disease. The take -home message was that family planning improves the

It is pertinent to note that at the Network: Towards Unity for Health Conference, held in Chia-Bogota, Colombia, our poster presentation (Figure 4), related to the study reported above, won the **Best Poster Award** in 2009.

Figure 4: Best Poster Award, Chia-Bogota, Colombia, 2008

b. Promoting Food and Nutrition Security: Indigenous Vegetables (Okra, Spinach, Jute, Fluted Pumpkin, and Bitter Leaf)

Reducing high rates of malnutrition through promoting healthy diets is important. My team explored the benefits of indigenous vegetables with specific reference to okra (Denton, Ogunwenmo, Aja, & Nwangburuka, 2014); Ceylon spinach (Ogunwenmo, Denton, Nwangburuka, & Aja, 2014); Corchorus olitorius (jute) (Denton, Ogunwenmo, Nwangburuka, Aja, 2014); Telfairia occidentalis (fluted pumpkin). (Denton, Nwangburuka, Ogunwenmo, Aja, 2014); Vernonia amygdalina (bitter leaf) (Nwangburuka, Ogunwenmo, Denton, Aja, 2014). The studies were commissioned and funded by the Plant Resources of Tropical Africa (PROTA), Wageningen, Netherlands. The projects led to the development of an Atlas, a promotional material, on indigenous fruits and vegetables in Africa, widely distributed and circulated by Food and Agriculture Organization (FAO). The Nigerian government currently supports initiatives aimed at promoting local foods to improve human nutrition.

c. Use of lay health workers in primary and community health care for maternal and child health and the management of infectious diseases

Increasing interest has been shown in the use of lay health workers (LHWs) for the delivery of a wide range of maternal and child health (MCH) services in low and middle income countries (LMICs). However, robust evidence of the effects of LHW interventions in improving MCH delivery is limited. With support from the World Health Organization, Lewin, Dick, Pond, Zwarenstein, Aja, van Wyk, Bosch-Capblanch, and Patrick (2005), and Lewin, Munabi-Babigumira, Glenton, Daniels, Bosch-Capblanch, vanWyk, Odgaard-Jensen, Johansen, Aja, Zwarenstein, and Scheel, (2010), assessed the effectiveness of lay health workers (LHWs) in primary and community health care and for maternal and child health and the management of infectious diseases respectively. The findings show that LHWs provide promising benefits in promoting immunization uptake and breastfeeding, improving tuberculosis treatment outcomes,

and reducing child morbidity and mortality when compared to usual care. The studies were published in the Cochrane Database of Systematic Reviews, a highly rated, global publication venue, with an impact factor of 6.103 (as at 2016).

9. Building a Healthy Community of Public Health Professionals

In 2013, I worked with colleagues in the Department of Public Health to organize a very successful international Public Health conference at Babcock University, in partnership with the University of Ibadan (led by Prof. Ademola Ajuwon), the University of Calabar (Prof. Nurudeen Olaniran), and the Federal University of Technology, Owerri (Prof. Okwuoma Abanobi). The conference brought together, other schools offering the BSc program in Public Health in Nigeria. The 2nd edition of the Public Health conference was held in Abuja, September 26-28, 2016.

Today, that successful initiative has led to the registration of a professional body called the Association for Public Health Teaching, Research and Service (APHTReS) "to organize scholars, scientists, technologists, and other professionally-trained persons and organizations in the public health fields into a body for the purpose of working together" to achieve the goal of "health for all". I am currently the Chairman of APHTReS.

Summary of My Contributions to Babcock University and other Institutions

Mr. President/Vice Chancellor Sir, beyond research, I have served in different capacities in the areas of teaching and community service, supervised and co-supervised PhD theses, MPH dissertations, supervised and coordinated practical sessions and fieldwork activities in BU, involving guided instructions of student's teams to implement field work practice in selected communities. I have continued to mentor students and younger faculty in the areas of project

proposal writing, research consultation, and health project planning, implementation and evaluation, and supported some BU graduates to obtain scholarship opportunities for advanced degrees, travel grants and fellowships. I have served and currently serving as external examiner and assessor to reputable institutions in Nigeria and abroad.

1. Development of the Bachelor of Science (BSc) Degree in Babcock University, the first of its kind in Nigeria

Having observed that clinically trained professionals alone cannot manage public health challenges effectively and efficiently in Nigeria, I was instrumental to the development of the Bachelor of Science in Public Health degree program in Babcock University (BU) in 1999; the first in Nigeria and Africa, and indeed globally. I coordinated the program from 1999 to 2004. The degree program was oriented towards training future managers/promoters of primary health care (not primary care) whose overall goal would be to initiate social, political, economic, environmental and cultural action that would lead to positive changes in the health status of the populace (Aja, 2001b).We developed the benchmark with which NUC used and is still using to accredit Public Health programs in Nigeria. Before then degree programs in Public Health were offered at the postgraduate level by few universities in Nigeria. The beneficiaries were physicians and few others from the allied health professions. Today, our humble initiative in the Department of Health Sciences, and later Department of Nursing and Community Health, and then back to the Department of Health Sciences, and now Department of Public Health, Babcock University, has consolidated Public Health training in Nigeria, with about 10 schools, and still counting, offering the BSc degree in Public Health.

2. Head, Department of Public Health (2011 2015)

As the head of department for two programs, Public Health and Social Work, the following were achieved:

- FULL Accreditation by the National Universities Commission in 2012, after 14 years of Interim accreditation.
- Received the Academic Partner Award from Livewell Initiative on behalf of the President/Vice Chancellor, September 30, 2012.
- Hosted the maiden International Public Health Conference that attracted over 400 participants, including representatives all Nigerian institutions offering degree programs in Public Health, May 12-15, 2013
- Initiated the St John Ambulance training and certification program on First Aid/Cardiopulmonary Resuscitation for final year students.
- Initiated the publication of Public Health, an electronic newsletter that reported departmental events, faculty research projects and publications, including scholarship and fellowship opportunities for final year students of public health.
- Initiated and facilitated participation of Public Health students in local, national and international conferences.
- Initiated Prof. GND Aja Women's Health Research Award for graduating students.
- Upgraded the Public Health museum and laboratory facilities to support effective instruction and learning.
- Initiated interactive sessions with traditional healers in 2012, through classroom-community partnership, to enhance students' understanding of local healing practices.
- Initiated interactive sessions with the elderly in 2015, through classroom-community partnership, to share their ageing experiences with undergraduate Public Health and Social Work students. Relevant experiences shared by the elderly were collated and

developed as research questions and case studies, for enhanced teaching and learning.

3. Deputy Director, Office of Research and International Cooperation (2010 - 2012)

As Deputy Director, Research and International Cooperation (RIC), now Research, Innovation and International Coperation (RIIC), I brought my extensive local, national and international exposure to bear in all RIC programs and projects. Some of them are as follows:

a. International Workshop on the Use of Geographic Information System & Remote Sensing in Research and National Development by RIC, February 22 - 25, 2011

With funding support from Loma Linda University (LLU), my alma mater, I attended the ArcGIS Software Conference in San Diego, California in July 2010. This conference afforded me the opportunity to mobilize support for BU International Workshop on the Use of GIS & Remote Sensing in Research and National Development. Major local collaborators (AAC Consulting, a GIS consulting firm, Lagos; Support Systems, the national GIS software marketer, Lagos; and University of Lagos, Geography Department), and ESRI regional GIS software distributor (Sambus Ghana Ltd) contributed immensely to the success of the GIS conference. As a result of this initiative, BU obtained, free of charge, ESRI licensed Software worth $25,000.00. Other collaborators at the GIS conference included National Space Research and Development Agency (NASRDA), Abuja Geographic Information System (AGIS) Abuja, Wema Bank PLC, New Horizons-an IT training institution, and Babcock Consulting. Following the success of the International workshop, an MOU was initiated between BU and NASRDA.

b. Fourth National Universities Research and Development Fair (NURESDEF 2010)

We led Babcock University to the 4th NURESDEF at the University of Nigeria, Nsukka, November 22-26, 2010, where

BU won the overall 3rd Best University position in Research and Development in Nigeria.

c. UNESCO - GEIFON Chair Program in Environmental Sciences

During my tenure, BU was selected as one of the four institution partners and the only private University in the UNESCO Sponsored Workshop on Curriculum Development, Fund-Raising and Strategic Planning for the UNESCO Global Educational Initiative for Nigeria (GEIFON) Chair Program in Environmental Sciences, held at the University of Benin, Benin City, Nigeria, January 27- 28, 2011. One of the objectives of the program was to promote an integrated system of research, training, information and documentation in the field of Environmental Sciences.

d. Research Management and Staff Development: Capacity Building School, University of Buea, Cameroon

I was part of the team that showcased Babcock University at the Capacity Building School on Research Management and Staff Development at the University of Buea, Cameroon from July 25 to 30, 2011. The training program informed the numerous positive changes we initiated in RIC during my tenure as Deputy Director.

4. Sponsor, Eagle Class 2015

I successfully executed the arduous task of coordinating the 2015 Eagle Class programs and projects. It was such a great privilege to have contributed to the leadership experiences of the students at their point of exit from Babcock University. I have found a strong bond of friendship that has led to a decision to organize the first Eagle Class Homecoming in 2018, by the grace of God.

5. Chair, Editorial Committee, International Conference of Private Universities in Africa, 2010

I worked with Prof. Samson Nwaomah to compile and publish a book titled, Private Education in Africa: Issues and

Challenges, a collection of conference papers, presented at the International Conference of Private Universities in Africa (ICPUA) in 2010.

6. Other Contributions to Community Health

a. I was involved in the process of reviewing the Monitoring and Evaluation Framework for the Health Sector in Nigeria, at a meeting held in Keffi, Nasarawa State, from January 16-19, 2017.

b. As a member of Nigerian Communications Commission (NCC) Expert Committee on Electromagnetic Fields (EMF) Exposure and Health, I have facilitated workshops on "Mitigating the effects of EMF on Health" for the South West / North Central, South East/South South Zones. I was also involved in the development of NCC staff training curriculum on EMF exposure and Health.

c. My team visited and adopted Oke-Ila community as a centre for community support and development project. The community is largely agrarian, with a large percentage involved in oil palm production. However, palm oil pressing and extraction is manual and laborious. With Babcock University Research Award in 2012, we purchased palm oil extractor for the community.

d. With support from Global Health Through Education, Training and Service (GHETS) USA, my team has, between 2007-2015, conducted workshops and projects to promote women's health in Ogun, Abia, Ebonyi, Oyo, and Kaduna States, as illustrated in Figures 4,5 and 6.

Figure 5: Author, with participants, at the women and health workshop in Kaduna, 2009

Figure 6: Posters for communicating and promoting women's health developed by adolescents using the "ABC of Women's Health: A Handbook for Girls"

e. With the Cochrane Opportunities Fund, my team developed innovative ways of disseminating information from Cochrane reviews to low literate people in Nigeria, using communication strategies that are particular to Africa (e.g., storytelling, drama sessions (skits), posters, etc) (Figure **7**).

Figure 7: Poster presented at the Cochrane Colloquium in Keystone, Colorado, USA, 2010

7. Benefits of my International Linkages to the Development of Babcock University

Mr. President/Vice Chancellor, Sir, my international connections have benefitted BU in several ways:

a. I subscribed Babcock University to the Health Internetwork Access to Research Initiative (HINARI), during my consultative visit to WHO Headquarters in Geneva in 2001. This great resource has supported BU tremendously during National Universities Commission and other accreditation visits. HINARI is an electronic library developed and provided by the

World Health Organization (WHO) to facilitate access to more than 10,000 full-text journals on health and sciences.

b. I served on the Board of The Cochrane Collaboration, during which Babcock University had free access to The Cochrane Library, adjudged by WHO as the best single most reliable source for evidence on the effects of health care. The Cochrane Collaboration is a global organization that prepares, maintains and promotes the accessibility of systematic reviews of the effects of healthcare interventions. The Cochrane Library, by subscription is worth thousands of UK Pounds. Numerous Babcock University faculty, staff and students have benefited from this treasure of resources.

8. My contributions to the National Open University of Nigeria

Mr. President/Vice Chancellor Sir, I spent my sabbatical leave at the National Open University of Nigeria (NOUN) in 2015/2016 school year. During the period, I served in various committees of the University, and initiated the publication of the School of Health Sciences Newsletter.

9.Other Service Positions (Table 4)

	Position	Organization/Institution	Period
1	Country Representative (Nigeria)	Pharmaceutical Network	1999 – 2004
2	Sub-regional Coordinator, Western Anglophone	Health Action International (HAI) Africa	1999 – 2004
3	Member	Health Action International (HAI) Africa Advisory Committee	1999 – 2004
4	Collaborator	Effective Health Care in Developing Countries Project, Infectious Diseases Group, Liverpool School of Tropical Medicine, UK	1999 – 2004

5	Member/Treasurer	Coordinating Committee, Cochrane Collaboration Consumer Network (CCNet)	2000 – 2007
6	Consumer Representative/Member	Cochrane Collaboration Steering Group (Board)	2004-2007
7	Member	Women and Health Taskforce of The Network: Towards Unity for Health	2004 till date
8	Temporary Adviser	World Health Organization (WHO) International Dialogue on Evidence-Action for Improving Health in Developing Countries (IDEA-Health)	2006
9	Member	Advisory Committee, First 5 Project, Desert Region, San Bernardino County, California	2007
10	Member	National Strategic Working Group of the Nigerian Branch of the South African Cochrane Centre on Evidence-based Health Care	2008 till date
11	Visiting Professor	Loma Linda University Department of Global Health, California, USA	2009 till date
12	External Examiner	University of Ibadan Department of Health Promotion & Education	2010 till date
13	External Examiner	University of Calabar Department of Public Health	2010 till date
14	External Assessor	Federal University of Technology, Owerri	2012
15	Adjunct Professor	Adventist University for Africa, Nairobi, Kenya	2013
16	External Assessor	University of Ghana School of Public Health, Legon, Ghana	2013
17	Member	Adventist Accrediting Association (AAA) Visitation Team to AIIAS, AUP and MAC, Philippines	2013
18	Temporary Adviser	World Health Organization (WHO) Department of Reproductive Health and Research	2013
19	Chairman	Supervisory Board, African Sanitation Knowledge Network (ASKNET), Mozambique	2014 till date

20	Member	Advisory Board, Nigerian Branch of the South African Cochrane Centre	2014 till date
21	Chairman	Association for Public Health Teaching, Research and Service	2014 till date
22	External Assessor	Novena University Department of Public and Community Health	2014 till date
23	Member/Consultant	Nigerian Communications Commission (NCC) Expert Panel on Electromagnetic Fields Exposure and Health	2014 till date
24	Chairman	Association for Public Health Teaching, Research and Service	2015 till date
25	Africa Representative and Member	Executive Committee (Board), The Network: Towards Unity for Health	2015-2019
26	Professor	School of Health Sciences, National Open University of Nigeria	July 2015 - June 2016

My Contribution to Spiritual Development

To the glory of God, Town Planning Seventh-day Adventist (SDA) Church, one of the leading churches in Western Nigeria Union, began from my living room, late 1994. It was from my house that the church moved to Olajumoke Primary School, till Dec. 2002; and to the house of Prof & Mrs. Adebawojo till, July 13, 2003; and to the permanent site in December 31, 2003. I was the First Elder from 1994 2004. If it were to be an independent ministry, I would have been the 'General Overseer', and my wife would have been the “Prophetess-General”. To God be the glory!

I was also Sabbath School Superintendent of SDA Church, Calabar from 1989 to 1992; Health and Temperance Director, Babcock University Church from 1994-2004 and 2009-2010, and First Elder, New Creation Chapel, Babcock University Church from 2008 to 2016 and currently First Elder of Prince Emmanuel Chapel. My wife and I lead a prayer group, “Fear Not Prayer Group”, to support the spiritual life of BU students.

My family collaborated with Kansas Avenue SDA Church in southern California, USA to build children's church in Uburu, Ohaozara, Nigeria, to the glory of God.

RECOMMENDATIONS

Mr. President/Vice Chancellor, Sir: I wish to recommend as follows:

1. That the 'ministry' in the Ministry of Health is a Christian religious concept, and should be treated as such in the delivery of health services. In other words, health as a ministry requires supra-professional collaboration with God.

2. Teaching of health professionals should include biblical history of health promotion and wellbeing.

3. Faith-based organizations should be agents of health promotion and ministers of health in their various constituencies.

4. Nigeria's Ministry of Health should reflect on her mission to enable her remain focused on the health of the people, by the people and for the people.

5. The Nigerian government should allow public health to drive the health system rather than the current huge investment on curative services.

6. The Nigerian government should develop inter-professional practice guideline involving professionals in Public Health, Medicine, Nursing, Medical Lab Scientists, etc.

7. The Nigerian government should develop intra-professional guideline for all public health disciplines - Health Promotion/Education, Epidemiology, Environmental Health, Biostatistics, etc.

8. Super-professionals, policy makers, in the health sector should engage public health specialists in the formulation of population-based policies.

9. The Nigerian government should invest and effectively utilize health promotion specialists to help progressively decrease the number of preventable deaths, and vigorously address lifestyle-related issues in the population.

10. The Nigerian government should monitor the undue influence of pharmaceutical industries, tobacco companies, food industries and others on health research and policy development.

11. BU School of Public Health should be organized along the major disciplines of public health to include Epidemiology, Biostatistics, Nutrition, Environmental Health, Global Health, etc.

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I sincerely appreciate the former Dean, Professor Dora Akinboye; my current HOD, Dr. Motunrayo Olanrewaju; Prof. Ihongbe, Head of Medical Laboratory Science; Prof. Roseline Opeke, Department of Information Resources Management; Professor S. P. Owolabi, a seasoned professor in the field of Public Health, and all the faculty and staff of SPAH, who are here today to attend the lecture.

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- I appreciate all my guests, well wishers and colleagues from different locations who are here to grace this lecture. You have made my day! Please forgive me if your name was not mentioned here.

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- To God I give all the glory!

CONCLUSION

Mr. President/Vice Chancellor, Sir, as demonstrated in this lecture, that the Bible provides ample support for health promotion. The ministry in the ministry of public health promotion calls for a God-centred, mission-driven, health eduction, service improvement and advocacy, needed to strengthen community action, create healthy policies, reorient health services, develop personal skills, and create supportive environment for achieving the people-oriented goal of "health for all" Nigerians. The current focus on the ministry of curative care is retrogressive. Medical science and technology do not have answers to all health problems. Scientific evidence is clear on the need to empower

communities to take charge of their health and wellbeing. Unfortunately, personal and commercial interests tend to undermine health promotion efforts, which are aimed at empowering population groups to attain optimum health. Engaging health promotion professionals, on a wider scale, in the implementation of existing health promotion policies, would go a long way to improve health outcomes for the generality of the people.

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Previous Inaugural Lectures

1. "Seventh-day Adventist Church in Nigeria since 1914: An Impact Analysis."
   Lecturer: Prof. David O. Babalola
   Date: Thursday, December 2, 2010.

2. "The Truth about Truth: Postmodernism and its Epistemological Implications for Christian Education."
   Lecturer: Prof. Ademola Stephen Tayo
   Date: Thursday, February 5, 2015

3. "Food for Thought in Thoughts for Food: Conceptual Genius of Local Ingredients in Global Diets and Food Habit of African Population."
   Lecturer: Prof. Yetunde Olawumi Makinde
   Date: Thursday, April 2, 2015

4. "One Kingdom, Many Kings: The Fungi-once Sidelined and Maligned, now Irrepressible and Irresistible."
   Lecturer: Prof. Stephen Dele Fapohunda
   Date: Thrusday, May 2, 2015

5. "The Hand that Handles the Scalpel."
   Lecturer: Prof. Iheanyichukwu Okoro
   Date: Wednesday, 10th June, 2015

6. "Parasitic Infections: Challenges of Control and Eradication in Public Health."
   Lecturer: Prof. Dora Oluwafunmilola Akinboye
   Date: Thrusday, 15th October, 2015

7. "The Oracle, Intellectual Property and Allied Rights, the Knowledge Economy and the Development Agenda."
   Lecturer: Prof. Bankole Sodipo
   Date: Tuesday, 17th November, 2015

8. “Challenges of University Education Quality in Nigeria. Placing Emphasis where it Belongs.”
   Lecturer: Prof. James Ahamefule Ogunji
   Date: Thursday 4th February, 2016

9. “Factionalism, Rampaging Economic Vampires, and the Fragile State.”
   Lecturer: Prof. Ayandiji Daniel Aina
   Date: Wednesday, March 9, 2016

10. “Footprints: Livestock Nutrient Management and the Environment.”
    Lecturer: Prof. Grace Oluwatoyin Tayo
    Date: Thursday, April 7, 2016

11. “Nursing on the move: Consolidating and Harnessing the Gains for Clinical Excellence.”
    Lecturer: Prof. Ezekiel Olasukanmi Ajao
    Date: Thursday, May 5, 2016.

12. “Accounting in the Digital Age: Creating Values with Paperless Decision Support Systems.”
    Lecturer: Prof. Enyi Patrick Enyi
    Date: Thursday, September 8, 2016

13. “Cost of Beating the Bug: Issues in Health Financing.”
    Lecturer: Prof. Solomon Ajayi Adebola
    Date: Thursday, November 3, 2016