EDUCATIONAL ASPECTS OF HUMAN HEALTH IN ADULTHOOD

Asst. Prof. Dr. Anna Gaweł

Jagiellonian University in Krakow

ABSTRACT

This paper discusses the issues concerning health in the education of adults. The starting point for this discussion is contemporary understanding of health in social sciences, which identifies it with the physical, psychosocial and spiritual well-being. Its processual nature is also emphasised, since a person's health level is determined by a number of subjective and environmental factors. This allows for adaptation of the salutogenic thesis regarding the possibility of health improvement through health education and health promotion. The concept of environmental and socio-cultural health determinants and the issues of a health-related quality of life serve, in addition, as a point of reference and theoretical background for this pedagogical discourse on health as a subject of adult education.

Keywords: *health, quality of life, health education, health promotion, adult education*

IZOBRAŽEVALNI VIDIKI ČLOVEŠKEGA ZDRAVJA V ODRASLOSTI – POVZETEK

Članek obravnava tematiko zdravja v izbraževanju odraslih. Izhodišče razprave je sodobno pojmovanje zdravja, ki se uveljavlja v družbenih vedah in se razume kot fizična, psihosocialna in duhovna dobrobit. Poudarjena je tudi misel, da je zdravje proces in da zdravstveno stanje določajo tako subjektivni kot okoljski dejavniki. To odpira vrata teoriji salutogeneze, povezani s prepričanjem, da je zdravje mogoče izboljšati s pomočjo zdravstvene vzgoje in promocije zdravja. Koncept okoljskih in sociokulturnih dejavnikov, ki odločajo o zdravju, in vprašanja, ki se nanašajo na z zdravjem povezani vidik kakovosti življenja, so tudi uporabljeni kot referenčni okvir in teoretska podlaga za to pedagoško razpravo o zdravju kot predmetu izobraževanja odraslih.

Ključne besede: *zdravje, kakovost življenja, zdravstvena vzgoja, promocija zdravja, izobraževanje odraslih*

UDK: 374.7:61

INTRODUCTION

Health is one of the most important values for human beings. It affects the way we live our everyday lives, fulfil our social roles, implement our plans and aspirations; it influences the level of satisfaction and contentment with life. Health also has economic implications for both the individual and the society. The good health of the population constitutes the basic condition for sustainable development. In view of the increasing demographic problems connected with ageing of the European Union population and the changes in social consciousness in recent years, in which the emphasis has been shifted from "living to survive" to "quality of living", health promotion in early, middle and late adulthood becomes an issue of the highest importance. Health promotion is inextricably linked with health education, thus the discussion centred around the goals of educational activities in this field, addressed to adult learners, becomes a significant task of andragogy.

RECOGNITION OF HEALTH IN SOCIAL SCIENCES

A dynamic development of interest in health by social sciences has been observed since the second half of the 20th century when the

definition proposed by the Constitution of the World Health Organization in 1948 became popular. This definition proposed a recognition of health that was much broader than the biomedical understanding, built originally on the Enlightenment philosophy of Descartes. In the biomedical approach, which persists in the pathogenic paradigm, health and illness are treated as wholly separable categories; health is regarded as absence of disease, its determinants are perceived as biological factors - primarily the genetic makeup - and effectiveness of the treatments provided by health services. The consequence of this biomedical approach, still alive in people's minds, is the belief that health is a medical category; and that as such it remains outside of a person's control and, consequently, cannot be subject of a person's conscious activities.

The health is a prerequisite for self-realisation.

By extending the scope of the concept, health has become associated with a holistic approach, which identifies it with physical, mental and social well-being and not merely the absence of symptoms of illness. In recent decades, spiritual health has become an aspect that attracts an increasing amount of attention. What is more, the ways in which spirituality influences the level of somatic health are also recognised (Heszen and Sęk, 2007: 72; Heszen, 2008). The concept of a holistic approach to health has been reflected in a holistic and functional model, which sees the human body as a dynamic system, subject to the principles of regulation and self-organisation. This approach invokes the Bertalanffy's systems theory (1984), in which the relationship between various dimensions of health and also between human health and life environment can be analysed in the context of their inherent potentials. The utilisation of these potentials allows for attainment of health as a state of dynamic equilibrium.

A typical trend, found in most of today's health approaches in social sciences, places emphasis on its variability. Health is regarded here as a person's continuous journey through life, recorded on the health-disease continuum. The route of this journey is determined by the availability of health-supporting subjective and environmental resources. This way of defining health falls within the salutogenic paradigm (Antonovsky, 1979), the assumptions of which allow the search for ways of achieving health through individual activities and environmental interventions. The issue of health is also discussed here in the axiological perspective. It is recognised that health is a prerequisite for self-realisation and a determinant of the quality of life (Woynarowska, 2007: 38).

To summarise, it can be stated that modern understanding of health in social sciences takes into account its multi-dimensionality. This is a relative emancipation from medical indicators, combined with simultaneous ennoblement of the subjective perception of health, which gives it the status of a quality which allows leading a full, meaningful and productive life. On the other hand, it also includes search for positive health indicators and the assumption that they can be formed in the course of a personal activity, which emphasises its targeted environmental impact. This approach also determines the basic foundations for a pedagogical interpretation of the phenomenon of health.

HEALTH AND QUALITY OF LIFE

In social sciences the concept of quality of life is sometimes related to an objective

assessment of a person's living conditions and the level of satisfaction of their material needs. However, the analyses carried out in this field place the emphasis primarily on the subjective approach, reflecting the level of personal well-being and life satisfaction. Hence it may be concluded that the inclusion of not only one's well-being and functional capacity, but also of the level of perceived life satisfaction in the concept of health, helps to emphasise the "living to survive" aspect of life quality. The subjective evaluation of the quality of life, regarded as a cognitive and emotional category - the essence of which is to make an assessment and evaluation of different walks of life and life as a whole - is clearly connected with the environmental context of the various spheres of life and human activities (family, education, work, leisure, health, civic life, etc.) on the one hand, and self-esteem, perception of one's own health and functioning in the psychosocial dimension on the other (Heszen and Sęk, 2007: 57-59; Kościńska, 2010: 24). As regards the latter, it can be reasonably concluded that health and social problems, generated by the rapid development of modern civilisation and the changing demographic profile of the population, have made quality of life an issue of individual experience of the world, the assessment of which cannot be made without consideration of positive health indicators, termed physical, psychosocial and spiritual well-being.

Due to the fact that the primary purpose of educational impact is "(...) the release of human potential, including physical, biological, social and spiritual resources, which can then be used in the quest for self-realisation leading ultimately to a sense of life fulfilment" (Daszykowska, 2007: 62), a pedagogical understanding of the quality of life often emphasises its association with the prospects of multi-dimensional development, human creativity and fulfilment of life aspirations and goals in compliance with adopted values and expectations (ibid.: 11,18). In this context it should be stated that one of the fundamental conditions for successful development and self-realisation at every stage of life is having appropriate health capacity.

The exemplification of the central position of health in the complexity of health pedagogical impacts, aimed at the improvement of the quality of human life, is the concept of *health-related quality of life* (WHO, 1991). This concept defines physical, mental, spiritual, social and environmental dimensions of the quality of life. Their operationalisation indicates that the development of health-related quality of life is part of educational activities in the field of education and social support. The physical dimension includes health education, sex education, education for physical activity and rational leisure as well as development of psychosocial competencies, including communication, which are related to building of self-image and coping with stress. Educators should also foster activities that help to awaken aesthetic sensitivity and the ability to explore and experience arts, the effects of which can be considered in the context of development of the spiritual dimension of the quality of life. It can therefore be reasonably argued that health constitutes an important reference point for a variety of pedagogical activities aimed at enhancing quality of human life.

HEALTH AS A SUBJECT OF EDUCATION

By adopting the provisions of the salutogenic approach, we are able not only to identify the "sources" of health, but also to search for

new ones. Placement of health resources in the human environment and identification of their components, which can be shaped by people in a manner that benefits the health of the population, help us to realize that the most efficient and cost-effective way of obtaining health resources are educational activities, which, in the context discussed, fall into the domain of health education.

The concept of health education is defined in a number of ways. According to Woynarowska and the authors she quotes (2007: 102) health education should be understood as a process of learning about health and disease, particularly about how to take care of one's own and other people's health. The aim of health education is development of a health-promoting lifestyle and raising of individual and group competences at a variety of social levels. It also includes creation of opportunities for planned learning, which should result in informed decisions regarding health, followed by appropriate behaviour. The author thereby substantially enlarges the understanding of health education, encompassing not only people in bad health but also healthy people. Included are the provisions of the Ottawa Charter for Health Promotion (WHO, 1986), stating that human health is created and experienced in daily life habitats and constitutes one of the key determinants of the quality of life. She defines health education as "… a life-long process in which people learn how to live in order to maintain and improve their own health and the health of the others, to actively participate in the treatment of any illness or disability, deal with the situation and reduce its negative effects" (Woynarowska, 2007: 103).

It should be emphasised that this concept of health education covers not only intentional activities, but also occasional and incidental, institutional and individual, and any other internally motivated activities, including self-education and self-training, which support positive personal development and enable people to become conscious creators of their own health and participants in the activities promoting other people's health and environmental protection (Gaweł, 2008: 157; Charońska, 1997: 24).

The contemporary image of health education is influenced by the changes in people's perception of the world, health and quality of life associated with it, which has been observed in recent years. The sources of these changes are believed to belong to the realm of philosophy and social activities. The changes concern the shift in social consciousness, replacing the biomedical understanding of health, based on the Cartesian philosophy, with a holistic and systems approach, in which health is recognised as an integral, organised system, evolving in the interaction with the surrounding biosphere, culture and physical and social environment. It is generally accepted that the level of health depends primarily on a person's lifestyle and health behaviour, which are, to a significant degree, determined by factors of personal and socio-cultural nature. One of the main tasks of health education in this context is to increase the understanding of the factors determining the level of health and, above all, to facilitate development of system of beliefs, complying with the salutogenic model of health. Health education should, therefore, focus on building a "health-oriented" consciousness at each stage of a person's life.

Specific health education as an area of pedagogical activity generates the need for multifaceted recognition. Firstly, it is characterised by the necessity to take into account the various forms of execution and the specificity of its recipients. Health education can in fact be implemented not only within the system of

education, but is also included in the health care system and local educational programmes, addressed to specific locations or vocational groups. The objectives of health education should take into consideration the characteristics of the human psychophysical structure, which is closely connected with a person's age and their biologically determined capabilities to acquire knowledge and gain skills. It should also observe the requirements and health issues of persons subjected to the educational activity. Designers of educational programmes should take into consideration everyday health behaviour of the participants, the level of their medical knowledge, their declared belief system regarding health determinants as well as their social skills. To keep the activities within the public health education diverse and multifaceted, it is necessary to involve many specialised disciplines of social and medical sciences, such as health pedagogy, social pedagogy, psychology of health, sociology of health, hygiene, epidemiology, etc. (Gaweł, 2006: 179 -180).

Making health a subject of pedagogical discussion fits into the paradigm founded primarily on the sources of health. It seems that identification of these sources in human consciousness constitutes a sufficient prerequisite for the claim that health may be obtained through the process of education. The social significance of such targeted educational activities is confirmed by the changes effected in the common health consciousness, ranking as a "third health care revolution" (Gaweł, 2011: 97-98).

ADULTS AS RECIPIENTS OF HEALTH EDUCATION

One of the effects of the rapid development of scientific and technical civilisation of the last decades is emergence of the ambition to reach high standards of living. It often entails the necessity to adjust one's lifestyle to the expectations of the labour market and an increased pace of life, disproportioned to human capabilities. At the same time, the requirements of modern life generate functional risk factors for chronic non-infectious diseases, which include a feeling of general discomfort, fatigue, sleep disturbances, distress and depression (Bielecki, 2008). On the other hand, the deepening social stratification, associated with demographic processes, inequalities in access to the labour market and social benefits, lead to expansion of poverty and social exclusion. These trends result in a deterioration of health conditions for modern man and are reflected in a high rate of civilisation diseases, manifest in the developed countries for several decades, among which the most common are cardiovascular diseases, cancer and mental health disorders.

Additionally aggravating this situation are the biomedical view of health and the "consumerist view of the quality of life", deeply rooted in the minds of many people. The former leads to the conviction that individuals are not accountable for their own health and to the belief that medicine has the power to heal and shall act as the "health provider". The latter has to do with the perception of health in people's minds, which is often neglected in the face of other values. One of the most important challenges of health education for adults is, therefore, creation of health awareness.

Health awareness as a substructure of human consciousness is a complex cognitive structure, consisting of a relatively fixed perception of health and illness. It contains knowledge and beliefs connected with health and diseases, including the beliefs

related to health valuation, attribution of health resources, personal susceptibility to disease, causality of disease and methods of treatment (Gaweł, 2011: 91). The significance of health consciousness in the discussion of the objectives of health education relies on a psychologically proven theory on the relationship between human consciousness and the sphere of health-related behaviours. Theoretical models of health behaviours, developed on the basis of empirical research, suggest that health beliefs, inherent in human consciousness, can be considered to be direct or indirect predictors of health-focused activities1. It can, therefore, be reasonably argued that health awareness is a category of education. Undertaking activities aiming at its development at each stage of life is an important educational task.

This task constitutes part of the strategy of education, aimed at improving the level of "health literacy", seen nowadays as one of the major challenges for public health in the 21st century. This strategy targets adults and focuses on the cognitive mechanisms and social skills, required to motivate them to seek information on health and to gain the skills needed to comprehend it and then translate it into activities which are designed to improve and maintain good health (Nutbeam, 1998). It assumes that systematic implementation should lead to "functional health literacy", the goal of which is to raise awareness of health determinants and the use of healthcare services. The next step, the "interactive health literacy", would motivate and enable adults to act in a health-promoting way. The highest level is referred to as the "critical health literacy". Its achievement is seen as a precondition for empowering people to take control of their own health and its determinants, depending on the social and economic conditions of life (Iwanowicz, 2009).

PEDAGOGICAL ASPECTS OF HEALTH PROMOTION

From a practical point of view, educational activities targeting adults have the greatest chance of successful implementation within the framework of health promotion. The most commonly quoted definition of health promotion, to be found in the Ottawa Charter (WHO, 1986), specifies it as the process which enables people to increase control of their health and improve it. Control of one's health involves awareness of one's health issues, understanding health risks and the factors enhancing its potential, motivation to work towards health improvement and the skills which enable these activities. Gaining control over health is therefore inherently connected with educational activities. These activities alone, however, cannot guarantee acquisition of health; it is also necessary to fulfil the conditions required to meet health needs and to implement a health-promoting lifestyle. The second trend in health promotion activities has, therefore, the nature of environmental interventions, the goal of which is sharing resources and ensuring the political, social and economic conditions which will help to protect, strengthen and improve health. A good example of these activities is implementation of legal regulations ensuring health protection and psychological support for the employees in the helping professions, distinguished by severe exposure to psychosocial burdens (see: Gaweł, Kościelniak, 2013: 229-232).

Recognition of health promotion as an intervention in the social systems, stimulating them to develop into healthy environments

(Karski, 2003: 17), means "incorporating" health in various social systems, ranging from family and workplace to local community.

When a personal environment becomes the field of educational intervention in health promotion, a number of social effects can be observed, e.g. involvement of people and their activation, a sense of belonging and social cohesion. This shows how educational activities can promote maintenance of health in individuals and communities by highlighting the role of activating educational activities in health building of individuals and communities. These activities are part of the model of health promotion, the goal of which is empowerment of individuals and communities, to make them properly informed and participate voluntarily in social activities increasing individual and social control over the conditions of life and health promoting activities (Woynarowska, 2007: 136).

The notion of empowerment in health promotion in the health strategy of the European "Health for All" programme (WHO, 1985) is expressed by the slogan "Your health is in your hands". Please note that this strategy has clear pedagogical implications, the responsibility for one's own health implies also dealing with social health inequalities.

HEALTH EDUCATION AND HEALTH PROMOTION IN THE FACE OF HEALTH INEQUALITIES

The concept of health inequalities regards avoidable differences in health status and occurrence of severe health problems in individuals or groups, resulting from inequalities in access to social, economic and geographic (security of place of living) health resources (Laskowska, 2012: 88).

The causes of health inequalities are differences in social status - poverty, unemployment and low educational levels - resulting in limited access to health protecting goods, and the differences in lifestyles, associated with social stratification in the context of typical health behaviours. Health-related behaviour of a person is conditioned not only by the characteristics of individuals, their level of knowledge, beliefs, personality traits and strength of motivation, but also by a combination of external factors, particularly socio-economic living conditions.

The relationship between health conditions and socio-economic factors can be explained with the cause-effect sequence occurring in a chain of events. This perspective makes it clear that a low socio-economic status and a difficult financial situation can, in the long term, lead to deterioration of the psychosocial condition of a person, which results in a low sense of security, low self-esteem and/or disintegration of one's social ties. A low level of psychosocial well-being constitutes a risk factor for unhealthy behaviour - smoking, alcohol consumption and drug abuse – which is a way of dealing with the challenging situation. Such behaviours, combined with health practices typical of people who, due to material deprivation, live in a world of "limited choice", e.g., poor diet or limited access to prescribed drugs, are likely to suffer worsening of their biological condition through worsening of the physiological parameters of the risk factors. This in turn results in a lower level of adaptability and, consequently, may lead to a predisposition to ill health (Słońska and Woynarowska, 2002: 17-18).

Finally, the correlation between a personal health condition and the capability to protect and improve it should be emphasised, since poor health, resulting from a chronic

illness or disability, constitutes a barrier in access to many areas of social activity, including education, work and recreation, without which it is not possible to achieve a state of physical and psychosocial well-being (Włodarczyk, 2007). In this context, provision of social support is an important component of the efforts for personal health protection and improvement. This supporting aspect, once clearly defined, must be reflected in a variety of institutionalised and informal educational activities, performed in the community.

A low educational level is often seen as a source of health inequality. In the literature on the subject it is emphasised that education is an important determinant of one's lifestyle, level of health and longevity. At the same time it should be noted that education constitutes capital, which determines the position of individuals in the society and their social and economic opportunities, as it facilitates acquisition of the basic social status resources, such as professional qualifications, a good job, satisfactory earnings, which indisputably have a positive impact on people's health (Tobiasz-Adamczyk, 2000: 117-136; Sowa, 2007: 25). In this context, the concept of education as a health resource (Woynarowska, 2012: 9-10) and the idea of lifelong education become particularly significant.

SUMMARY

Health as a phenomenon of human life and the foundation of its quality is not granted to us by nature as a kind of *status quo*; it requires constant protection and improvement. The research of social sciences concerning the risks and protective factors provides the basis for the assumption that health should be a subject of educational activities. These are highly important for adults who, due to their roles and the fact that they have to struggle with numerous risks, generated by the modern world, need the educational and social support to develop a health-oriented self-awareness and the capability to use health resources.

To summarise, in the light of U. Beck's concept of risk society, health education and promotion should be seen as the key strategy for improvement of the quality of human life in the 21st century. The progress of science, technology, modernisation of the society and globalization may generate various types of risk, which affect numerous areas of private and social life of modern man, among which health risk is essential. Its negative consequences - illness, disability, suffering and death - constitute a specific code for interpretation of all dimensions of human life (Gałuszka, 2008: 18-19).

REFERENCES

Ajzen, I. (2005). *Attitudes, Personality and Behavior.* Maidenhead: Open University Press.

Antonovsky, A. (1979). *Health, stress and coping*. San Francisco: Jossey-Bass.

Bertalanffy, L. (1984). *Ogólna teoria systemów. Podstawy, rozwój, zastosowania*. Warszawa: Państwowe Wydawnictwo Naukowe.

Bielecki, W. (2008). Funkcjonalne czynniki ryzyka przewlekłych chorób niezakaźnych – między teorią a socjomedyczną praktyką. V: Gałuszka, M. (Eds.), *Zdrowie i choroba w społeczeństwie ryzyka biomedycznego.* Łódź.

Charońska, E. (1997). *Zarys wybranych problemów edukacji zdrowotnej*. Warszawa: Centrum Edukacji Medycznej.

Daszykowska, J. (2007). *Jakość życia w perspektywie pedagogicznej.* Kraków: Oficyna Wydawnicza „Impuls".

Gałuszka, M. (2008). *Społeczeństwo ryzyka i biomedycyna ryzyka.* V: Gałuszka, M. (Eds.), *Zdrowie i*

choroba w społeczeństwie ryzyka biomedycznego. Łódź.

Gaweł, A. (2006). Zdrowie w perspektywie pedagogicznej. Indywidualne wybory i społeczne interes. V*:* Kowalski, M.; Gaweł, A., *Zdrowie – wartość – edukacja*. Kraków.

Gaweł, A. (2008). Wychowanie zdrowotne w perspektywie teoretycznej. V: Kubiak-Szymborska, E., Zając, D. (Eds.), *Teoria wychowania w okresie przemian*. Bydgoszcz.

Gaweł, A. (2011). Świadomość zdrowotna jako kategoria wyznaczająca cele edukacji zdrowotnej. V: Gaweł, A.; Bieszczad, B. (Eds.), *Kategorie pojęciowe edukacji w przestrzeni interdyscyplinarnych interpretacji*. Kraków.

Gaweł, A.; Kościelniak, M. (2013). Health Education in Teacher Education and professional Development. V*:* Karlovitz, J.T. (Eds.), *Questions and Perspectives in Education*. Komarno.

Heszen, I. (2008). *Zasoby duchowe człowieka a zdrowie somatyczne*. V:.Brzeziński, J. M; Cierpiałkowska, L. (Eds.), *Zdrowie i choroba. Problemy teorii, diagnozy i praktyki*. Gdańsk.

Heszen, I.; Sęk, H. (2007). *Psychologia zdrowia*. Warszawa: Wydawnictwo Naukowe PWN.

Iwanowicz, E. (2009). Health literacy jako jedno ze współczesnych wyzwań zdrowia publicznego, *Medycyna Pracy*, 60 (5): 427-437.

Karski, J. B. (2003). *Praktyka i teoria promocji zdrowia. Wybrane zagadnienia*. Warszawa: CeDeWu Sp. z o.o.

Kościńska, E. (2010). *Edukacja zdrowotna seniorów i osób przewlekle chorych.* Bydgoszcz: Wydawnictwo Uniwersytetu Kazimierza Wielkiego.

Laskowska, I. (2012). *Zdrowie i nierówności w zdrowiu – determinanty i implikacje ekonomiczno-społeczne*. Łódź: Wydawnictwo Uniwersytetu Łódzkiego.

Nutbeam, D. (1998). Health promotion glossary. *Health Promotion International*. 13: 349–364.

Schwarzer, R. (1997). *Poczucie własnej skuteczności w podejmowaniu i kontynuacji zachowań zdrowotnych. Dotychczasowe podejścia teoretyczne i nowy model*. V: Heszen-Niejodek, I.; Sęk, H. (Eds.), *Psychologia zdrowia*. Warszawa.

Słońska, Z.; Woynarowska, B. (2002). *Programy dla zdrowia w społeczności lokalnej*, Warszawa: Instytut Kardiologii im. Stefana Kardynała Wyszyńskiego.

Sowa, A. (2007). *Społeczne uwarunkowania zdrowia. Podejścia badawcze* In S. Golinowska (Eds.), *Polityka zdrowotna wobec dostępności opieki zdrowotnej, wykluczenia oraz nierówności w zdrowiu. Raport z badań*. Warszawa: Instytut Pracy i Spraw Socjalnych.

Tobiasz-Adamczyk, B. (2000). *Wybrane elementy socjologii zdrowia i choroby*. Kraków: Wydawnictwo Uniwersytetu Jagiellońskiego.

WHO (1985). *Targets for health for all 2000*. Copenhagen: World Health Organization Regional Office for Europe.

WHO (1986). *Ottawa Charter for Health Promotion. An International Conference on Health Promotion. The move towards a new public health.* Ottawa: World Health Organization.

WHO (1991). *Report of the WHO Meeting on the Assessment of Quality of Life in Health Care*. Geneva: World Health Organization (MNH/PSF/91.4).

Włodarczyk, C.W. (2007). Polityka zdrowotna i wykluczenie społeczne. V: Golinowska, S. (Eds.), *Polityka zdrowotna wobec dostępności opieki zdrowotnej, wykluczenia oraz nierówności w zdrowiu.* Warszawa: Instytut Pracy i Spraw Socjalnych.

Woynarowska, B. (2007). *Edukacja zdrowotna. Podręcznik akademicki*. Warszawa: Wydawnictwo Naukowe PWN.

Woynarowska, B. (2012). Związki między zdrowiem a edukacją. V: Woynarowska, B. (Eds.), *Organizacja i realizacja edukacji zdrowotnej w szkole. Poradnik dla dyrektorów szkół i nauczycieli gimnazjum*. Warszawa.

1. The meaning of the beliefs mentioned in a person's intentional health activity can be seen in the models of health behaviours designed within health psychology, e.g.: *Theory of Planned Behaviour (TPB)* by I. Ajzen (2005); *Health Action Process Behavior (HAPA)* by R. Schwarzer (1997).