CHAPTER THREE

LITERATURE REVIEW

3 .0 INTRODUCTION

HIV/AIDS problem has for the past two decades been a global problem that has affected global community, both the developed and developing community alike. In the early 1980s, an apparently new disease acquired immune deficiency syndrome (AIDS) appeared in the United States of America and spread rapidly. Today, the world is facing an unprecedented social disease, the most devastative and dilemma in modern history which has caused millions of lives around the world and has also affected development. Following the above observation, this section deals with general issues related to HIV/AIDS as per its global effects: how devastative it has been and the dangers the society faces toward tackling this problem.

More importantly is that at present, there has no medical cure for HIV/AIDS infection. The preventive strategies so far being applied are very high in terms of cost. From indication, it is only the middle class who could afford to buy the drug while the lower class could not. The HIV/AIDS problem has been more hard-hitting in developing countries where most people could hardly eat three square meals a day. One could now imagine the kind of extraordinary problem such people faces if they contract HIV/AIDS.

3.1 HEALTH EDUCATION

This section clearly deals with Health Education by stating its meaning vis-a-vis Health and Education, before forging ahead to discussing various views and charters on the importance of health education as it arms the people against various diseases. The explanation on health according to World Health Organizations says:

> "A healthy nation is not only one which has an equitable distribution of resources but one which also has an active empowered community which is vigorously involved in the creating the conditions necessary for a healthy people"[1]

The people's health is not just an individual responsibility; our health is to a large extent governed by the physical, social cultural and economic environments in which we live and work. To cajole the individual into taking responsibility for his or her health, while at the same time ignoring the social and environmental circumstances which conspire to make them ill, is fundamentally defective strategy and unethical.[2]

Education both as an institution and as a process has been given the responsibility of "solving" a number of societal problems such as drug use, learning disabilities, racism, intolerance, teenage pregnancy, sexually transmitted diseases, poverty, lack of moral values, child abuse and other scores of other dilemmas addressed and resolved by our educational system. And now, the serious threat of HIV infection and the diagnosis of AIDS faces us in a context where we are told that "education" is the only solution the moment

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[1] World Health Organization (WHO) in Laurna Rubinson et.al, Health Education foundation for the future, timesmirror/mosby college, St Louis Missouri,USA1984,p.14.

Most people in education recognize that they are being assigned the tasks for which our system was never designed, for which they do not have adequate training, for which there is a lack of basic knowledge to guide them, and for which they were given less than necessary resources. HIV infection and AIDS present tremendous challenges and opportunities. These are issues that bring together many other issues, such as intoxication, sexuality, and racism, which demand that we work at changing behaviors.[3] In noting the essence of education, Ernest Brown sees

> "Education as the instrument of reform, the giver of hope, the guide which directs the conscious individual efforts without which health cannot be attained"[4]

Educational system has been widely seen as a major institution for the delivery of health from individual outcomes within the classroom to national policies that affect the entire society. The question is does health education works? Is it really successful in preventing unhealthy behaviors and reducing health service cost? Yes, it does. The reason for such confident assertion is derived from the fact that health acquired related knowledge has brought significant decline in premature death and incidence of disease in USA, Britain and many other developed nations with respect to substantial reduction in coronary heart disease"[10]. Bringing into fore the meaning of health education, Keith Tones et.al define health education as

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[2] ibid.
[3] Hochhauser Rothenberger,AIDS Education,publisher, winc ,Brown, Minnisota, USA, 1992, p 9
[4] Laurna Rubinson op cit, p.1.
[10] ibid

"Any intentional activity which is designed to achieve health or illness related learning i.e. some permanent change in an individual capability or disposition, effective health education may thus, produce changes in knowledge and understanding or ways of thinking, it may influence or clarify values about some shift in belief or attitude, it may facilitate the acquisition of skills; it may even effect changes behavior or lifestyle"[11].

In a reaction to health and law requirement, Warren Earl states:

" Law may require all of us to be vaccinated against some diseases, especially when we are threaten by an epidemic, but in general, it has no way of controlling habits, even those inevitably leading to disease"[12]

The above observation of Warren is obvious, which health education is designed to control, unlike many traditional educational disciplines, health education has consistently sought not merely to provide understanding about its substantive subject matter, but has concerned itself also with such goals as attitude change and lifestyle modification. Indicators of successful health education have defined much more than gains in knowledge and understanding. Moreover, since health education is regarded as an arm of preventive medicine at any rate by health professionals. It has been subjected to the same economic imperative as other branches of the health service. Furthermore, since health education occasionally and usually unwisely claims that the prevention can save money by reducing the need for expenditure on curative medicine.

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[11] ibid p 11
[12] Warren Earl in Hochhauser Rothenberger AIDS Education op cit p.3

It is not at all surprising that the question "Does health education work? This should really mean "Is it successful in preventing unhealthy behaviors and reducing health service costs? Such a perspective is, of course, as limited as the narrowly conceived view that economic growth and productivity is the most important recipe for human happiness. It is nonetheless important to recognize the impetus which economic philosophy provides in creating a demand that education should provide itself".[13]

Health education by its program of knowledge stands to modify character and change behavior that could be injurious to health. Access to health education programs would perhaps address major issues which according to Mcewan,

> "Should inform young people about HIV and AIDS and enable them to act on that information"[14]

Providing information alone is of limited value and can be argued that health education techniques must actively engage young people both intellectually and emotionally. The information must be both relevant and meaningful to its intended recipients. Health education ought to empower the individual, using techniques such as skills training which in turn may lead to action and a healthier lifestyle. Used in this way, information therefore becomes a catalyst for action, in the context of HIV. It should mean that people see themselves as potentially at risk of infection and possess the necessary social and behavioral skills to avoid infection. Mcevan again stated ---

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8 Laurna Rubinson op cit p.13
9 AIDS: Psychological and Socio-Medical Aspects of HIV/AIDS. Volume 8, 1996,p.321.

"Information should lead not only to greater awareness, but also, through self empowerment, to effective behavioral patterns especially among those engaging in risk behavior.[15]

World Health Organization (WHO) in accepting health education program for school health education noted that the ultimate aim is to :

> "Develop in the students the knowledge and skills needed for human relationships, effective communication, and responsible decision-making for behavior that will protect themselves and others from HIV/AIDS Infection and optimum health".[16]

The goals of such a program include promoting behavior that prevents the transmission of HIV/STD, fostering attitudes and behavior that will prevent discrimination against those who are infected with HIV/STD and promoting solidarity with them. The problem of preventing HIV/STD infection and fighting discrimination are faced by the community as a whole and school health education activities ought to prevent their spread and also help to promote ideas and values that are conducive to social concern, willingness to cooperate, and respect for human rights".[17]

The stance of World Health Organization on health suggest that health education plays effective knowledge base-role in changing behavior. That means that health education as a general knowledge, would remain a landmark program in the war against diseases and a

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10 ibid
11 World Health Organization (WHO) AIDS Series 10, School Health Education. To prevent AIDS and Sexually Transmitted disease in Collaboration with the United Nations Educational ,Scientific and cultural Organization. Geneva, Switzerland,1992, p.3

benchmark for evaluating an individual knowledge of disease and prevention, even though it is still an evolutionary field. But accessing and comparing its effectiveness in some countries, so far, it has provided much more impetus behind contemporary development and a succor to life against modern time revolutionary diseases. As Truman reports in USA stated:

> "It is a frustrating paradox, given their relative effectiveness in effecting change, while health information has grown year by year in volume and in excellence, health education developed much more slowly"[18].

The above assertion does identify the truth about the position of health education in some countries, when education is not giving a place in the school curriculum, but taught through inform-media, targeting the middle class who can afford the electronic gadgets and of course out of reach of ordinary people. World Health Organization again spoke on education by stressing that effective AIDS education is not, however, a simple matter of giving out health information, while accurate information is essential. Young people need information to develop skills in making responsible decisions about their own sexual behavior. AIDS education should enable each individual to clarify his values, to assume new lifestyles, if necessary, to raise questions about the responsibility people have towards others and thus be able to combat the AIDS threat through responsible behavior".[19] The USA bureau of health education expresses health profession

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12 ibid.
13 Laurna Rubinson op cit.p.152.
14 World Health Organization (WHO) Education to prevent AIDS/STD in the Pacific. A teaching guide for secondary school. United nations educational, scientific and cultural organization,1991,p 2

"As to prepare children and youths for life decision through the mission of health education in preventing illness and disability through lifestyles modification and early identification".[20]

The school as a social structure provides an educational setting in which the total health of the child during the impressionable years is of priority concern".[21]

An analysis of the above statement shows that the United States has portrayed health education in good light as important role player in health care delivery system. It also mean that health education has remained much practice oriented focusing on problem solving without having a well-acceptable consensus in some countries. Perhaps, the circumstances and constraints placed on health education might be seen in this way. Health means different things to different people, serves different purposes for different people. Because of this, it is impossible to justify the imposition of rigid criteria of appropriate health behavior, unless a behavior has been judged by society as a whole to be a sufficient hazard to the common good to warrant the curtailment of individual choice. Accordingly, "Health education as any combination of learning experiences designed to predispose, enable and reinforces voluntary adaptations of behavior conducive to health".[22]

Health education as area of study stands for predisposing, reinforcing and enabling causes in educational diagnosis and evaluating to draw attention to the necessity of determining what behavior precedes each health benefits and what causes each health behavior that must be addressed in a health education plan. An important factor in the successful teaching and learning of anything is the cultural acceptance of the subject and

15. Laurna Rubinson op cit p. 133
16. ibid

approaches employed especially on topics related to subject-matter. In 1976, a conference on professional preparation was held in Towson Maryland, the United States. It was accepted that health education should provide "meaningful experiences that can positively influence health behavior; facilitates the primary prevention of health problem".[23]

It is an educationally oriented process, its targets is the individual, even when conducted in community or mass-media settings, which was very much concerned with individual and collectively the behavior of people in various situations. That is why according to Matarazzo

> "Health education and behavioral sciences have common means and ends, strengths and weakness. Both are oriented toward studying human behavior and improving the quality of life for the individual family and society through teaching, research and service".[24]

Matarazzo suggests three ways in which the behavioral science and health education may relate to one another. These include continuing to compete with each other for larger resources allocations through claiming primacy in common areas and to interact with each other for multi-disciplinary collaboration in which cross-fertilization of ideas is stimulated".[25]

In a point of view, is health education a part of health care? A partial answer to this question is provided in the discursive dictionary of health care that was prepared for the use

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17. ibid
18 ibid p. 14
19 ibid p. 44
20 ibid

of the subcommittee on health and environment of the United States Congress. The following statement was excerpted from this reports on the definition of preventive medicine:

> "it is now operatively assumed that most if not all problems are preventable at some stage of their development, preventive medicine is also concerned with measures aimed at improving the healthfulness of our environment--- avoidance of hazardous substances, modified diet and family planning in particular the promotion of health through altering behavior, especially by health education is gaining prominence as a component of preventive care".[26]

Apart from the collaborative working of health education and preventive medicine, health education has been characterized by its three fold objectives of health, attitudes and behavior. However, the degree to which these objectives are emphasized is to a large extent determined by the particular point of view held regarding the purpose of health and the theory of learning and behavior change.

3.2 HEALTH PROMOTION

Health education and health promotion explicitly works toward achieving the same goal. While health education facilitates behavioral change through teaching and learning, health promotion sustains behavior change practices acquired through health education. The commitment to a lifestyle that promotes wellness is the ultimate aim in the context of prevailing HIV/AIDS epidemic today. The success of health education will depend on people's choice to promote their health and the government ability to assist the public to do

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21 ibid

the same. In that manner Joseph Califino was of the conviction that "the road to better health in the nation's future cannot be paved only with the golden bricks of medicine and expensive technology, the next dramatic break-through in the health of our people should be prevention and health promotion"[27]

Mahler cited in the Laurna Rubinson et.al, "Health Education is the Foundation for the Future" noted on the importance of the progress towards health promotion as evidenced in the 1978, "Alma Ata" declaration in Soviet Union. The declaration made several important key points like health for all by the year 2000, which was later, incorporated into health promotion. Above all, it declared that the existence of gross inequalities between advantaged and disadvantaged people were politically, socially and economically unacceptable".[28]

Equity was the foundation for achieving health for all by the year 2000. Economic and social development was therefore essential to the achievement of health. On the other hand, people themselves have not only a right but also a duty to participate individually and collectively in the planning and implementation of their health care. Primary health care (PHC) was considered to be the key to achieving health for all by the year 2000; and PHC was seen as not only more than primary medical care but ideologically different. Alma Ata declaration broadened considerably the definition of health services by redefining agriculture, animal husbandry, food, industry, education, housing, public works, communications, and other sectors as services essential for the promotion of health "[29]. Kickbusch et.al described

22 Laurna Rubinson et.al, Health Education Foundation for the future. Publisher timesmirror/mosby college, St Louis Missouri. USA.1998, p.150
23 Mahler, The meaning of health promotion cited in Laurna Rubinson ibid p.3
24 WHO in Laurna Rubinson ibid

"Health promotion as a new force field for health which integrates social action, health advocacy and public policy, it offers new challenges to existing professional groups, commercial and corporate bodies, cultural norms and the inertia of health institutions---it reiterates the health for all components of inter sector action and advocacy for health, stressing the need to go beyond health care and equity into access to a healthy life"[30]

The 1986 "Ottawa Charter" for health promotion provided an international clarion call for action towards a new public health. It embodied the principles of health promotion; its major thrust was for social change and political activity. Although, it urged the development of personal skills, its paramount recommendation was the need to build healthy public policy. By so doing, it could be said that it marginalized health education--dislodging it from the center stage position which the Alma Ata bestowed on it, bearing in mind our interest in operational sing the notion of health in the context of developing performance indicators and measurable educational objectives. We should at this point note that the Ottawa Charter was preceded by the development of like (civic pride etc) targets for achieving health for all by the year 2000 in the European region. These targets are clearly significant for our present purpose in that they could be said to provide the criteria whereby the success of health promotion might be judged.[31]

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25 ibid
26 ibid

Kick Busch et.al again observed that:

> "European cities in pursuit of health promotion developed sense of civic pride uniquely placed to develop the kind of citizen responsive to health promotion initiatives which are necessary to tackle the new health problems of the 21st century"[32]

Adding value to a number of international charters for health promotion, the Jakarta international conference on health promotion identified some key points to carry health promotion agenda forward into 21st century. These agenda includespromoting social responsibility for health; increasing investment for health developments; consolidating and expanding partnership for health; increasing community capacity for health promotion"[33]

This shows that the worth of life is championed through catalogue of health conferences, seminars, workshops, etc is an indicator for health values as stated by Jakarta conference. The United States Disease Prevention and Public Health Services listed a wide range of settings for health promotion. These settings include the home, school, worksite, and health care facilities. Variety of techniques were to be employed to achieve the stated goals, among them are health education, risk reduction program, environmental controls, mass-media presentations and activities that promote a health lifestyle".[34]

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27 ibid

28 Ziglio E. Indicators of Health promotion policy direction for Research in Jonathan Watson (ed) research health promotion. Publisher Routledge, London 2000,p.25

29 ibid

30 Meeks Mitchell Heit, Merrill Health A wellness Approach publisher, Merrill company, Ohio, USA, 1987 PP 5-9

Meeks in his contention said

> "Health promotion is the quality of your life; it is influenced by the behavior you choose. Your life style is a major influence in your wellbeing. Your quality of life depends whether you select healthful or risk behavior stressing that health promotion is the informing and motivating of people to maintain or adopt health behavior. Every day you make a choice invariably it affects your life.".

According to Meeks, there are four important steps in achieving optimum health: acquire health knowledge to enable you differentiate between healthful or risk behavior; examine your behaviors to develop health awareness (to be aware of the behavior that may increase the likelihood of disease or premature death), set personal goals and design a specific plan to reach each goal; after examining your behaviors, identify the risk behaviors, assume responsibility of changing these into healthful behavior".[35]

On the same health promotion, in 1974, the president's committee on health education in the USA described health promotion as an integral part of high quality care. Arguing those hospitals and other health care institutions had obligations to promote, organize, implement, and evaluate health education programs. Four years later the Alma Ata declaration on primary health care positioned health as the focal activity in the development of acceptable and accessible primary health care".[36] In the interim period, official statements in many

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31 Laurna Rubinson op cit p.5.
32 ibid

countries have made recommendations on education in health care settings, of which the health of the nations in Britain is a recent example".[37]

Health promotion is represented by those activities such as regular exercises, balance diet, personal hygiene etc designed to improve the well being of an already healthy person or group. It is more than an attempt to prevent sickness. Primary prevention (health promotion) seeks to enhance well being by reinforcing healthy behavior and discourages lifestyles that eventually lead to illness. The primary prevention recognizes that medicine, technology and the entire medical system (disease) care delivery system can do little in this regard, instead, it was the individual and collectively the society that can improve the overall level of health. It represented societal ethics by which pressure was exerted on the individual to work towards a healthy lifestyle. The challenge of health promotion is huge and meeting it is beyond the capacity of one segment of the society. But cooperative efforts, however, can produce a synergistic effect, capable of bringing drastic changes in the health of a nation

3. 3 DEVELOPING COUNTRIES EXPERIENCES OF HIV/AIDS

In every nation, community, family, individuals etc it is the same story of HIV/AIDS. Most nations are deeply concerned that the global HIV/AIDS epidemic, through its devastating scale and impact constitutes a global emergency. It posed formidable challenges to human life and dignity thereby overriding the effective enjoyment of human rights which undermines socio-economic development all over the world and affects all levels society. HIV/AIDS has no gender bias, whether rich or poor, the virus has no class distinction. Furthermore, the people in developing countries are the most affected, leaving women, young

adults and children, particularly girls very vulnerable. It is on this context that Michael Pollak said,

> "AIDS a challenge for action in social research, an unforeseen phenomenon provoking discrimination and stigmatization of affected group in the society". [47]

The above statement clearly espouse the idea that HIV/ AIDS is obvious problem in social research, hence, the preventive measures are hardly adhered to by some people. The fear and trauma that goes with HIV/AIDS had not forced the people to adopt a protective lifestyle responding to HIV/AIDS epidemic. Festus Mogae appeal to the world community saying:

> "To be innovative, bold and courageous in fighting AIDS ---that is the only way to effectively combat this dangerous disease otherwise more life and development will affected in the near future" [48]

A close assessment of the underlining assertion suggests that all is not well, meaning that a global coalition is required in the fight against this virus. As Kelly in her submission agreed "AIDS is the most serious infectious disease-epidemic of the modern time, worldwide in scope and devastating to individuals, communities and countries most affected by it" [49]

The wind of HIV/AIDS is blowing no body in particular coupled with the fact that the mode of infection and spread has bearing on people's lifestyles. The catastrophe is not far

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[47] Michael Pollak, AIDS; problems for Sociological studies, Sage publication, London, 1992,p.1.
[48] The Sun June 27, 2001. p. 26
[49] Kelly in C.S. As worth et. al, An evaluation of school based HIV/AIDS, evaluation program for high school students, journal of adolescent Health, 1992, p.3

from Vietnam as the deputy minister said the first cases of HIV were detected in 1990. Since the discovery, the prevention program was started, and the government priority has been to implement a national strategy. An initial reviews of their last ten years shows an encouraging results in slowing down the prevalence rates, about 60% of the population has the basic knowledge of HIV/AIDS and how to prevent it. The result has been less stigmatization of HIV infected people. So far 36,000 people have tested positive which if the current rates of infection continue unabated, it will be a challenge to other developments affecting the economy, workforce, society, culture and public health.[50]

Anderson in his contention holds the view that in the worst affected areas AIDS is likely to change population growth rate from positive to negative values in a few decades leading to demographic problem[51]. In the like manner, working together in Thailand, the Choice Magazine reports, at the epicenter of the battle against HIV/AIDS, Dr. Somak Supaivikul then the Director of Maechan's only hospital, faced with many patients and not enough beds, knew early enough that he was not in position to prolong every one's life and offer costly drugs, rather he began to build a coalition of groups involved in health care, counseling and education to break down isolation of suffers, improve their physical well-being and inform the community about the methods of HIV transmission, a holistic approach aimed at caring for both body and spirit.

In a revelation, the Choice Magazine cited a good example of the effects of the syndrome in Thailand where his wife, a commercial sex worker, infected Mr Sonpong.[52] Although the woman died in 1998, the husband now moves around Thailand to raise

[50] Choice Magazine, United Nations Development Publication, December 2001 p.9
[51] Anderson in Mart As worth (edited) Confronting AIDS: evidence from the developing world. World selected background paper for the world bank policy research report. The European Commission, Belgium 1998. p.11
[52] Choice Magazine, United Nations Development Publication, December 2001 p.14

awareness on the danger of HIV/AIDS infection. He visits schools, youth's centers and groups' housewives to encourage them to use condoms. According to him "I know I am going to die, but I want to share my experience with people and educate youths on the role of HIV/AIDS education"[33]. Following the above statements, the story is one among many stories of HIV/AIDS around the world. The world Health Organization (WHO) reports that HIV situation among the Chinese is unprecedented. About 600,000 people in China were living with HIV infection while epidemiological situation in China is not well defined with new cases of HIV not being reported annually[34]. At present, there is great difficulty in determining the actual risk of infection among people because acquiring the virus depends on several factors which includes "the individual's degree of susceptibility, mode transmission, duration of the person's direct contact with the virus, strength of the dose of infection and degree of resistance to the virus"[35].

In Indonesia, with 212 million people, the fourth largest country in the world, affected by regional wide economic slump in 1998, along with domestic-political and social turmoil, has created widespread unemployment, impoverished millions and caused extensive human suffering with millions of Indonesians now living below poverty line and cannot meet basic needs has an estimated zero prevalence rate of only 0.05%. Meaning that HIV/AIDS pandemic has yet to invade Indonesia, but the current unstable environment provides more opportunities for the rapid spread of infection like rate of migration, wide spread prostitution, absence of sex education. [36] Tim Rhodes et.al clearly says:

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[33] Ibid p.15
[34] World Health Organization (WHO) National Center for STD and Leprosy Control Ministry of Health of the People's Republic of China, September 2001, p.3
[35] Gopal S Ankara (edited) HIV/AIDS in sport, impact, issues, and challenge, publisher, human kinetic inc, Auckland, New Zealand, 1995, p.3

"For any form of community-based intervention would be encouraged, promoted and built on those positive health behaviors and risk management strategies that already forms part of the lifestyles. Intervention would discourse behavior that is prejudicial to risk mamnagement".[57]

The UN AIDS estimated 53.000 children and adult are living with HIV in Myanmar, spread through heterosexual intercourse and needle sharing. HIV prevalence against injecting drug users in Yangon reaches 73% in 1989 and reports of increase in HIV transmission since the 1990s. HIV prevalence among sex workers increase from 4% to 26% 1995. The same picture was presented in Cambodia. UN AIDS file reported that the estimated national prevalence in 2000 is 169,000 or 2.8%, the highest in Asia Pacific".[58]

The reports from Sub-Sahara Africa, the Global AIDS Survey found HIV infection in Nigeria to be 2.7 million while AIDS deaths in 1999 is 250.000, the sentinel survey among pregnant women over the past decades shows an increase in the prevalence of HIV infection from less than 2% in 1991 to 5 4% in 1999. Infection was detected in all sentinel sites with infection rate ranging from 0. 58% in Geidam Yobe State to 21% in Otukpo in Benue State in 2001. The prevention program includes behavior change, messages through interpersonal communication, counseling, blood safety services etc.[59]

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[57] Global summary of HIV/AIDS epidemic, fact sheet, United Nations industrial development service December 2000

[58] Tim Rhodes (edited) HIV/ Drugs and prevention perspective on individual and community action, publisher. Routledge ,London, 1996. p.154.

[59] Ibid.

While Senegal recorded HIV prevalence rate of 79,000, the Global AIDS Survey reported HIV situation in Senegal was relatively low, noting that several factors may help to explain how Senegal has been able to contain the AIDS epidemic which began with the regulation of sex workers since 1960s, resulting to a sexually transmitted control program. The priority areas for HIV control in Senegal "building capacity and strengthen HIV surveillance system and laboratories capacity to support surveillance expand and advance in a few sites; provide assistance with monitoring and evaluation of national program[60]. The disease AIDS is believed to have recently surpassed malaria as the leading killer disease between adult and will likely to do so for children. Pakalitha sound warning to Lesotho--- "over the next ten years, HIV/AIDS pandemic will have a very adverse impact on Lesotho as AIDS focuses on and ravages those in 15-49 years of age group, the prime and reproductive years, which will dissipate the economically by force"[61]. In Zimbabwe, the Choice Magazine cited the United Nations development program has observed "that women and girls were bearing the burden of HIV/AIDS alone because of certain customary observances". The reports conclude with a story; "Hen Mariah husband died of AIDS, she decided not to tell anybody for fear of isolation. She first knew of her HIV status when my husband got ill, they both went to HIV testing and were counseled and were given their results. They were both found positive, her husband died, Mariah adds, she was kicked out of her Mutoko home by her brother in-law and separated from her three childern[62]

In Zimbabwe for a while women and girls have become the primary helpers of other relatives who have HIV. They also assume the responsibility of caring for the orphans left behind when both parents die of AIDS. Majority of care givers are women in child bearing

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[59] Global summary of HIV/AIDS epidemic, fact sheet, United Nations industrial development service December, 2000.
[60] Choice Magazine, United Nations Development Publication, December 2001 p.5
[61] ibid p.1

ages who have no previous experience in caring for patients with AIDS and usually face practical nursing problems with their patients due to inadequate information[63] The Uganda business council has it that Uganda was one of the first countries in African continent to witness the occurrence of AIDS cases. In 1986, during the world earth Assembly, the country bravely reported the presence of HIV/AIDS epidemic. Since then President Yoweri Museveni has consistently shown strong leadership and promoted openness in the fight against HIV/AIDS which has contributed in the declining trend in HIV rates among pregnant women attending ante-natal clinics from an estimated 6.8% 1999 to 2000[64]

Over the last decades HIV/AIDS has become one of Namibia's most pressing social and economic problems along with Botswana and Swaziland. Namibia now ranks among the countries most affected by HIV in the world. At least one in five Namibian aged 15-49 years was already infected and likely to die within the next seven years. The indirect costs caused by HIV/AIDS epidemic are already being felt by "economic sector through loss of productivity, absenteeism, and the lost of replacing HIV infected employees and a reduction in the market for their products or services.[65] To this end the Minister of Labor promulgated a national code on HIV/AIDS in employment which outlaws "discrimination on the basis of HIV status in the context of employment; prohibit direct or indirect pre-employment test for HIV; guarantee confidentiality regarding HIV/AIDS in the workplace; encourage implementation of HIV prevention and educational program"

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[62] ibid
[63] ibid
[64] Sexual Health Exchange published by Southern African AIDS information dissemination service and Royal Tropical Institutes, Netherlands, April 4, 2001. p.6
[65] Miller Turner et.al Sexual behavior and intravenous drug use, National Academy press Washington DC 1989.p. 103

According to Brazil's National AIDS program, the highest HIV infection rates are found among the socially and economically productive age group of 20-49 years. The report states that 215,610 cases of AIDS had been diagnosed in Brazil. Since the beginning of the epidemic through June 2000, the number of people living with HIV/AIDS is now estimated at 597.000. This figure notwithstanding is generally accepted that the growth rate of the epidemic is decreasing. This attributed prevention to the masses such as "harm reduction strategies among drug users, media campaigns and continuous education efforts in community centers and school which led more and more people using male female condoms--- adequate monitoring of the epidemic".[66]

Miller in his submission categorically stated that AIDS epidemic is a social as well as biological phenomenon---from social perspective, AIDS for the most part a preventable disease that is inextricably rooted in the behavior that transmit HIV.[67]

Reviewing the underlining assertion, perhaps, one might not dispute the contention bearing in mind the nature of the disease, also considering the process of acquiring the HIV virus like sexual relationships, infected blood products, transplanted organs, tissues, sperm and from mother to child had made it basically or primarily social and biological disease. It is already a leading cause of death in Jamaica. Among the people between 30-39 age groups, the premature death of people in their most productive years is expected to have a negative impact on all aspects of social and economic life of the Jamaican society.

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[66] Sexual Health Exchange published by Southern African AIDS information dissemination service and Royal Tropical Institutes, Netherlands, April 4, 2001. p 20.

The strike by AIDS had increased the number of orphans, who mostly loss either both of their parents before turning 15 years due to the disease. As a result, the government of Jamaica initiated mobilization/prevention program directed to "behavioral changes, communication and appropriate care and support for people living with HIV/AIDS action focused on most vulnerable groups; young people, adolescents in and out of schools and individuals with high- risk behavior"[68]

Following the consequences of HIV/AIDS, the Peruvian President Alejandro noted – in order to confront this disease in Peru, the government of Peru initiated an action to drive home the message, based on objectives consistent with the present epidemiological reality in Peru; devise strategies that have scientific basis found in research and international domestic experience; develop firm support for activities to combat HIV/AIDS by ensuring multi sector participation"[69]. Reporting from Bridgetown, the capital of Barbados, Only Daly noted that the Caribbean was the hardest hit territories by HIV/AIDS pandemic, a major cause of death among men women, more than half of the Caribbean. HIV/AIDS victims were under 25 and as many as 60% of the newly infected were in their 15 to 24-age ranges. This infection rate was estimated to be seconding that of Sub-Sahara Africa. Together, these Islands have a population of approximately one million people and based on the experience of Sub-Sahara Africa, it was expected that the epidemic would deepen already high level of poverty there.

Notably Caribbean islands are Windwards of the Dominican, poverty rate 28%, Grenada 32%, St Lucia 25%, St Vincent and the Grenada Lines 37%. Among these Islands, an increase of HIV/AIDS related illness is placing enormous stress on families and

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[67] ibid p.16
[68] ibid p.9

household, impacting the Sub-region's economic development. These islands face special obstacles in the monitoring of the spread of the disease, hence, cultural norms concerning sex in the Caribbean work to inhibit HIV/AIDS prevention through parents, older persons, church groups and some educators, claiming that sex education might increase sexuality among the young peoples[70].

In Poland, the gravity of HIV/AIDS was quite understood earlier with over 7,000 cases since the epidemic stated the Polish President. The worked detailed obligations and principles of cooperation between the central government, local authority and non-government organizations. He concluded that HIV/AIDS was not merely a medical issue, to succeed in this fight they need to address unemployment, homelessness, drug addiction, and commercial sex working.[71] Sheik Saaid argued that to stop the spread of AIDS, one should stop the factors that perpetuate HIV/AIDS having noted that poverty fuel AIDS and brings poverty; if we are to fight AIDS we must develop our community[72]. Agreeing with Sheik contention, it true that to fight disease we must have to fight poverty because a new disease enters the community when the condition is ripe for it.

3.4 DEVELOPED COUNTRIES EXPERIENCES OF HIV/AIDS

HIV/AIDS a global epidemic, as it is experienced in developing countries so also is being experienced in the developed societies. The Global Summary of HIV/AIDS epidemic cited Australia first AIDS as detected in 1981; Australia is the first country in the world to report an AIDS case. The local authorities estimated HIV infection rates peaked by mid- 1980s as

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[69] ibid p.9
[70] ibid
[71] ibid

close to 3,000 infections annually. The officially reported diagnosis of HIV infection fell from 2,300 in 1987 to 680 in 1999. In 2000, UNAIDS estimated 12,000 Australians as living with HIV 0.13% of the adult population, a number which has been deflated by the success of ant-retroviral drug in prolonging lives of the disease from symptomatic infection to AIDS. The measure taken by Australian government includes effective campaign combined with public education against needle sharing, efforts to limiting the spread of the virus among infected drug users.[73]

In Canada the HIV/AIDS legal network stated that more than 46,000 people are known to be infected with HIV, while publishing the morbidity and mortality report of this disease, which is hitting the gay men. Responding to challenges posed by HIV/AIDS problem in Canada, different organizations or agencies responded positively in the struggle against HIV spread and caring for the affected. To this end, these voluntary organizations provide the citizens with the information and support needed to deal with HIV related issues by advocating through individuals, communities and population issues around HIV. It does also provide support to enhance the lives of those infected; limiting the transmission particularly through population health promotion".[74]

Whereas in the United States where HIV was originally discovered, the American citizens thought initially that HIV was the disease of the gay men and Haitian stock, but they later found themselves in the epicenter of HIV which was attacking them (infecting) from left and right and of the center. A cause for concern to USA Center for Disease Control, the CDC presents HIV/AIDS statistics in the year 2002 in United States as thus: 793,026 cases, of

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[72] Islamic Medical Association of Uganda, AIDS education through imams, A spiritually motivated community effort in Uganda . UNAIDS. A case study, October, 1998, p.20
[73] Global Summary of HIV/AIDS epidemic Fact Sheet, UNAIDS December 2000
[74] Canadian HIV/AIDS legal network, twenty years of AIDS , last update, May 2000

these 79% were men, 21% were women and 1% was children less than 13 years of age. 41% were in whites, 38% were in blacks, 2% in Hispanics, 1% in Asians and Pacific Islanders, and 1% in American Indians Alaska Natives. 46% were in men who have sex with men, 25% in injecting drug users. 11% in persons infected heterosexually, 1% in persons infected through blood or blood product. Jonathan Mann said Americans perceived HIV/AIDS as disease of Homosexuals and Haitian origin "because they were the most affected by it---individuals who did not identify with these groups falsely believe they were safe from AIDS"[75].

Wodak concluded that injecting drug users are the source of HIV/AIDS in at least three quarter of heterosexually transmitted cases of AIDS.[76] In the United Kingdom as of March 2002, HIV/AIDS stood at 49,715 cases. The health authority identified three routes of infection, which were sex between men, heterosexual sex and injecting drug use, have been identified as the main determinant of the HIV infections in the UK.[77] But Stimson aptly noted that "in Europe, it was estimated that drug injectors constitute the second largest group of reported cases of AIDS while 40% of all new reports are currently attributed to injecting drug"[78]. P. Mezzelani et.al reiterated by contending that "AIDS has become the primary cause of death among injecting drug users since 1980s and is rising in an area with a moderate HIV zero prevalence"[79].

In a research conducted in three countries; testing HIV for prevention, a comparative analysis of policies in Britain, Hungary and Sweden, the research revealed that in Britain, the testing for HIV has not significantly featured as a prevention strategy and name testing has been generally being carried out only with the voluntary informed consent of the individuals,

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[75] U.S. Department of health , human services, center for disease control and prevention, last update, June, 2002
[76] Jonathan Mann op-cit p.330
[77] AIDS: Psychological and Socio-Medical Aspects of HIV/AIDS .Volume 10, October ,1998 p.1
[78] HIV/AIDS summary of Statistics. United Kingdom UK AIDS last up date July 2002

whereas in Hungary, testing is central to HIV prevention and required by law of certain groups. HIV testing is carried out only on voluntary basis in Sweden. But unlike in Britain, public health authorities have actively promoted it and widely accepted practice that name linked for HIV should only be carried out with the informed consent of the person. HIV testing is regarded primarily as a diagnostic device rather than intervention for HIV prevention[80]. The UNAIDS and WHO in conjunction with research institution in Japan established that AIDS cases in adult and children have occurred since the beginning of the epidemic. AIDS cases stood at 1,900, estimated deaths were 260, orphans at 1000. Episode 2, a micro-computer program originally developed by WHO was used to calculate AIDS deaths and the number of children infected through mother- to-child transmission of HIV.[81]

Epidemiological fact sheet of UNAIDS reported that HIV/AIDS in New Zealand presented the estimated number of adult and children living with the disease are 1300 (adult age 15-49), 1300 Women (age15-49), 1300 children (Age 0-15), 100 cumulative death, 530 cumulative orphan 120. This has thus far proved accurate in producing estimates, which gives a good indication of the magnitude of the epidemic. So the above range was used as the denominator in calculating prevalence in New Zealand.[82] The emergence of this disease had led to cynicism to the victims hence people with HIV/AIDS are deserted, denied proper medical care, physically brutalized, children with HIV/AIDS have been prohibited from attending schools and churches, stigmatized and treated as outcast.

It was found that a quarter of nurses surveyed in the United States agreed that they deserved the rights to refuse to work with patients found with AIDS. While a minority also

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[79] AIDS :Psychological and Socio-Medical Aspects of HIV/AIDS, Volume 8, 1996 p.322.
[80] ibid
[81] Japan Epidemiological Fact Sheet on HIV/AIDS and Sexually transmitted disease, UNAIDS/WHO 2000.
[82] New Zealand Epidemiological Fact sheet ibid

indicated that they have the right to refuse to work with homosexual and bisexual males. Kelly et.al accused nurses of reacting with more attitudinal negativity towards a patient labeled as having AIDS than towards a patient with leukaemia[83]. Burhain in his contention observed that "significant portion of health care providers are not well equipped with the skills and knowledge in managing AIDS--- this posed a problem as they were front line people from who the public seeks help".[84]

3.5 PAST INTERNATIONAL EFFORT ON HIV/AIDS HEALTH EDUCATION PROGRAMS

The Declaration of commitment on HIV/AIDS is a potential watershed in the history of the HIV/AIDS epidemic. Adopted by the world's governments at the Special Session of the United Nations General Assembly on HIV/AIDS in June 2001, it was established for the first time ever, time-bound targets to which governments and the United Nations may be held accountable.[85]

AIDS is an issue related to sexuality, abuse of drugs, poverty, women and children. In addition to being a health problem, AIDS also poses economic, social and spiritual challenges. As such, it provides communities with an opportunity to support, unit and inspire their member. Various community groups are already responding positively to the AIDS epidemic, with programmes aimed at both combating the spread of the infection and assisting those already affected. As the HIV and AIDS have become pandemic, there comes a need for

[83] William A. Rushing Vanderbilt, The AIDS Epidemic, social Dimensions of an infectious disease publisher, west view press inc, Colorado, USA 1995,pp.5-6
[84] AIDS : Psychological and Socio-Medical Aspect of HIV/AIDS

international co-operation and collaboration. A network needs to be established in the field of research, and to facilitate the exchanges on information and experiences in the field of prevention and control of HIV/AIDS. Various international bodies such as UNAIDS, WHO and ASEAN (through the ASEAN task force on AIDS) are implementing various HIV/AIDS prevention and control projects which would be beneficial to all.

Surveillance of human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS) cases is important for monitoring the course of the HIV pandemic and planning appropriate public responses. For the surveillance of HIV infection, WHO recommends HIV sentinel surveillance. This is a method in which the prevalence of HIV infection is measured in specific population whose blood has been obtained in the health care setting for other purposes (e.g. for syphilis testing in the ante-natal or sexually transmitted disease clinics) and then tested for antibody to HIV after all patient identifiers have been removed. For the surveillance of AIDS cases WHO recommends the systematic reporting of AIDS cases using an appropriate national AIDS surveillance case definition.

Each year, statistics kept on the incidence and prevalence of HIV/AIDS in the United States, indicated the number of those infected has grown exponentially. And, while billions of dollars have been spent on HIV/AIDS-related research, there is still no cure in sight. Moreover, researchers, initially hopeful of developing a vaccine to prevent contracting HIV or a medicine to stop progression of the disease once contracted, are now increasingly pessimistic about the development of either in the near future.

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[85] AIDS Epidemic Update December 2002 Joint United Nation Program on HIV/AIDS.World Health Organizattion(WHO) Geneva 2002

Public-health prevention education is generally regarded to lie at the heart of any comprehensive strategy to stem the spread of HIV infection. [86]

According to the United Nations General Assembly, prevention must be the mainstay of response. By 2003 to establish time-bound national targets to achieve the internationally global prevention goal to reduce by 2005 HIV prevalence among young men and women aged 15 to 20 in the most affected countries by 25 percent, and by 35 percent globally by 2010, to intensify efforts to achieve these targets as well as to challenge gender stereotypes and attitudes and gender inequalities in relation to HIV/AIDS. By 2003, to establish national prevention targets, recognizing and addressing factors leading to the spread of the epidemic and increasing people's vulnerability to reduce HIV incidence for those identifiable groups; strengthen the response to HIV/AIDS in the world by establishing and implementing prevention and care programs in public, private and informal work sectors; to develop and begin to implement national, regional and international strategies that facilitate access to HIV/AIDS prevention programs for migrant and mobile workers, including the provision of information on health and social services; to implement universal precaution in health-care settings to prevent transmissions of HIV infection; to ensure that a wide range of prevention programs which take account of local circumstances, ethics and cultural values is available in all countries particularly the most affected countries, including information, education and communication. [87]

The World Bank has been a long-standing partner with developing countries in their efforts to educate their people, and todate it is the largest external source of financing for health education and for HIV/AIDS programs and activities worldwide. It has, equally, been

[86] Plan of Action for the preventionand control of HIV infection.AIDS/STD control Division . Department of public Health. Ministry of Health Malaysia. 2002 .p35

at the forefront of efforts to push HIV/AIDS on the global development agenda. The Bank is deeply committed to supporting the world in an education–centered fight against AIDS-an objective that resonates strongly with its mission of poverty reduction. This objective also fits squarely within the Banks strategic framework; which emphasizes support to countries to invest in people and to strengthen the investment climate as the basis for progress towards the Millennium Development Goals.

The Bank is well positioned to help countries open the window of hope that education offers by virtue of its dialogue with most of the world's developing countries and its current commitment of US$23.7 billion to 397 active projects in the human development sectors worldwide. In terms of the advocacy role for which the Bank is especially well equipped, key priorities relevant to education are to help strengthen awareness at high, as well as functional, levels of government on the importance of education in the fight against HIV/AIDS; and support macroeconomic reform with careful attention to their social implications-to ensure the needed national counter for the achievement of education goals.

An urgent challenge is to integrate HIV/AIDS issues into the Bank's dual-focused support. A call for such action has most recently been voiced by the Group of Eight Task Force on Education, established in 2001 to accelerate progress. For the Bank, this directive implies helping countries to pursue overall education goals more vigorously while factorizing in the epidemic's impact; and ensure adequate education aimed specifically at HIV/AIDS prevention.[88]

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[87] Ibid.P.38

[88] Education and HIV/AIDS. A Window of hope. The international Bank for Reconstruction and Development. Published by World BANK 2002.P55

UNAIDS and its co-sponsors have established a set of yardsticks for tracking movement towards those targets. Work on the report measuring progress against these indicators starts in 2003 by the one hundred and eighty nine countries that adopted the declaration. Already, though, there is substantial evidence of progress, more countries are recognizing the value of pooling resources, experience and commitment by forging regional initiatives to combat the epidemic. Example is multiplying, among them the following.

The Asia Pacific Leadership forum, which was tasked with improving key decision-makers' knowledge and understanding of HIV/AIDS and its impact on different sectors of society

Members of the Commonwealth of independent States have developed a regional program of urgent Response to the HIV/AIDS epidemic, which government leaders endorsed in May 2002. In Sub- Sahara Africa, 40 countries have developed national strategies to fight HIV/AIDS. In mid-2002, the Pan-Caribbean Partnership against HIV/AIDS signed an agreement with six pharmaceutical companies as part of wider-ranging efforts to improve access to cheaper antiratroval drugs.[89]

Well, having critically reviewed some of the important literatures necessary in this work, it is also right to understand the major premise of social study of disease, although all diseases are medical phenomenon, but they cannot be adequately understood in medical (or biological) terms alone. Diseases also has social features that can be understood only in terms of social concepts and principles, HIV/AIDFS is no exception. The immediate cause of any infectious disease is a microorganism. However, social factors influence person-to person

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transmission and may explain why the prevalence of a disease varies between populations. Although, HIV is the apparent biological cause of AIDS, social factor determine the behavior that is crucial in most of the transmission of HIV and may explain why some groups and populations have higher rates than other groups and populations

For this reason, most experts on HIV/AIDS, which this research agrees, those differences in prevalence between populations are due to differences in certain behaviors. This is a valid idea, but unless social conditions like cultural norms and social institutions that regulate these behaviors are also specified. Sociological analysis of behavioral differences between populations is generally guided by the principle that these differences are related to variations in social conditions. This seeks to understand the dynamics of the relationship between social conditions and individual behavior. The principle that behavioral differences are related to social condition is the central principle in the analysis of the causes of disease; it applies to HIV/AIDS, no less than to other diseases.

Conclusively, in this literature review, it was noted that HIV/AIDS has eaten deep into the fabric of human society, creating dilemma and devastation to individuals, communities and nation states, most regrettably is the situation of children who has lost their parents in death because of HIV/AIDS. The work cited some scholars, leaders, agencies etc reflecting their views, observations, arguments, criticisms, suggestions, efforts and recommendation. Some countries were used as the researchers' point of departure. Health education and promotion were extensively reviewed in relation to the issue under diagnosis.

In this wise, many scholarly works on the various aspects of HIV/AIDS health education and promotion in Malaysia appear to have been left out or given merely a snappy treatment to role-play of health education and promotion in the fight against HIV/AIDS as devastative disease that has sent millions of live to the grave. These lapses constitute a missing link, which this study has provided to enrich and give greater value to the study of monitoring and evaluation of HIV/AIDS health education and promotion in Kuala Lumpur. As no field is conclusive, therefore, this field of research is open for further studies

3.6 Operational Definition of Concepts

Monitoring: Monitoring literarily means to keep close watch or observing rules. Longman Dictionary defined monitoring as "to carefully watch and check a situation in order to see how it changes or progress over a period of time[85]. Webster's encyclopedic described monitoring as "to view or listen to, for a specific purpose or to monitor a group taking an examination.[90]

Evaluation: Laurna Rubinson describes evaluation as comparing an object of interest against a standard of acceptability i.e. to finds out the worth of activity or progress, in order to continue or discontinue. The fundamental purpose of evaluation process is to determine the value or worth of activity[91]

[85] Long man Dictionary of contemporary English, New edition. Long man group ltd, Edinburgh, England 1987, P.921

[91] ibid

Health: Health is absence of physical and mental disease. The World Health Organization (WHO) defines health in a wider concept by stating thus: "Health means that all people should have the opportunity to fulfill their genetic potential. This includes ability to grow and develop physical and mentally without the impediment of nutrition or environmental contamination and to be protected as much as possible against infectious disease." And education is a general concept; it can refer to learning to a system of transmitting the culture to a quality of an individual reflecting his status. But education according to New International Webster Encyclopedic is "systematic development and cultivation of natural powers, by inculcation e. g instruction and training in an institution, the knowledge resulting from such training"[92]

Health education: Health education simply means the practical application of knowledge acquired through teaching and learning of health education principle. World Health Organization define health education as "aimed primarily at the voluntary actions people can take on their own, individually or collectively, as citizens looking after their own health or as decision makers looking after the health of others and the common good of the community"[93]

Health Promotion: Health promotion is about developing the potential of people to take increased responsibility for their own and others health. Oxford Medical Dictionary defined "health promotion as a program of surveillance planned on a community basis to maintain the best possible of life of the members of that community, both collectively and individually. Programs include a blend of such personal services as health education,

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immunization and screening tests with environmental monitoring of the atmosphere, housing, water and food supplies etc"[94]

HIV: This three letters means "Human immune virus"[92]. This virus if contracted can lead to AIDS. **AIDS**: This four letters means "Acquired Immune Deficiency Syndrome. When HIV/AIDS are contracted, it leads to serious health problem[95].

3 .8 Theoretical Framework:

There are different models or approaches that could be applied in social research namely health education model, health promotion model, model of monitoring and evaluation model. Each of these models will be reviewed and the specific model adopted for this work will be identified. Luck and Luckman provided a useful general definition of models. They stated that a model is a representative of the significant features of the problem understudy. It can be a simple verbal disruption or three-dimensional designers, or it can be an abstract logical or mathematical representation. Since it is usually too expensive and risky to experiment blindly with the problem in the real world, e need a model to allow us to examine the effect of a range of possible changes, either initiated by the decision makers or coming spontaneously from the environment. The model builder always has to satisfy two conflicting needs; he wants his model to be a faithful representation of the problem; he also wants model range of alternative courses of action. The term model is often used in a rather too casual fashion. It is a theory driven construct, which ideally, encapsulates the essential elements of the theoretician's formulation of particular aspect of reality. A good model will not only incorporate the essence of the structure, it will also represent reality in a simplified

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[94] ibid.
Origin and History of HIV/AIDS, last update, West Sussex, England, December, 2001.

form. This simplification should hopefully, clarify thinking and facilitate planning[97]. The health promotion model presented by Elizabeth Perkins sought to provide a simplified version of people's beliefs about the purpose of health education and values loading those belief as health tends to be defined in terms of absence of disordered functioning.

The promotion model is concerned with sustaining knowledge about the dangers diseases. The promotion model presents levels of disease prevention and function of health education. Primary level concerns to prevent onset of disease and reduce incidence. The function of health education level includes persuading individuals to adopt behaviors believed to reduce this risk of disease and adopting a healthy lifestyle. Persuade individuals to promote health services concerned with health behavior; those activities undertaken by individuals believing themselves to be healthy in order to prevent future health problems.[98]

Micro level theory: The health action model in the form of Rogers and Shoemakers formulation. Argued that there is nothing so practical as good theory, operating at the micro level and considering how an understanding of psychological, social and environmental factors may influence individual decision-making and subsequent choices and behaviors. The action model is used to explicate the relationship between these psychological and environmental influences and to provide a framework for the prudent selection of indicators of performance. Green noted that there are wide ranges of theoretical models at the disposal of health educators and we might reasonably ask why one particular model selected at the expense any other[99]. Models according to Green are derived from theory and have sought to

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97 Luck and Luckman in Elizabeth Perkins Evidence-based Health promtionEdited.Publisher. JohnWily and Son Ltd, WestSussex England;1989.p14

98 Elizabeth Perkin Ibid. p383

99 Rogers and Shoemaker in Elizabeth Perkins Evidence-Based Health Promotion (Edited) publisher.JohnWilyand Son Ltd, West Sussex England, 1989. p13

provide an explanation of some features of our world. Model does not provide a detailed replica of reality but rather they offer partial and simplified representation of whatever aspect of the real world; is of interest to the theoretician or practitioner. The process of simplification is necessary because it allows us to concentrate on what is most important for particular needs while excluding irrelevancies and unnecessary detail. A good model will achieve this goal of simplification while including all key elements. For instance, a 'technician' as opposed to (ideological) model in health education should incorporate the various components, which are essential to human decision-making and explain their inter-relationships. A better model would quantify those relationships and facilitate predictions about likelihood of an individual or, more problematically, a group of individuals–adopting and sustaining a particular course of action under given circumstances.[100]

Health education model by Martin Forest is particularly to determine the effective attempt at changing or engaging in new behavior. An important mediator between an intention to engage in a new behavior and its inaction is the development of action plans: thinking through how a new behavior may be performed. What obstacles may appear, how this may be dealt? Where the individuals lack skills to affect any necessary behaviors, these may be taught through a process of modeling and vicarious learning[99]. In some cases, such process may be an informed one within a broader counseling framework. Other skills training may be a component of a more formal intervention. For example, now teaching safer sex negotiation skills which O'Donnell et.al said such a process may involve participants viewing a video or role playing someone effectively negotiating safer sex. The strategies and skills used are then analyzed and the individual practices their use within the safety of the group. Her skill behaviors are model and individual gains confidence in their use combined

[100]Ibid

with appropriate feedback. This model is regarded as a tool or framework to guide people through the counseling process. It is not to be used rigidly and in reality the stages may merge and not occur in a straightforward sequence. All the stages may not be necessary for all clients, nor need they involve long periods of time. While the model allows individuals to develop a clear understanding of their problems and the changes they wish to make, some people may not have the skills or resources to do so. For this reason Forest saw his basic framework as being able to integrate a number of adjunctive counseling and skills based interventions. Two facts pertinent to health promotion are techniques used in stopping smoking and stress management skills in the health professional priority[101]

Jane Powell used her Monitoring Tension Model to monitor physical tension, while learning relaxation skills. According to her, individuals can begin to monitor their levels of physical tension throughout the day. This helped them to identify how tense they are during the day (most people are quite surprise) that they are likely to triggers tension in the future and do not to consider how these may be moderated either through changing the context in which any stress arises or the use of relaxation techniques. After one or two weeks of monitoring tension and learning relaxation techniques, individuals began to gradually integrate them into their daily lives. Here, relaxation does not involve taking time out to relax fully. Instead, it involves learning to monitor and reduce tension to appropriate levels, and continuing to deal with the cause of the stress in other ways. Achieving this level of relaxation, when other things have to be attended to, takes time and practice to achieve. Initially, therefore, relaxations are best used at times of relatively low levels of excess tension. The consistent use of relaxation techniques can prepare the person to cope with times of greater tension whilst without practice, the use of relaxation skills at times may be difficult

[101] ibid

if not impossible. Jane questioned the need for monitoring and concluded that there is substantial evidence to demonstrate the benefits. Monitoring cardiac rehabilitation, for instance, has shown to benefit other groups of patient's not just clients who have experienced a myocardiac infarction. The cardiac rehabilitation program applied the model to the main risk factors as a means of assessing the client, thereby enabling appropriate intervention to be investigated client this way enables the health promoter to monitor change and maintenance of that change. This model enable health promoter to view the client who has not been able to adopt a lifestyle change, not as a failure, but as someone who is going through a process of change. Use of the model can facilitate effective use of resources. Some individuals have multiple risk factors to change and find it difficult to change them simultaneously. In these instances, it is necessary to change what the individual sees as their priority and this may vary from limits imposed by time, finance and expertise available[102] . Graham Simmonds, in his Get Moving Model of evaluation study, noted that an increasing number of projects nationally have focused on promoting physical activity in general practice and most have omitted rigorous evaluation. His approach has usually cantered 'exercise prescription model where GPS are encouraged to send patients who are deemed to be inactive to leisure centers to receive motivational advice. In 1993, the Bristol Area Specialist Health promotion Services Avon now called Avon Health Authority were considering using the approach for direct future planning.[103]

Evaluation is generally considered by health professionals to be an essential part of any project. Within the competitive cash limited environment of today's health care, few would refute the importance of knowing the extent to which a projects aims and objectives have been achieved and the process by which these outcomes were arrived at. However,

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health promotion practitioners who seek to apply these expectations by commissioning an evaluation or conducting an evaluation study themselves find that the practice of evaluation is considerably more complex than the rhetoric. The evaluation models and techniques chosen by non-specialist practitioner, evaluation will inevitably be a compromise between the ideal textbook design and limits imposed by time, finance and expertise available Graham Simmonds evaluation Model, he noted that an increasing number of projects nationally have focused on promoting physical activity in general practice and most have omitted rigorous evaluation. The approach adopted has usually centered on exercise prescription model where GPS are encouraged to send patients who are deemed to be inactive to leisure centers to receive motivational advice. In 1993 Bristol Health promotion services were considering using this approach. However with strong evidence available, research project was needed to help direct future planning.

The health behavior theory is chosen, as it tends to explain more the very relevance in health education. At present there is considerable agreement among health educators like Hoachbaum, Dwore, Freudenberg etc that the ultimate goal of the profession is health behavior.[103] The critical outcome of health education intervention is that the individual possess the understanding, skills, and experiences needed to make and implement informed decision.[104] Most health educators believe that what peoples do about health is more important than what they know about health. However, the goal of many health education programs has been to increase knowledge or to change attitude. For many years the predominant theory in health education is simple: an increase in knowledge plus favorable attitude will lead to a behavior change that is health generating.[105] An increase in knowledge is the knowledge an individual acquired as a result of experience or several experiences

[103] Laurna Rubinson
[104]

resulting to change of attitude or behavior. As new information is learnt and added to earlier information, knowledge keeps increasing. An increase in knowledge—positive knowledge as a result of experience ultimately produces worthwhile action that is health generating.

Increase knowledge	**Behavior change**	**Health**
Means	**Indicators**	**Absence-of Disease**
teaching-learning	cautious of risk behavior	This described the quality of life that include your physical, mental
observations	avoiding sexually transmitted diseases	and social well-being, ending in pursuit of happiness
group-discussions field-work, assignments. literatures-like newspapers magazines, books-and periodicals	and un-sterilized syringes	
lectures, conference, seminars, symposiums, Workshops etc	Maintaining a single sex- partner, checking blood before transfusion, stopping smoking to avoid lung cancer, eating healthful foods, getting sufficient rest, relaxation and regular exercises	Physical health is the condition of the body. Mental health is condition of the mind and emotion. Social health is the way you relate to others. It involves a continual state of adjustment of these areas to your hereditary and environment.[106]

Table 1.Increase in Knowledge, Behavior Change, and Absence of Disease

Analyzing the above table, common sense tells us that a want on change in behavior shall sort a means that focus on increasing knowledge or changing attitudes that reflects a real

[105] Laruna Rubinson
[106] ibid

group or personal experience. Therefore a change of attitude will ultimately lead to a change in behavior; an increase in knowledge will lead to a change in attitude and will result in a change of behavior. The need to promote health education activity is based on the desire to enhance the process of development and change in such a way as to maintain positive health behavior or interrupt behavior pattern that are linked to increase risk of illness, injuries, disabilities or death.

When behavior change occurs as a result of learning or when learning has actually taken place, the individual or the persons perceptions, thoughts, reasoning on issues change. The changes are based on the knowledge acquired either through teaching and learning or personal experience. At the end, the individual becomes cautious of certain actions that are not worthwhile, hence, behavior change could be noticed when the individual starts putting into practice those acquired knowledge. Therefore an indicator of behavior change according to Meek Mitchell is reflected in a person's action, the action helps to prevent illness or accident, promote health for you and others or improve the quality of the environment.[107] Thus, this has fallen as the basic assumption of this approach that the goal of many health education programs has being to increase knowledge leading to change of attitude or behavior. Dwore and others express concern about health knowledge being the goal of health education citing that the major issues in health education revolve around demonstration of result, namely—what good has this information done for the recipient. But no matter where, how and by whom it is offered, health is a process related to health decisions and practices, knowledge, values, perceptions and motivation[108]. Arguing that health education programs should be altering behavior not knowledge because it recognizes behavior change and uses a

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[107] ibid
[108]

diagnostic approach for health education program planning, stressing that health behavior should be compelled only in cases in which the health of others is threatened.

The proponents of this approach uphold that in the final analysis, health education programs are effective to the extent that they influence health practices which in research are found to be causally related to desired health outcomes, it emphasizes behavior diagnosis as necessary to establish a cause-and effect relation between behavior and health. The method used in behavior change approach is client—contract behavior modification, in this type of program, a person voluntarily enters a program, is fully informed of the methods used, decide on and makes open commitment to a degree of desired behavior change and has full freedom to withdraw from the program at anytime.[109] The essence of health program is to influence behavior that is worthwhile—produce through change in behavior or lifestyles. Health education for social change identifies the health damaging element in our society, its goal is to involve people in collective action to create health promoting environments and lifestyles The following principles characterizes health education for social change: it recognizes the social and economic determinants of health and disease, it combines education, service, and political action, each enhances the contribution of the other, emphasizes the need for collective action and mutual support, its starting point is the problem that the people face in their daily lives, its primary allegiance is to the people its serves".

The emergence of AIDS as public health problem has become necessary to strengthen the community and the family unit, so that it can survive the vicissitudes of rapid and complex social change. The concern for the health of the family unit is not limited immediate physical problem, but also extends to social and biological environment. Health

[109] Hochbaaum g.m. Communication and behavior changes, factors of an active participation of the populationfor document of better health in Laruna Rubenson ibid. p140

education as a program should stimulate and influence behavior/attitude change achieved through targeting individual, organize and unorganized groups cum classroom students by enunciating National health education policy that would affect the entire society.

Table 2 Level of Health Education Operation: National policy

Macro

Strategic Level:
mass-media; community development;
social action.

Settings :
schools; workplace; primary care; pharmacy;
local authorities; voluntary bodies.

Methods :– one to one ; groups; role play; games; life skills etc.

Resources-videos: leaf lets; posters; educational broadcasts;
worksheet etc

Micro[110]

Source: Lurna Rubinson et al, Health education foundation for the future, 1984.

Admittedly, health behavior as applied in explaining health education is designed to increase knowledge. The desiring and expected outcome is a change in individual behavior or attitudes that expose them to increase pattern of risk injuries or death. So it becomes a challenge to health educators to educate the public against undesired behavior that threatens life. As many people do not realize and understand the implications of living certain lifestyles until they fell sick.

[110] Laruna Rubinson ibid

The health educators owe it as duty to create effective program that has enduring and credible life influence and experience on the people and the society at large if they wish to remain relevant as engineer and motivator of social change in relation to public health. Hence, the medicine, technology and entire medical delivery system can do very little, instead, it is you the health educators, and the individual and collectively the entire society can improve the overall level of health. In addition to improve the overall level of health, Anne Garwood stress what everyone can do to fight AIDS like learning about HIV/AIDS; helping people living with AIDS; raising awareness in your community; getting young people involve; doing more; and mourning those lost to AIDS. Kofi Annan, the UN Secretary General said, in the war against HIV/AIDS, there is no us and them, no developed and developing countries, no rich and poor- only a common enemy that knows no frontiers and threatens all peoples. But we must all remember that while HIV/AIDS affects both rich and poor, the poor are much more vulnerable to infection and much less able to cope with the disease once infected.[114] The precondition for mobilization against AIDS. Michael Pollak concludes thus: recognition of AIDS as a major health problem for concern group and the whole population; the existence of community based network that can be mobilized; the possibility of alliance building with medical sector; health authorities; sympathetic publics and asses to financial resources.[115]

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[114] Kofi Annan in the declaration of commitment on HIV/AIDS , United Nation General ASSEMBLY special Session on HIV/AIDS 25-27 June, 2001 UN department of public information with UNAIDS. August .2001. p.3

[115] Michael Pollack. AIDS A problem in Social Research punblishee Sage. London., 1992. P4.