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KNOWLEDGE, ATTITUDE, PRACTICES (KAP) OF DELHI YOUTH TOWARDS HIV/AIDS AND THEIR PREFERENCES IN ENTERTAINMENT

A dissertation submitted in partial fulfillment of the requirement for the award of

Post-Graduate Diploma in Health and Hospital Management

By
Abhimanyu Singh Tomar
Roll Number: PG/10/061

International Institute of Health Management Research
New Delhi -110075

1st February 2012 to 30th April 2012

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CERTIFICATE OF INTERNSHIP COMPLETION

Date:……..

TO WHOM IT MAY CONCERN

This is to certify that Mr. Abhimanyu Singh Tomar has successfully completed his 4 months internship in our organization from January 1.2012 to April 30, 2012. During this intern he has worked on UNAIDS bi-annual report, ECI's Social Media Campaign and IKEA's baseline research under the guidance of me and my team at Center for Human Progress.

We wish him good luck for her future assignments.

(Signature) _____
ASH (Name)
CEO & DIRECTOR Designation
CHP

Certificate from Dissertation Advisory Committee

This is to certify that **Mr. Abhimanyu Singh Tomar**, a graduate student of the **Post- Graduate Diploma in Health and Hospital Management** has worked under our guidance and supervision. He is submitting this dissertation titled **"KNOWLEDGE, ATTITUDE, PRACTICES (KAP) OF DELHI YOUTH TOWARDS HIV/AIDS AND THEIR PREFERENCES IN ENTERTAINMENT"** in partial fulfillment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management**. This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

Faculty Mentor MINAKSHI GAUTAM
Designation ASSISTANT PROFESSOR
IIHMR
New Delhi
Date

Organizational Advisor
Designation DIRECTOR & CEO
Organization CHP
Address 60 GOLF LINKS · N·D-03
Date MAY 11, 2012

Certificate of Approval

The following dissertation titled "**KNOWLEDGE, ATTITUDE, PRACTICES (KAP) OF DELHI YOUTH TOWARDS HIV/AIDS AND THEIR PREFERENCES IN ENTERTAINMENT"** is hereby approved as a certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award of **Post- Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is Understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation

Name	Signature
DR. NITSY DOGRA	
PRAGYA T. GUPTA	

Abstract

KNOWLEDGE, ATTITUDE, PRACTICES (KAP) OF DELHI YOUTH TOWARDS HIV/AIDS AND THEIR PREFERENCES IN ENTERTAINMENT

Abhimanyu Singh Tomar (Center for Human Progress)

Introduction:

The estimates by World Health Organization (WHO) shows that 10.3 million aged 15–24 years are living with HIV/AIDS and half of all new infections are occurring among young people on a global basis. AIDS is a global problem today. Infection is spreading very fast in India. There is no cure as such for AIDS and an effective vaccination still remains a dream. Many studies done in India have proved that childhood followed by adolescence is a phase of physical growth & development accompanied by sexual maturation, often leading to behavioral, biological, economical and social vulnerability towards HIV/AIDS, STD, obesity, substance abuse, alcohol, tobacco, suicides, and child abuse majorly due to lack of knowledge & awareness on these issues. Health education is the only method to prevent or control this scourge. There are myths about the modes of spread of disease even among the literates. Sex education can help prevent the risk of unplanned pregnancy and sexually transmitted diseases (STDs) by providing information to young people about reproductive issues and encouraging the consistent use of contraception or STD protection. Studies demonstrate the lack of correct knowledge about HIV is due to poor interventions and health education. Interventions should be designed to build a bridge between preferences and the message of education to capture the intergenerational impact, as the effectiveness of the intervention depends on the choices, preferences, acceptability and the positive response generated after it.

Objectives:

General Objective

- To evaluate the knowledge, attitudes and practices about HIV of the population aged (15-29 years) in Delhi.

Specific Objective

- To ascertain the preferred choices for type of entertainment among Delhi youth (15-29 years).

- To ascertain the preferred choices for leisure time activity among Delhi youth (15-29 years).
- To establish relationship between background variables like age, gender, socioeconomic status and religion of the youth with the preferences in terms of entertainment and knowledge, attitude, practices.

Methodology:

Pre tested closed ended questionnaire was administered among 176 people aged (15-29yrs) who were selected through stratified random sampling. Subjects included hotel attendants, school and college students, beauty parlors' employees, transportation industry workers etc. The data analysis was done by using SPSS version16.0.

Result and Conclusions:

The correct response rate about questions whether mosquito bites can transmit HIV, whether to share shaving kits and what is the relationship between STD with HIV was satisfactory; and their attitudes towards people living with HIV/AIDS needed to be improved. The present study highlights the need to design interventions for educating youth using the preferred entertainment formats as a vehicle and recommends that policy makers increase use of entertainment for educating populations about HIV/AIDS.

Acknowledgement

I wish to express my deep sense of gratitude to our project Guide, Dr. Ash Pachauri, Director, Center for Human Progress (CHP), Delhi for his guidance and useful suggestions, which helped me in completing the project work on time. His willingness to motivate me by inspiring, appreciating the efforts contributed tremendously to my project.

I am extremely grateful to my mentor Mrs.Minakshi Gautam (Assistant Professor) at IIHMR, New Delhi for taking time to share her vast knowledge with me.

Words are inadequate in offering thanks to the Project Mentors for their encouragement and cooperation in carrying out the project work. I would also like to thank my college IIHMR Delhi for giving me this opportunity to pursue Dissertation at Center for Human Progress. Delhi

Abhimanyu Singh Tomar

PG/10/061

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LIST OF ABBREVIATIONS

AIDS: Acquired Immuno Deficiency Syndrome

ARSH: Adolescent Reproductive and Sexual Health

ARTC : ART Clinic

BB : Blood Bank

BCC: Behavior Change Communication

BTS : Blood Transfusion Services

CBO : Community Based Organisation

CCC: Community Care Centre

CHC : Community Health Centre

DACU : District AIDS Control Unit

DDAP : Drug Diversion Assessment Programme

DIC : Drop In Centre

EID : Early Infant Diagnosis

FSW: Female Sex Worker

HBV : Hepatitis-B Virus

HRG: High Risk Group

HTC : Hospital Transfusion Committee

ICTC : Integrated Counseling and Testing Centre

IDU: Injecting Drug Users

IDUF: Indian Drug User Forum

IEC: Information Education Communication

KP: Key Population

LSE : Life Skill Education

M & E: Monitoring & Evaluation

MSM: Men who have Sex with Men

NACO: National AIDS Control Organisation

NACP: National AIDS Control Programme

NBTC : National Blood Transfusion Council

NCB : Narcotics Control Board

NSEP: Needle and Syringe Exchange Programme

NSP : Needle Syringe Programme

OD: Overdose

ORW: Outreach Worker

OST: Opiate Substitution Therapy

PE: Peer Educator

PHC: Primary Health Centre

PLHA: People Living with HIV/AIDS

PPTCT: Prevention of Parent to Child Transmission

RMC: Regular Medical Checkups

RTI : Reproductive Tract Infection

SAC : State AIDS Council

SBTC: State Blood Transfusion Council

SHG: Self Help Group

STI: Sexually Transmitted Infection

STIC : STI Clinic

STRC : State Training and Resource Centre

TB : Tuberculosis

TG: Transgender

TI: Targeted Intervention.

VBD : Voluntary Blood Donation

VCTC: Voluntary Counseling & Testing Centre

PART 1

INTERNSHIP REPORT

1. **Organization Profile:**

Center for Human Progress (CHP)

The Center for Human Progress (CHP) aims to improve the quality of life of individuals and society by supporting, promoting and encouraging knowledge mobilization for sustainable change. As a social change organization we aspire to build knowledge-based leadership and create community empowerment in the process. To achieve these goals we conduct the following activities.

- Life Skills Education & Coaching
- Training & Capacity Building
- Education & Awareness Building
- Communication & Advocacy
- Research & Documentation

Life Skills Education & Coaching.

Life coaching is a professional service providing clients with feedback, insights and guidance from an outside vantage point. Coaching is similar to the practice of counselling, but the major difference is that coaching is an on-going collaborative partnership built on taking action.
Provides face-to-face and online individual and group coaching sessions.

Projects at the Center for Human Progress (CHP)

- **Knowledge FAN**

Knowledge FAN is a national knowledge initiative about young people and marginalized communities' risks and vulnerabilities to HIV, health issues and human rights. Knowledge FAN

promotes knowledge, creates dialogue and builds sustainable networking around young people and communities' issues in health, HIV and human rights issues. Knowledge FAN is currently being implemented by CHP and partners (Galaxy Club, Care Foundation, Kripa Foundation, Prodigals Home and consultant resource persons from Project Orchid) in the north eastern states of Manipur and Nagaland with the support of UNAIDS.

- **Student Knowledge Initiative (SKI)**

The Student Knowledge Initiative (SKI) has been designed to recognize and celebrate adolescents' and young people's rights and understanding about HIV and sexual and reproductive health in the context of their lives and realities. The initiative brings together students from across schools in Delhi and the country more widely to share their voices and engage as youth leaders**.** SKI in New Delhi is being implemented with the support of UNAIDS and Vasant Valley School.

- **Meri Awaaz/My Voice**

Meri Awaaz/My Voice is a national knowledge sharing initiative which celebrates voices from the ground. It focuses on exchange of HIV and STI risk and vulnerability reduction strategies and approaches being implemented on the ground by high risk groups (e.g., men who have sex with men, sex workers and injecting drug users) and programs themselves. Meri Awaaz/My Voice is being implemented by CHP and the State Training and Resource Centres (STRCs) of NACO.

- **Theatre for Dialogue (Magnet Theatre)**

This CHP initiative led by marginalized and vulnerable (young) people uses Magnet Theatre (an established form of participatory theatre) to create dialogue. Magnet Theatre is a mid-media communication method, which unlike conventional stage theatre and some other forms of participatory street theatre, invites the audience to create and re-create scenarios to solve the dilemmas presented in the performance. Messages are not given to the audience through the performance, rather discussion encourages the audience to generate practical solutions to their barriers (e.g., to HIV prevention, care and treatment) and dilemmas.

- **Expressions of Empowerment (e2)**

This CHP initiative promotes media and arts to generate and create knowledge and mobilize young and marginalized communities about socially relevant issues (e.g., health, including sexual and reproductive health, HIV, sexual violence, gender-based violence, social inequalities, abuse, human rights and others) to create empowerment as a solution for sustainable development. Communities are trained in the use a number of tools.

- **The Environment and Health Project**

Young members of CHP voice their concerns about Delhi's water pollution issue. They have been documenting the causes of water pollution and its many health impacts.

- **Project 19**

Project 19 is a national initiative which celebrates health and human rights and understands HIV in the contexts of the lives of young people and vulnerable and marginalized communities. Its builds capacities of young people and communities at-risk and vulnerable to HIV and supports their knowledge leadership and empowerment for health.

- **Research Connect**

Research Connect lends support and mentoring as well as relevant field exposure and on-ground learning to young and other researchers around the world. The Center for Human Progress (CHP) nurtures enquiring minds and supports them to conduct investigation and contribute to enquiry on human development and social science issues. If you are an undergraduate, postgraduate or doctoral student and/or other researcher who wishes to develop your research, whilst contributing to human progress through implementation of social transformation studies, CHP can help you through internship, short-term projects and ongoing collaboration.

- **We the Change**

We the change (WTC) is a collective effort to mobilize youth and youth networks globally to 1) build youth leadership and engagement and create social change and 2) to combine strengths of

diverse youth organizations under one umbrella and promote collective action and reach to more young people in the process.

- **The Music Initiative**

The Music Initiative empowers underprivileged adolescent and young people through music. Young people themselves identify relevant issues related to HIV and AIDS and develop songs based on messages they create together with their peers. Adolescents and young people are trained to develop songs and use technology to create audio casts (to share music online and through mobiles), make CDs and develop music videos (to share online and offline). Overall, the process is extremely empowering for young people and powerful and potentially life-saving for the community. From the programmatic perspective, the Music Initiative creates a powerful platform to mobilize and reach youth with messages they consider critical.

1. 2 PROJECT ENGAGEMENT

1.2.1 Documenting Bi-Annual Report for Joint UN Program, India (2010-2011)

CHP was assigned to develop a bi-annual report articulating the key successes of the joint UN program in India over the period 2010-2011. The context of the document was set against the UNDAF benchmarks established for the program over 2008-2012. The final report was a 15-20 page print-ready document, which was to be submitted to UNAIDS by 15-20 January, 2012.

Developing the report involved the following key steps:

- Conducting a review of key joint UN documents and other bi-annual reports.
- Developing interview guides with 3-4 targeted questions to support discussions with partners across 9 agencies. Interview questions will typically be designed to support 30-40 minute discussions and will specifically probe the joint program's strengths and achievements as well as how challenges have been successfully overcome.
- Sharing draft interview guides and a preliminary report structure with UNAIDS for feedback.
- Establishing an interview schedule with support from UNAIDS.

- Sharing key questions with relevant joint UN partners in preparation for interviews and discussions.
- Preparing and finalizing plans for interviews (including use of voice recording equipment and cameras for photography to enhance the visual appeal of the final report).
- Analyzing data and report writing.
- Sharing a draft report with UNAIDS for feedback.

1.2.2 Election Commission of India's Social Media Campaign for Sensitizing Youth

a. Objective

- Mobilizing Social Media in our SVEEP campaign, using Social Marketing techniques.

b. Goal

- To increase voter participation, especially youth in Electoral Roll
- Ethical campaigning/MCC watchdogs
- To Increase voter turnout

c. Participants

- Internet savvy Youth - Jaago Re/Janagraha \
- NSS units of Universities/Colleges/Schools
- Principals/Teachers
- Election Officials
- Web savvy media agencies
- Advertisement Agencies
- Civil Society activists like ADR

d. Develop Research Methodology

- Develop Tools to assess impact

- Concept Precept
- Pretest prototypes
- Midcourse evaluation
- Impact evaluation

e. Expected Output

- Volunteers identified
- Participants take pledge
- Increase in National Voter's Day (NVD) response
- Increased turnout in polls
- Citizen awareness for ethical voting

1.2.3 IKEA's Baseline Survey

a. Objective

- To Promote the Health and Welfare of Truck Drivers
- To Promote Dialogue about HIV Vulnerabilities and Explore Practical Solutions for Vulnerability Reduction

b. Rationale

- Truck Drivers Are Critical Stakeholders in IKEA's Indian Business Operations
- Contribute to the Community and Economy
- Address Issues Beyond HIV to Encompass Health and Welfare of Truck Drivers

c. Methodology

- Pilot Test Red Ribbon on the Road at Dadri
- Implement Main Intervention Along IKEA's Key Trucking Route Points
- Integrate I-WAY Standards Throughout Intervention

1.3 Managerial Tasks Performed

- Bi-Annual Report for Joint UN Program – the major task was to interview the high officials at the major UN organizations and get the valuable feedbacks and inputs for the report.
- Election Commission of India- the major task was to produce creative's like videos, scripts, voice over's, tweets etc for the social media. To guide the team of professionals from the media department to develop the creative's with essential ingredients required to sensitize the next generation youth.
- IKEA's Project- The major task was to interview the 100 truck drivers as a part of the baseline survey to know about the problems related with the transport industry and to analyze the content of all IDIs.

1.4 Reflective Learning

It was a great experience to work with such an organization which has supported my growth as a versatile health professional by nurturing it with the valuable opportunities and showing the unconditional trust in me and my work. The timely guidance from the mentor and the colleagues has been a great support in the process of learning like teaching me all the Inter Personal Counseling tools in the field. It is the most important phase which prepares a professional for the actual battle of his/her life into mainstream job. It beautifully teaches you what to do, what not to do and the most important how to learn from your mistakes and apply the next time you are on job. I can never forget the field work which use to look boring and untidy in the beginning as we were supposed to interview in the slums and transport areas but now I am comfortable with the places like it and can anytime work in near future. The field work teaches the difficulties which a common man faces everyday with its solution. I have not only made a niche into health sector but also have touched the different genres of the development sector at the same time during my dissertation.

PART 2

DISSERTATION REPORT

1. INTRODUCTION

1.1 HIV/AIDS

Acquired immune deficiency syndrome or acquired immunodeficiency syndrome (AIDS) is a disease of the human immune system caused by the human immunodeficiency virus (HIV). The illness interferes with the immune system, making people with AIDS much more likely to get infections, including opportunistic infections and tumors that do not affect people with working immune systems. This susceptibility gets worse as the disease continues.

HIV is transmitted in many ways, such as: sexual intercourse (including oral sex and anal sex); contaminated blood transfusions and hypodermic needles; and exchange between mother and baby during pregnancy, childbirth, and breastfeeding. It can be transmitted by any contact of a mucous membrane or the bloodstream with a bodily fluid that has the virus in it, such as the blood, semen, vaginal fluid, pre-seminal fluid, or breast milk from an infected person.

The virus and disease are often referred to together as HIV/AIDS. The disease is a major health problem in many parts of the world, and is considered a pandemic, a disease outbreak that is not only present over a large area but is actively spreading. In 2009, the World Health Organization (WHO) estimated that there are 33.4 million people worldwide living with HIV/AIDS, with 2.7 million new HIV infections per year and 2.0 million annual deaths due to AIDS. In 2007, UNAIDS estimated: 33.2 million people worldwide were HIV positive; AIDS killed 2.1 million people in the course of that year, including 330,000 children, and 76% of those deaths occurred in sub-Saharan Africa. According to UNAIDS 2009 report, worldwide some 60 million people have been infected since the start of the pandemic, with some 25 million deaths, and 14 million orphaned children in southern Africa alone.

Genetic research indicates that HIV originated in west-central Africa during the late nineteenth or early twentieth century. AIDS was first recognized by the Centers for Disease Control and Prevention (CDC) in 1981 and its cause, HIV, identified in the early 1980s.

Although treatments for HIV/AIDS can slow the course of the disease, there is no known cure or HIV vaccine. Antiretroviral treatment reduces both the deaths and new infections from HIV/AIDS, but these drugs are expensive and the medications are not available in all countries. Due to the difficulty in treating HIV infection, preventing infection is a key aim in controlling the AIDS pandemic, with health organizations promoting safe sex and needle-exchange programmes in attempts to slow the spread of the virus.

1.1.2 Diagnosis

The diagnosis of AIDS in a person infected with HIV is based on the presence of certain signs or symptoms. Since June 5, 1981, many definitions have been developed for epidemiological surveillance such as the Bangui definition and the 1994 expanded World Health Organization AIDS case definition. However, clinical staging of patients was not an intended use for these systems as they are neither sensitive, nor specific. In developing countries, the World Health Organization's staging system for HIV infection and disease is used (using clinical and laboratory data), and in developed countries the CDC's classification system is used.

1.1.3 World Health Organization

In 1990, the World Health Organization (WHO) grouped these infections and conditions together by introducing a staging system for patients infected with HIV-1. An update took place in September 2005. Most of these conditions are opportunistic infections that are easily treatable in healthy people.

- Stage I: HIV infection is asymptomatic and not categorized as AIDS
- Stage II: includes minor mucocutaneous manifestations and recurrent upper respiratory tract infections
- Stage III: includes unexplained chronic diarrhea for longer than a month, severe bacterial infections and pulmonary tuberculosis
- Stage IV: includes toxoplasmosis of the brain, candidiasis of the esophagus, trachea, bronchi or lungs and Kaposi's sarcoma; these diseases are indicators of AIDS.

1.1.4 Center for Disease Control

There are two main definitions for AIDS. The older definition is to referring to AIDS using the diseases that were associated with it, for example, lymphadenopathy, and the disease after which the discoverers of HIV originally named the virus. In 1993, the CDC expanded their definition of AIDS to include all HIV positive people with a $CD4^+$ T cell count below 200 per μL of blood or 14% of all lymphocytes. The majority of new AIDS cases in developed countries use either this definition or the pre-1993 CDC definition. The AIDS diagnosis still stands even if, after treatment, the $CD4^+$ T cell count rises to above 200 per μL of blood or other AIDS-defining illnesses are cured.

1.1.5 HIV test

Many people are unaware that they are infected with HIV. Less than 1% of the sexually active urban population in Africa has been tested, and this proportion is even lower in rural populations. Furthermore, only 0.5% of pregnant women attending urban health facilities are counseled, tested or receive their test results. Again, this proportion is even lower in rural health facilities. Therefore, donor blood and blood products used in medicine and medical research are screened for HIV.

HIV tests are usually performed on venous blood. Many laboratories use *fourth generation* screening tests which detect anti-HIV antibody (IgG and IgM) and the HIV p24 antigen. The detection of HIV antibody or antigen in a patient previously known to be negative is evidence of HIV infection. Individuals whose first specimen indicates evidence of HIV infection will have a repeat test on a second blood sample to confirm the results.

The window period (the time between initial infection and the development of detectable antibodies against the infection) can vary since it can take 3–6 months to seroconvert and to test positive. Detection of the virus using polymerase chain reaction (PCR) during the window period is possible, and evidence suggests that an infection may often be detected earlier than when using a fourth generation EIA screening test. Positive results obtained by PCR are confirmed by antibody tests. Routinely used HIV tests for infection in neonates and infants (i.e., patients younger than 2 years), born to HIV-positive mothers, have no value because of the presence of

maternal antibody to HIV in the child's blood. HIV infection can only be diagnosed by PCR, testing for HIV pro-viral DNA in the children's lymphocytes.

1.1.6 Prevention

Estimated per act risk for acquisition of HIV by exposure route (US only)	
Exposure Route	**Estimated chance of infection**
Blood Transfusion	90%
Childbirth (to child)	25%
Needle-sharing injection drug use	0.67%
Percutaneous needle stick	0.30%
Receptive anal intercourse*	0.50%
Insertive anal intercourse*	0.065%
Receptive penile-vaginal intercourse*	0.10%
Insertive penile-vaginal intercourse*	0.05%
Receptive oral intercourse*§	0.01%
Insertive oral intercourse*§	0.005%

The three main transmission routes of HIV are sexual contact, exposure to infected body fluids or tissues, and from mother to fetus or child during the perinatal period. It is possible to find HIV in the saliva, tears, and urine of infected individuals, but there are no recorded cases of infection by these secretions, and the risk of infection is negligible. Anti-retroviral treatment of infected

patients also significantly reduces their ability to transmit HIV to others, by reducing the amount of virus in their bodily fluids to undetectable levels.

1.1.7 Sexual contact

The majority of HIV infections are acquired through unprotected sexual relations between partners, one of whom has HIV. The primary mode of HIV infection worldwide is through sexual contact between members of the opposite sex.

During a sexual act, only male or female condoms can reduce the risk of infection with HIV and other STDs. The best evidence to date indicates that typical condom use reduces the risk of heterosexual HIV transmission by approximately 80% over the long-term, though the benefit is likely to be higher if condoms are used correctly on every occasion. Studies on couples where one partner is infected show that with consistent condom use, HIV infection rates for the uninfected partner are below 1% per year. Prevention strategies are well known in developed countries, but epidemiological and behavioral studies in Europe and North America suggest that a substantial minority of young people continue to engage in high-risk practices despite HIV/AIDS knowledge, underestimating their own risk of becoming infected with HIV.

The male latex condom, if used correctly without oil-based lubricants, is the single most effective available technology to reduce the sexual transmission of HIV and other sexually transmitted infections. Manufacturers recommend that oil-based lubricants such as petroleum jelly, butter, and lard not be used with latex condoms, because they dissolve the latex, making the condoms porous. If lubrication is desired, manufacturers recommend using water-based lubricants. Oil-based lubricants can be used with polyurethane condoms.

Female condoms are commonly made from polyurethane, but are also made from nitrile and latex. They are larger than male condoms and have a stiffened ring-shaped opening with an inner ring designed to be inserted into the vagina keeping the condom in place; inserting the female condom requires squeezing this ring. Female condoms have been shown to be an important HIV prevention strategy by preliminary studies which suggest that overall protected sexual acts increase relative to unprotected sexual acts where female condoms are available. At present, availability of female condoms is very low and the price remains prohibitive for many women.

Three randomized controlled trials showed that male circumcision lowers the risk of HIV infection among heterosexual men, from 51% to 60%. Based on these studies, WHO/UNAIDS both recommended male circumcision as a method of preventing female-to-male HIV transmission in 2007. Programs to encourage condom use, including providing them free to those in poverty, are estimated to be 95 times more cost effective than circumcision at reducing the rate of HIV in sub-Saharan Africa.

Some experts fear that a lower perception of vulnerability among circumcised men may result in more sexual risk-taking behavior, thus negating its preventive effects. However, one randomized controlled trial indicated that adult male circumcision was not associated with increased HIV risk behavior. Studies of HIV infection rates among women who have undergone female genital cutting (FGC) have reported mixed results.

A three-year study in South Africa, completed in 2010, found that an anti-microbial vaginal gel could reduce infection rates among women by 50% after one year of use, and by 39% after two and a half years. The results of the study, which was conducted by the Centre for the Aids Programme of Research in South Africa (CAPRISA), were published in *Science* magazine in July 2010, and were then presented at an international aids conference in Vienna.

1.1.8 Body fluid exposure

Health care workers can reduce exposure to HIV by employing precautions to reduce the risk of exposure to contaminated blood. These precautions include barriers such as gloves, masks, protective eyeware or shields, and gowns or aprons which prevent exposure of the skin or mucous membranes to blood borne pathogens. Frequent and thorough washing of the skin immediately after being contaminated with blood or other bodily fluids can reduce the chance of infection. Finally, sharp objects like needles, scalpels and glass, are carefully disposed of to prevent needlestick injuries with contaminated items. Since intravenous drug use is an important factor in HIV transmission in developed countries, harm reduction strategies such as needle-exchange programmes are used in attempts to reduce the infections caused by drug abuse.

1.1.9 Mother-to-child

Current recommendations state that when replacement feeding, as with a wet nurse, is acceptable, feasible, affordable, sustainable and safe. HIV infected mothers should avoid breast-feeding their infant. However, if this is not the case, exclusive breast-feeding is recommended during the first months of life and discontinued as soon as possible.

1.1.10 Education

One way to change risky behavior is health education. Several studies have shown the positive impact of education and health literacy on cautious sex behavior. Education works only if it leads to higher health literacy and general cognitive ability. This ability is relevant to understand the relationship between own risky behavior and possible outcomes like HIV-transmission. In July 2010, a UNAIDS Inter-Agency Task Team (IATT) on Education commissioned literature review found there was a need for more research into non-African especially non-South African contexts), more research on the actual implementation of sex-education programmes (such as teacher training, access to related services through schools and the community, or parental attitudes to HIV and AIDS education) and more longitudinal studies on the deeper complexities of the relationship between education and HIV.

1.1.11 Management

There is currently no publicly available HIV vaccine or cure for HIV or AIDS. The only known methods of prevention are based on avoiding exposure to the virus or, failing that, an antiretroviral treatment directly after a highly significant exposure, called post-exposure prophylaxis (PEP).[PEP has a very demanding four week schedule of dosage. It also has very unpleasant side effects including diarrhea, malaise, nausea and fatigue.

1.1.12 Antiviral therapy

Current treatment for HIV infection consists of highly active antiretroviral therapy, or HAART. This has been highly beneficial to many HIV-infected individuals since its introduction in 1996 when the protease inhibitor-based HAART initially became available. Current optimal HAART options consist of combinations (or "cocktails") consisting of at least three drugs belonging to at least two types, or "classes," of antiretroviral agents.

1.1.13 Prognosis

Without treatment, the net median survival time after infection with HIV is estimated to be 9 to 11 years, depending on the HIV subtype, and the median survival rate after diagnosis of AIDS in resource-limited settings where treatment is not available ranges between 6 and 19 months, depending on the study. In areas where it is widely available, the development of HAART as effective therapy for HIV infection and AIDS reduced the death rate from this disease by 80%, and raised the life expectancy for a newly diagnosed HIV-infected person to about 20 years.

As new treatments continue to be developed and because HIV continues to evolve resistance to treatments, estimates of survival time are likely to continue to change. Without antiretroviral therapy, death normally occurs within a year after the individual progresses to AIDS. Most patients die from opportunistic infections or malignancies associated with the progressive failure of the immune system. The rate of clinical disease progression varies widely between individuals and has been shown to be affected by many factors such as host susceptibility and immune function health care and co-infections, as well as which particular strain of the virus is involved.

Even with anti-retroviral treatment, over the long term HIV-infected patients may experience neurocognitive disorders, osteoporosis, neuropathy, cancers, nephropathy, and cardiovascular disease. It is not always clear whether these conditions result from the infection, related complications, or are side effects of treatment.

The largest cause of AIDS morbidity today, globally, is tuberculosis co-infection. In Africa, HIV is the single most important factor contributing to the increase in the incidence of TB since 1990.

1.1.14 Epidemiology

The AIDS pandemic can also be seen as several epidemics of separate subtypes; the major factors in its spread are sexual transmission and vertical transmission from mother to child at birth and through breast milk. Despite recent, improved access to antiretroviral treatment and care in many regions of the world, the AIDS pandemic claimed an estimated 2.1 million (range 1.9–2.4 million) lives in 2007 of which an estimated 330,000 were children under 15 years. Globally, an estimated 33.2 million people lived with HIV in 2007, including 2.5 million children. An estimated 2.5 million (range 1.8–4.1 million) people were newly infected in 2007, including 420,000 children.

Sub-Saharan Africa remains by far the worst affected region. In 2007 it contained an estimated 68% of all people living with AIDS and 76% of all AIDS deaths, with 1.7 million new infections bringing the number of people living with HIV to 22.5 million, and with 11.4 million AIDS orphans living in the region. Unlike other regions, most people living with HIV in sub-Saharan Africa in 2007 (61%) were women. Adult prevalence in 2007 was an estimated 5.0%, and AIDS continued to be the single largest cause of mortality in this region.

South Africa has the largest population of HIV patients in the world, followed by Nigeria and India. South & South East Asia are second worst affected; in 2007 this region contained an estimated 18% of all people living with AIDS, and an estimated 300,000 deaths from AIDS. India has an estimated 2.5 million infections and an estimated adult prevalence of 0.36%. Life expectancy has fallen dramatically in the worst-affected countries; for example, in 2006 it was estimated that it had dropped from 65 to 35 years in Botswana.

In the United States, young African-American women are also at unusually high risk for HIV infection. African Americans make up 10% of the population but about half of the HIV/AIDS cases nationwide. This is due in part to a lack of information about AIDS and a perception that they are not vulnerable, as well as to limited access to health-care resources and a higher likelihood of sexual contact with at-risk male sexual partners.

There are also geographic disparities in AIDS prevalence in the United States, where it is most common in the large metropoliton areas of the east coast and California and in urban areas of the deep south. Approximately 1.1 million persons are living with HIV/AIDS in the United States, and more than 56,000 new infections occur every single year.

1.1.15 History and origin

AIDS was first reported June 5, 1981, when the CDC recorded a cluster of *Pneumocystis carinii* pneumonia (now still classified as PCP but known to be caused by *Pneumocystis jirovecii*) in five homosexual men in Los Angeles. In the beginning, the CDC did not have an official name for the disease, often referring to it by way of the diseases that were associated with it, for example, lymphadenopathy, the disease after which the discoverers of HIV originally named the virus. They also used *Kaposi's Sarcoma and Opportunistic Infections*, the name by which a task force had been set up in 1981.

In the general press, the term *GRID*, which stood for gay-related immune deficiency, had been coined. The CDC, in search of a name, and looking at the infected communities coined "the 4H disease," as it seemed to single out Haitians, homosexuals, hemophiliacs, and heroin users. However, after determining that AIDS was not isolated to the gay community, the term GRID became misleading and *AIDS* was introduced at a meeting in July 1982. By September 1982 the CDC started using the name AIDS, and properly defined the illness.

The earliest known positive identification of the HIV-1 virus comes from the Congo in 1959 and 1960 though genetic studies indicate that it passed into the human population from chimpanzees around fifty years earlier. A 2007 study states that a strain of HIV-1 probably moved from Africa to Haiti and then entered the United States around 1969.

HIV descends from the related simian immunodeficiency virus (SIV), which infects apes and monkeys in Africa. There is evidence that humans who participate in bushmeat activities, either as hunters or as bushmeat vendors, commonly acquire SIV. However, only a few of these infections were able to cause epidemics in humans, and all did so in the late 19th—early 20th century. To explain why HIV became epidemic only by that time, there are several theories, each invoking specific driving factors that may have promoted SIV adaptation to humans, or initial

spread: social changes following colonialism, rapid transmission of SIV through unsafe or unsterile injections (that is, injections in which the needle is reused without being sterilised), colonial abuses and unsafe smallpox vaccinations or injections, or prostitution and the concomitant high frequency of genital ulcer diseases (such as syphilis) in nascent colonial cities.

One of the first high profile victims of AIDS was the American Rock Hudson, a gay actor who had been married and divorced earlier in life, who died on 2 October 1985 having announced that he was suffering from the virus on 25 July that year. It had been diagnosed during 1984. A notable British casualty of AIDS that year was Nicholas Eden, a gay Member of Parliament and son of the late Prime Minister Anthony Eden. The virus claimed perhaps its most famous victim yet on November 24, 1991, when British rock star Freddie Mercury, lead singer of the band Queen, died from an AIDS related illness having only announced that he was suffering from the illness the previous day. However he had been diagnosed as HIV positive during 1987. One of the first high profile heterosexual victims of the virus was Arthur Ashe, the American tennis player. He was diagnosed as HIV positive on 31 August 1988, having contracted the virus from blood transfusions during heart surgery earlier in the 1980s. Further tests within 24 hours of the initial diagnosis revealed that Ashe had AIDS, but he did not tell the public about his diagnosis until April 1992. He died, aged 49, as a result of the AIDS virus on 6 February 1993.

A more controversial theory known as the OPV AIDS hypothesis suggests that the AIDS epidemic was inadvertently started in the late 1950s in the Belgian Congo by Hilary Koprowski's research into a poliomyelitis vaccine. According to scientific consensus, the available evidence does not support this scenario.

1.1.16 Society and culture

AIDS stigma exists around the world in a variety of ways, including ostracism, rejection, discrimination and avoidance of HIV infected people; compulsory HIV testing without prior consent or protection of confidentiality; violence against HIV infected individuals or people who are perceived to be infected with HIV; and the quarantine of HIV infected individuals. Stigma-related violence or the fear of violence prevents many people from seeking HIV testing,

returning for their results, or securing treatment, possibly turning what could be a manageable chronic illness into a death sentence and perpetuating the spread of HIV.[

AIDS stigma has been further divided into the following three categories:

- *Instrumental AIDS stigma*—a reflection of the fear and apprehension that are likely to be associated with any deadly and transmissible illness.

- *Symbolic AIDS stigma*—the use of HIV/AIDS to express attitudes toward the social groups or lifestyles perceived to be associated with the disease.
- *Courtesy AIDS stigma*—stigmatization of people connected to the issue of HIV/AIDS or HIV- positive people.

Often, AIDS stigma is expressed in conjunction with one or more other stigmas, particularly those associated with homosexuality, bisexuality, promiscuity, prostitution, and intravenous drug use.

In many developed countries, there is an association between AIDS and homosexuality or bisexuality, and this association is correlated with higher levels of sexual prejudice such as anti-homosexual attitudes. There is also a perceived association between AIDS and all male-male sexual behavior, including sex between uninfected men.

1.1.17 Religion and AIDS

The topic of religion and AIDS has become highly controversial in the past twenty years, primarily because many prominent religious leaders have publicly declared their opposition to the use of condoms, which scientists feel is currently the only means of stopping the epidemic. However, there is a growing openness to faith-based methods due to the failure rates associated with condoms. Other issues involve religious participation in global health care services and collaboration with secular organizations such as UNAIDS and the World Health Organization.

The religious approach to prevent the spread of AIDS according to a report by American health expert Matthew Hanley titled *The Catholic Church and the Global Aids Crisis* argues that

cultural changes are needed including a re-emphasis on fidelity within marriage and sexual abstinence outside of it.

In addition to prevention, some religious groups have interrupted the treatment of AIDS. According to the African Health Policy Network, some churches in London claim that prayer will cure AIDS and the Hackney-based Centre for the Study of Sexual Health and HIV reports that several people have stopped taking their medication, sometimes on the direct advice of their pastor, leading to a number of deaths. The Synagogue Church Of All Nations advertise an "anointing water" to promote God's healing, although the group deny advising people to stop taking medication, and US patent application 2001051133 similarly suggests that intravenous pure distilled water will eradicate HIV through the mercy of God.

1.2 **YOUTH**

1.2.1 Young Population

Nearly half of the world's population (almost 3 billion people) is under the age of 25. Over 1.2 billion people are between 10 and 19 years old. About 85 per cent of the world's youth live in developing countries. Youth comprise a substantial proportion of world's population and helps into development process as they are an affluent human resource. Much like the world the current population of India is 1.22 billion and 50% of its population is in the age group of 0-25yrs (Indian census 2011).

1.2.2 The Science of development

Childhood followed by adolescence (10-19) is a phase of physical growth & development followed by sexual maturation, often leading to behavioral, biological, economical and social vulnerability.[1] The adolescence is divided into early, middle and late stages ranging from (10–13 years) in which independence-dependence struggles are heralded by rapid physical changes with the onset of puberty with onset of puberty, (14–16 years) in which there is increased scope of feelings, and increased importance of peer group values and more risk-taking behaviors, (17–19 years) with emerging adults who have successfully transitioned into accepting responsibility for their behaviors with acceptance on the basis of psychological, physiological and social development. [2]

1.2.3 Young People and HIV

The health status of the community can be raised by the good health of adolescents as they are highly vulnerable to HIV/ AIDS and STIs.[1] The estimates by World Health Organization shows that 10.3 million youth aged 15–24 years are living with HIV/AIDS (most without knowing that they are infected) and half of all new infections are occurring among young people on a global basis. [3.1] An estimated 6,000 youth each day become infected with HIV — one every 14 seconds. The majority are young women. Young people at the age of 15 to 24 account for half of all new HIV infections: a total of approximately 3 million a year. At the end of 2001, an estimated 11.8 million young people aged 15-24 were living with HIV/AIDS. Only a small percentage of these young people know they are HIV-positive. An estimated 7.3 million young women are living with HIV/AIDS, compared to 4.5 million young men. Two thirds of newly infected youth aged 15-19 in sub-Saharan Africa are female. Worldwide, young women (15-24 years) are 1.6 times as likely as young men to be HIV positive.[3.2]

1.2.4 Young People and STD's (Sexually Transmitted Diseases)

Each year, about 4 million people younger than 20 years are diagnosed with STIs including herpes, human papilloma virus (HPV), Chlamydia, gonorrhea, and the HIV.[4] STD's are most common among young people between 15 and 24 years old. Girls are more at risk getting infected with an STD than boys, mainly because of biological causes. So, it becomes very imperative to create awareness and to educate them on the various issues to which they are vulnerable through interventions.[4.2]

1.2.5 Young people and HIV knowledge

Misconceptions about HIV/AIDS are widespread among young people. They vary from one culture to another, and particular rumors gain currency in some populations both on how HIV is spread (by mosquito bites or witchcraft, for example) and on how it can be avoided (by eating a certain fish, for example, or having sex with a virgin). Surveys from 40 countries indicate that more than 50 per cent of young people aged 15 to 24 harbour serious misconceptions about how HIV/AIDS is transmitted.[5]

Even when they do have information, some adolescents engage in unprotected sex because they lack the skills to negotiate abstinence or condom use. They may be fearful or embarrassed to talk with their partner about sex.

Adolescence is often a time of experimentation with drugs and alcohol. In the United Republic of Tanzania, young people aged 16 to 24 who smoke and drink alcohol are four times more likely than their peers to have multiple sex partners. In the United States of America, college students who have sex under the influence of drugs or alcohol are 2.5 times more likely not to use protection.

1.2.6 Entertainment and Education (EE)

EE is the process of purposely designing and implementing a media message to both entertain and educate, in order to increase audience members' knowledge about an educational issue, create favorable attitudes, shift societal norms, and change overt behavior (Singhal & Rogers, 1999; Singhal & Rogers 2002)

- It's a communication strategy to bring about behavioral and social change.
- It can influence members' awareness, attitudes, and behavior toward a socially desirable end.

Interventions should be designed in such a way which should build a bridge between likings or preferences and the message of education or awareness to capture the intergenerational impact: as the effectiveness of the intervention majorly depends on the choices, preferences, acceptability and the positive response generated after it. The rapid growth in recent years of interactive media (e.g., video games and the Internet) is garnering significant attention as a potential source of influence on children's development. Studies have shown that the inventions mixed with entertainment & education is very impactful on youth then normal regular interventions.

As mentioned above young people constitute half of the world's population. Widespread ignorance even amongst 'educated' youth, due to absence of uniformly established sexual and reproductive health education in school system. Over the past decade, India has had increasing exposure to a variety of aspects of Western culture, through the internet, movies, media,

literature, fashion, etc. Lacking of the necessary knowledge and skills, younger adolescents are less likely to protect themselves from HIV than young people in their early 20s. The Youth get into high risk practices like sex without condoms, drugs and experimentation with sex workers. In this research we want to know about the basic HIV knowledge and their attitude and practices towards Condom use. What they feel about using condom etc.

The research is designed with the main focus on the basic knowledge about HIV/AIDS and; attitude and practices related to the Condom use during the sex.

1.2.7 Vulnerability

Physiologically, young people are more vulnerable to STIs than adults; girls more than boys. Gender imbalances, societal norms and economic dependence contribute to this risk.
Lack of access to correct information (almost 73 percent of young people have misconceptions about modes of HIV transmission), tendency to experiment and an environment which makes discussing issues around sexuality taboo adds to their vulnerability.

1.2.8 Vulnerable groups

Most young people become sexually active during adolescence. In the absence of right guidance and information at this stage they are more likely to have multi-partner unprotected sex with high risk behaviour groups. Particularly vulnerable are impoverished, unemployed, under-employed, mobile/migrant youth, adolescents in sex work, young injecting drug users and street children as they are faced with high risk behaviour in their everyday life. They are also less likely to have information on the risks of contracting HIV and means of protecting themselves from the infection. Such youth may face repeated risk of HIV infection through sexual exposure due to coercion or other compulsions.

Young women are biologically more vulnerable to HIV infection than young men – a situation aggravated by their lack of access to information on HIV and even lesser power to exercise control over their sexual lives. Early marriage also poses special risks to young people,

particularly women. This is especially relevant for India, where almost 50 percent girls are married off by the time they are 18 years of age.

Many youth are illiterate or have very low educational attainment

- Thirty-one percent of young women and 14 percent of young men are illiterate.
- However, literacy is much higher among the youngest youth age 15 years (77% among women and 92% percent among men) than among youth only a decade older (63% among women and 84% among men).
- Despite improvements over time, educational attainment remains very low even among youth: only 29 percent of young women and 38 percent of young men have completed 10 or more years of education.
- Urban-rural differentials are much wider for women than men in literacy and educational attainment and the gender gap is also much greater in rural than in urban areas.
- Only 41 percent of adolescents age 15-17 were attending school in the school year 2005-06, suggesting a very high school dropout rate. School attendance rates for youth age 15-17 years increase sharply with household wealth. The gender gap is also much narrower in wealthier households than in poorer households.

Most youth are exposed to some form of media

- Seventy percent of women and 88 percent of men age 15-24 have at least weekly exposure to television, radio, or newspapers/magazines or monthly exposure to the cinema. Media exposure is much lower in rural than in urban areas.
- The most common form of media to which youth are exposed is television.
- Women are much less likely than men to be exposed to each type of media. Women with no education and women in rural areas have particularly low levels of regular media exposure.

Female youth are more likely than male youth to belong to the lowest wealth quintile and less likely to be in the higher wealth quintiles

- Female youth, on average, live in poorer households than male youth.

- ***The majority of unmarried youth live in nuclear households, whereas the majority of married youth live in non-nuclear households***

Many youth are economically active

- Thirty-four percent of women and 67 percent of men age 15-24 were employed at any time in the 12 months preceding the survey, with the vast majority being currently employed.
- Among men, the proportion employed increases sharply with age from 33 percent among those age 15 to 92 percent among those age 24; among women, by contrast, employment varies little with age.
- Employment is higher among rural than among urban youth and is much lower among youth with 10 or more years of education than among those with no education. Almost all men with no education are employed.
- The majority of employed women are agricultural workers; however, there is greater diversity in male employment.
- Less than two-thirds of employed women (64%) earn cash for their work, compared with 88 percent of employed men.

Many youth are married

- Half of women and almost one in five men age 15-24 are currently married.
- Nineteen percent of women age 15-17 and 7 percent of men age 15-20 are married.
- About 2 percent of youth are married but their *gauna* has yet to be performed and a very small proportion (1% of women and 0.3% of men) have experienced a marital disruption.

Many youth are heading households

- One percent of women and 8 percent of men age 15-24 are household heads. Among currently married men age 15-24, 29 percent are heading their own households.
- Youth in households headed by youth are poorer than youth from households headed by someone who is older.

A majority of youth think that HIV/AIDS education should be part of the school curriculum

- Most young men and women believe that information on HIV/AIDS should be part of the school curriculum.
- Two-thirds of men and less than half of women say that both boys and girls should be taught about sex and sexual behaviour in school.

2. OBJECTIVES:

2.1 General Objective

- To evaluate the knowledge, attitudes and practices about HIV of the population aged (15-29 years) in Delhi.

2.2 Specific Objective

- To ascertain the preferred choices for type of entertainment among Delhi youth (15-29 years).
- To ascertain the preferred choices for leisure time activity among Delhi youth (15-29 years).
- To establish relationship between background variables like age, gender, socioeconomic status and religion of the students with the preferences
- To establish relationship between backgrounds variables like age, gender, socioeconomic status and religion of the students with the Knowledge, Attitude and Practices.

3. METHODOLOGY:

3.1 Study Design and Data Collection

A descriptive survey was conducted using self-administered questionnaires among 176 youth (15-29yrs) across Delhi. These were selected through Convenient Sampling and were from selected from Schools, Colleges, Parlors, Pubs, Call Centers, Market Places, Salon, Shops, Metro Stations, and Slums etc. Youth were approached and asked to volunteer; those who agreed to participate were asked to complete a set of questionnaires. The questionnaires were distributed to the youth. The questionnaires took an average of ten minutes to complete. The completed questionnaires were retrieved immediately.

3.2 Study location

This study was conducted in Delhi which is officially the National Capital Territory of Delhi (NCT), is the largest metropolis by area and the second-largest metropolis by population in India. It is the eighth largest metropolis in the world by population with 16.7 million inhabitants in the Territory at the 2011 Census. There are nearly 22.2 million residents in the greater National Capital Region urban area (which also includes the cities Noida, Greater Noida, Ghaziabad, Gurgaon and Faridabad along with other smaller nearby towns).

3.3 Questionnaire

The study instrument was a self-administered questionnaire which comprised of five parts. Part A related to respondent's socio-demographic background, part B on knowledge regarding HIV/AIDS, Part C on AIDS Attitude Scale, and Part D on high risk behavior or practice related to HIV/AIDS transmission and Part E on the preferences in Entertainment. The knowledge, attitude and practice questionnaire was modified from the instrument used by a survey on HIV/AIDS knowledge, attitude & practice (KAP) which was adopted from the JOHNS HOPKINS UNIVERSITY (2011).

Knowledge was assessed using a 36-item questionnaire which includes knowledge on ways of infection, myths, disease detection and progression, and treatment and prevention of HIV/AIDS. Attitude was assessed using a 08-item questionnaire on attitude towards HIV/AIDS, with

HIV/AIDS patients and about using condom. The questions on high risk behaviors had 08 items related to unprotected sex and needle sharing. Prior to the survey, the questionnaire was pre-tested to assess its clarity, sequencing and time needed to complete. Pre- test of questionnaire was done on twenty respondents who were chosen to ensure that the questions are easily understood. The result of the pre-test was used to improve the phrasing of questions in questionnaire.

3.4 Scoring

For knowledge, each right response was given a score of 1 while a wrong or unsure response was scored 0. Total knowledge scores can range between 0-36. Knowledge scores from 0 to 15 were considered as poor knowledge while knowledge scores more than 15 was considered as having good knowledge regarding HIV/AIDS. Attitude towards HIV/AIDS patients was assessed using a 08-item questionnaire where attitude scores between 0 to 4 were considered as negative attitude, and scores 4 to 8 were considered as positive attitude. High risk behavior or practice was assessed using a 07-item questionnaire where report of at least one negative behavior related to HIV transmission is considered as having high risk behavior.

3.5 Ethics Consideration

The Permission letters were sent to the colleges and schools and on getting permissions the survey was done. Prior to data collection, all study participants were also given information on the study and assured that all data is confidential and will only be analyzed as aggregates. All respondents signed the informed consent form before participation.

3.6 Data Analysis

Data analysis was done using Statistical Package for Social Sciences (SPSS) Version 16.0

4. RESULTS AND FINDINGS

4.1 Response Rate

One hundred seventy six youth (15-29yrs) agreed to participate and completed the questionnaire. Thus we achieved 64 % percent of the sample size we set for our study (271 at 90% Confidence Interval with 5% Margin error).'

4.2 Youth's profile

The youth can be further classified into the following group on the basis of:

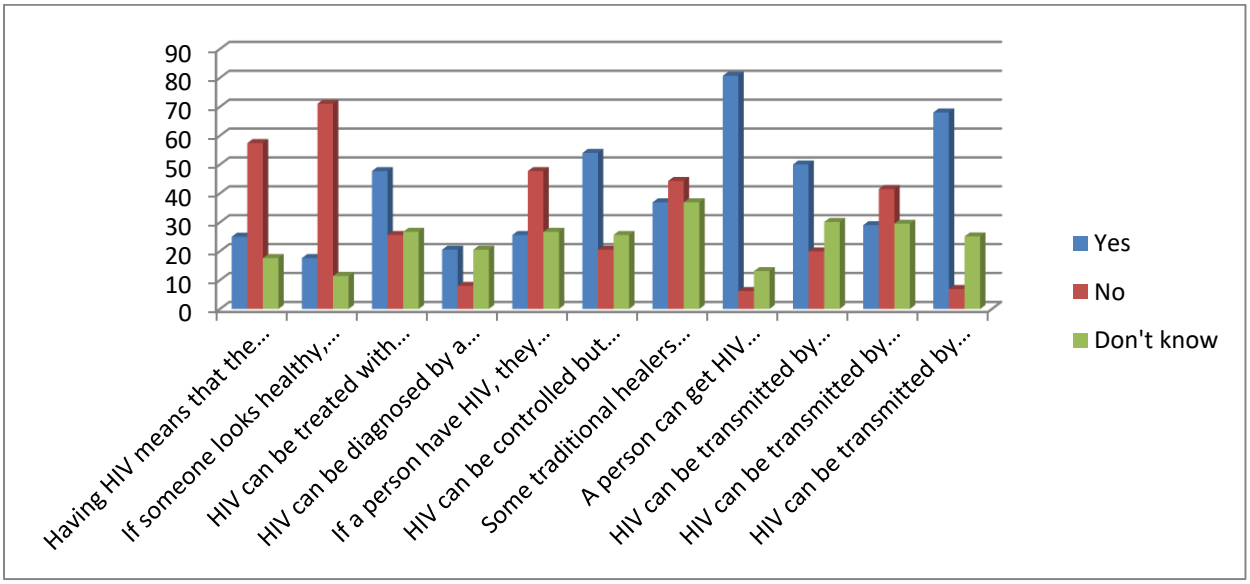
- **Education Level**: Illiterate (**5.1%)**, Primary (**11.9%)**, High School (**1.1%)**, Graduation **(67.0%)**, Post Graduation **(14.8%).**
- **Gender:** Male **88**(no.) and Female **88** (no.)
- **Economic Class:** Lower Economic Class (**22.2%**), Lower Middle Economic Class (**13.1%)**, Upper Middle Economic Class (**15.3)**, Upper Economic Class (**49.4%).**
- **Age:** 15-17 yrs (3.4%), 18-21 yrs (52.3%), 22-25 yrs (30.1%), 26-29 yrs (**14.2%)**
- **Religion**: Hindu (**88.1)**, Muslim (**3.4**), Sikh (**4.0)**, Christian **(2.3**), Others (**2.3)**
- **Employment Status:** Working 33.5% and Non Working 66.5%

4.3 Knowledge

Among 176 respondents, on asking about Having heard of STI's (Sexually Tranmitted Infections) 76.1% said Yes, 22.2% said No and 1.7% Don't Know. On asking about the prevention of STI 73.7% said Yes, 10.9% said No and 15.4% said Don't know. On asking about Have you ever heard of HIV/AIDS 92% responded Yes, 6.8% responded No and 1.1% responded don't know.

4.3.1 Basic Knowledge

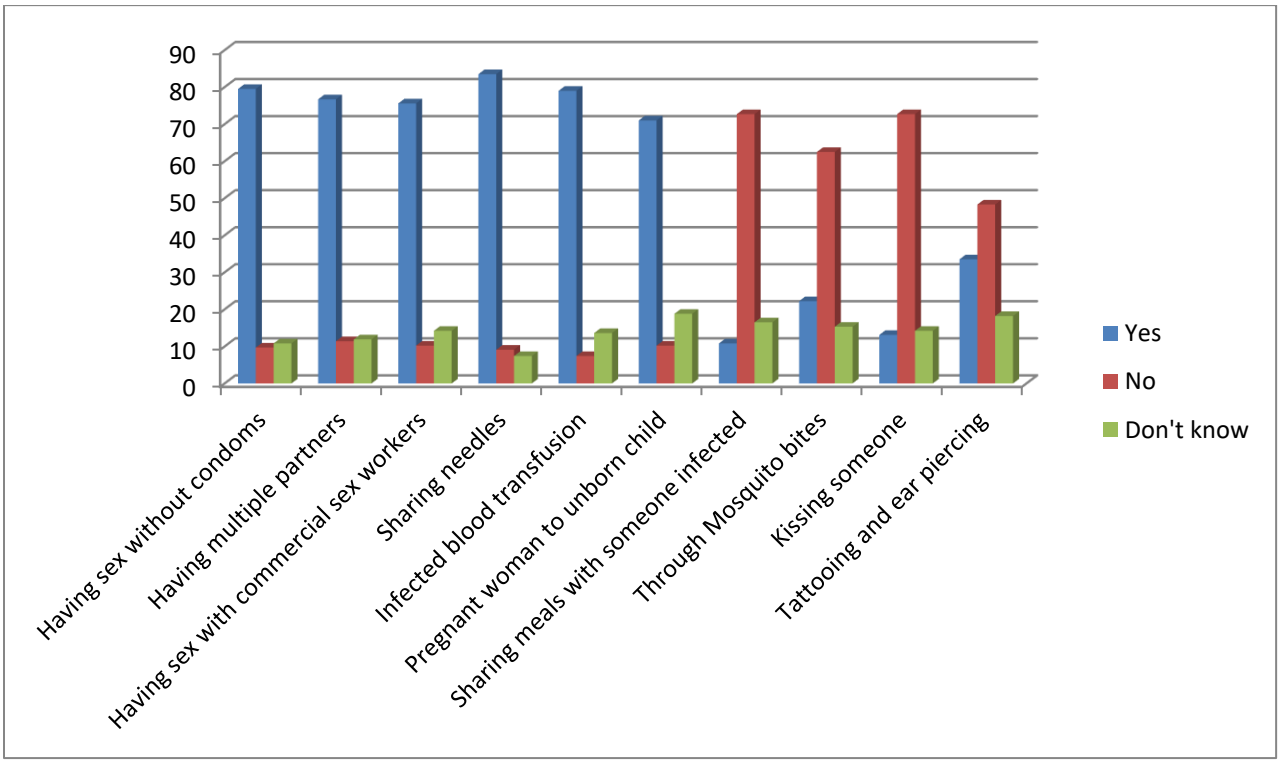
The frequency on asking Having HIV means that person will die was 25% Yes, 57.4% No, 17.6% Don't Know; If someone looks healthy, then he or she cannot have HIV was 17.6% Yes, 71% No, 11.4% Don't Know; HIV can be treated with certain drugs/medicines was 47.7% Yes, 25.6% No, 26.7% Don't Know: If a person have HIV, they will always develop AIDS was 25.6% Yes, 47.7% No, 26.7% Don't Know: HIV can be controlled but not completely cured was 54% Yes, 20% No, 25.6% Don't Know: Some traditional healers have the power to cure AIDS was 18.8% Yes, 44.3% No, 36.9% Don't Know: A person can get HIV infection from sharing needles used to inject drugs was 80.7% Yes, 6.2% No, 13.1% Don't Know; HIV can be transmitted by Anal sex was 50.0% Yes, 19.9% No, 30.1% Don't Know; HIV can be transmitted by Oral sex was 29.0% Yes, 41.5% No, 29.5% Don't Know; HIV can be transmitted by Vaginal sex was 67.6% Yes, 6.8% No, 25% Don't Know



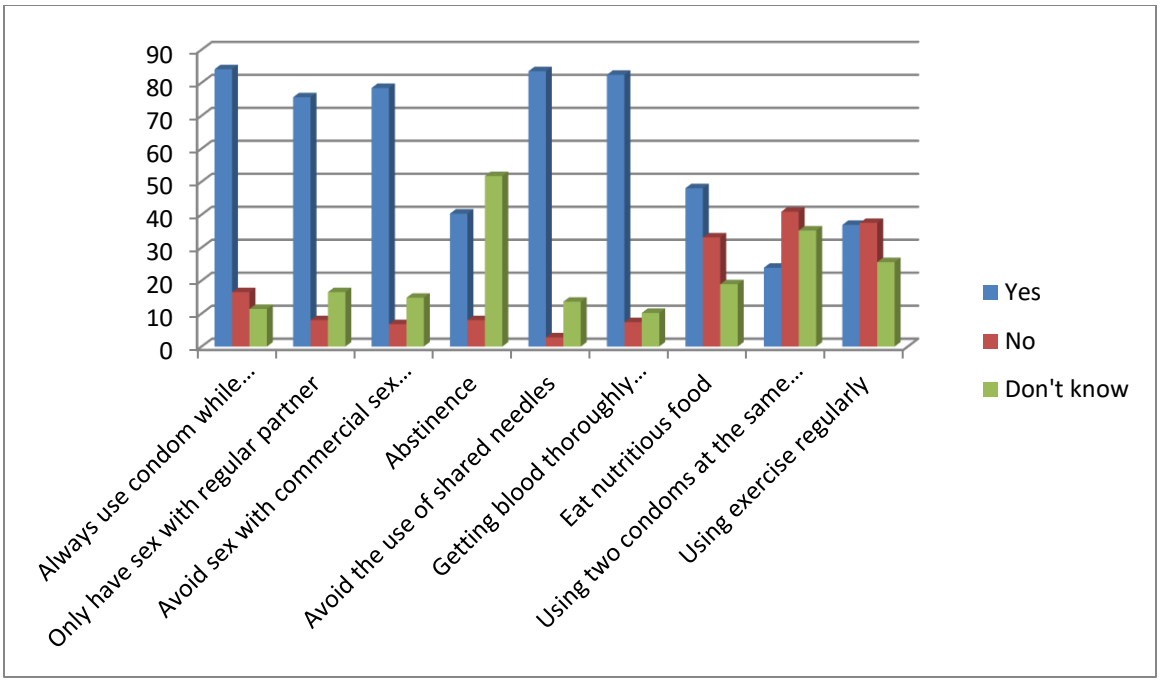
4.3.2 Knowledge about Modes on transmission:

When they were aksed the question that the Aids can't be transmitted if having sex without condoms was 79.5% Yes, 9.7% No, 10.8% Don't Know **;** Having sex with commercial sex workers was 75.6% Yes, 10.2% No, 14.2% Don't Know; Sharing needles was 83.5% Yes, 9.1% No, 7.4% Don't Know; Infected blood transfusion was 79.0% Yes, 7.4% No, 13.6% Don't Know; Pregnant woman to unborn child was 71% Yes, 10% No, 18.8% Don't Know; Sharing meals with someone infected was 10.8% Yes, 72.7% No, 16.5% Don't Know; Through Mosquito bites was 22.2% Yes, 62.5% No, 15.2% Don't Know; Kissing someone was 13.1%

Yes, 72.7% No, 14.2% Don't Know; Tattooing and ear piercing was 33.5% Yes, 48.3% No, 18.2% Don't Know



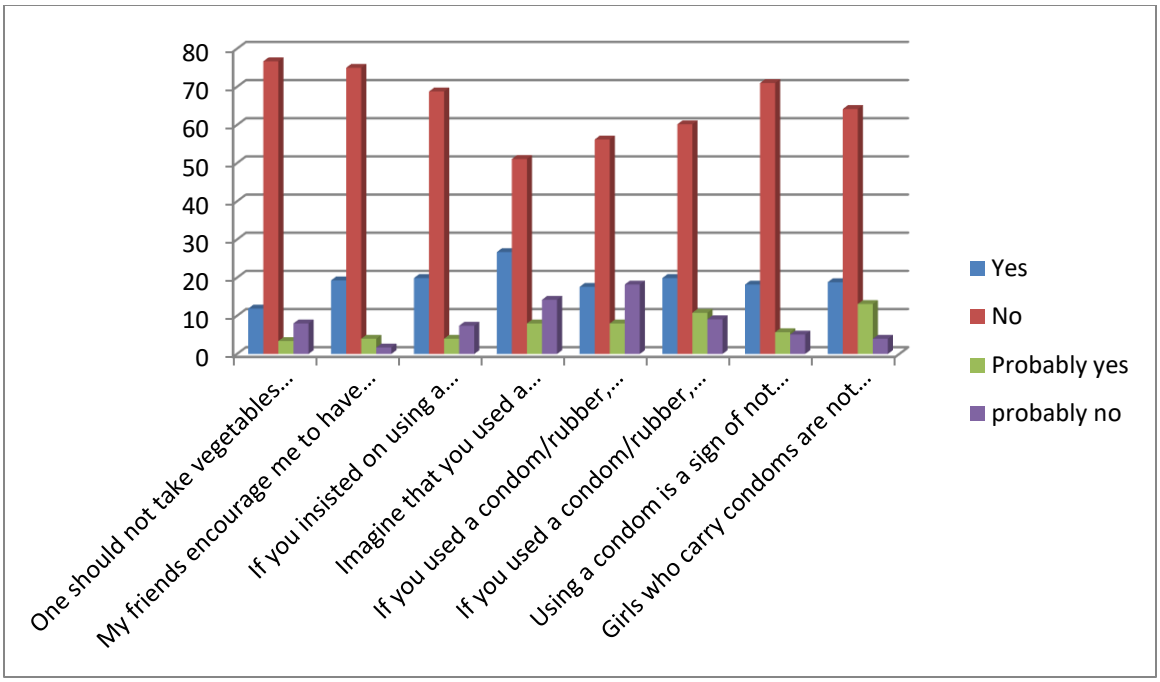
4.3.4 On asked about HIV/AIDS can be prevented, majorly replied using condom always while engaging in sex ; 75% think only to have sex with regular partner; 78.4% youth Avoid sex with commercial sex workers , 83.5% youth thinks of not using shared needles; 40.9% think of not using two condoms at the same time of intercourse.



On being asked about that are you aware that you could get a confidential test done to find out whether you are infected with HIV 69.8% respondents replied Yes and 30.2% respondents replied No; Have you ever heard of ICTC (Integrated Counseling and testing centre) or HIV testing centers then 56.2% replied Yes and 43.8% replied No which shows that half of people are not aware about services provided by the government. On being asked more in details about the cost of ICTC test 47.7% responded yes and rest 52.3% replied no.

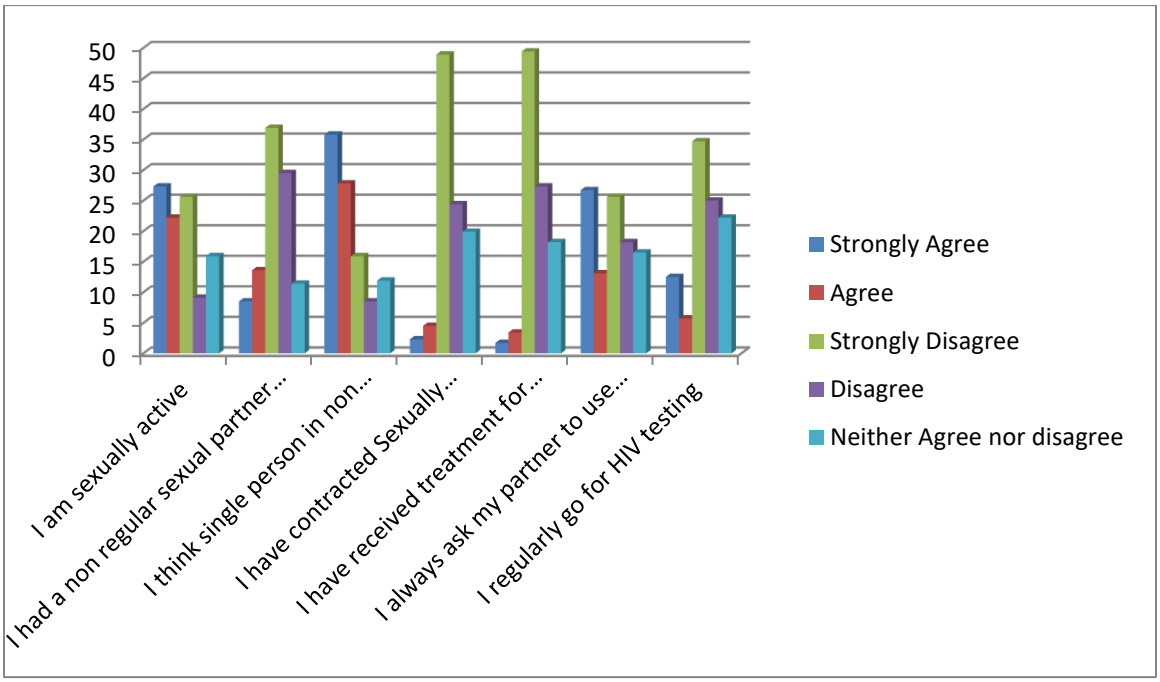
4.4. ATTITUDE

The Attitude of youth towards using condom and PLHIV is good. They know that if they will mix up with the community it will not harm them in getting infected. On being asked if they will buy vegetable from a shopkeeper who have HIV then majorly 76.7% replied that why not to take vegetables. Most of the respondents (i.e.75%) replied that they are not encouraged by their peers to have sex. 18.2% respondents think that using condom is like not trusting your partner. Very few (18.3%) think that the girls who carry condoms are not respected.



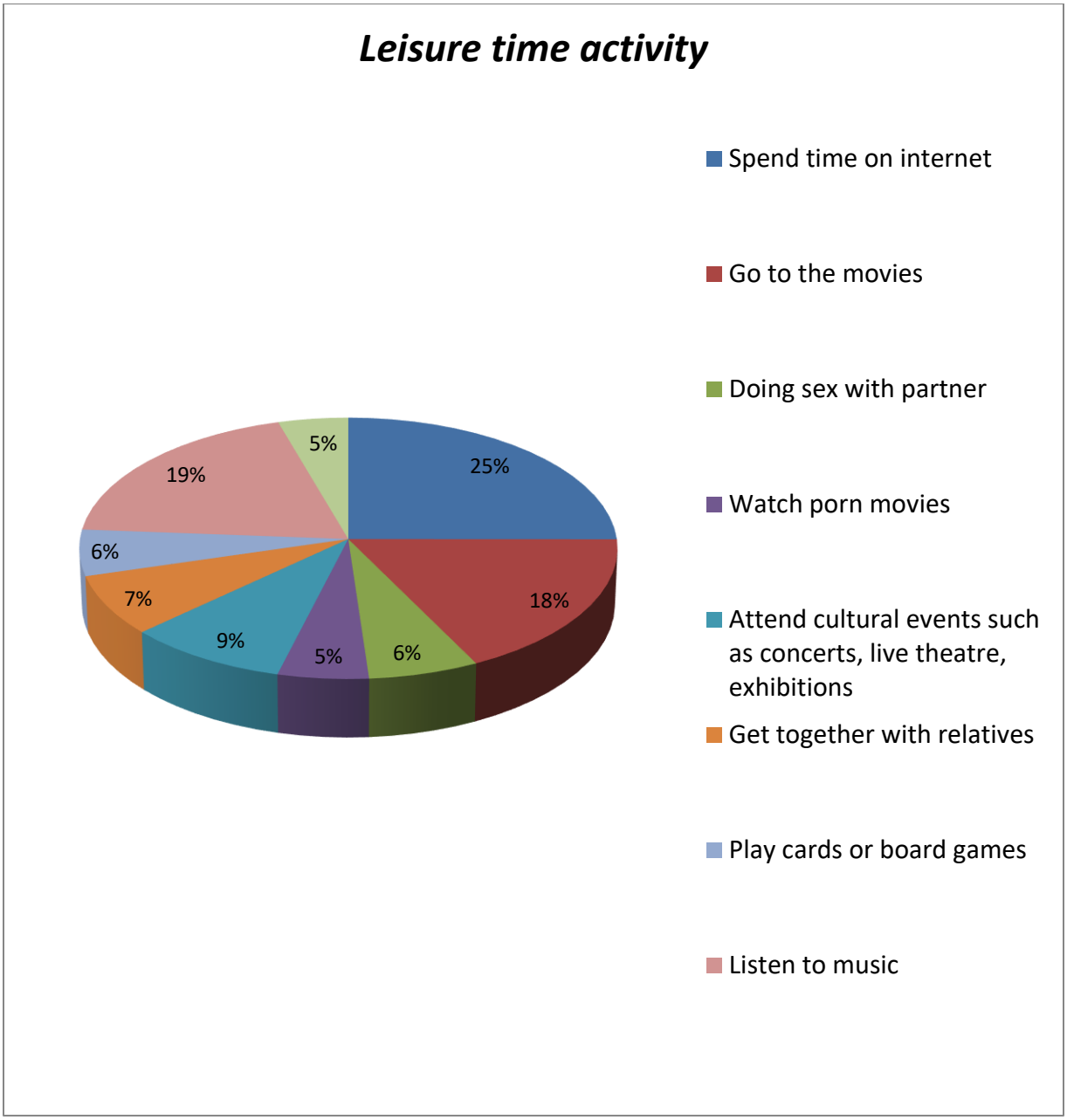
4.5. Practices

On being asked about the practices, 27.2% strongly agree and 22.2% agree being sexually active, 36.9% strongly disagree to have non regular partner and half of the respondents disagreed to have ever contacted STI. Only 18% youth goes for regular HIV testing.



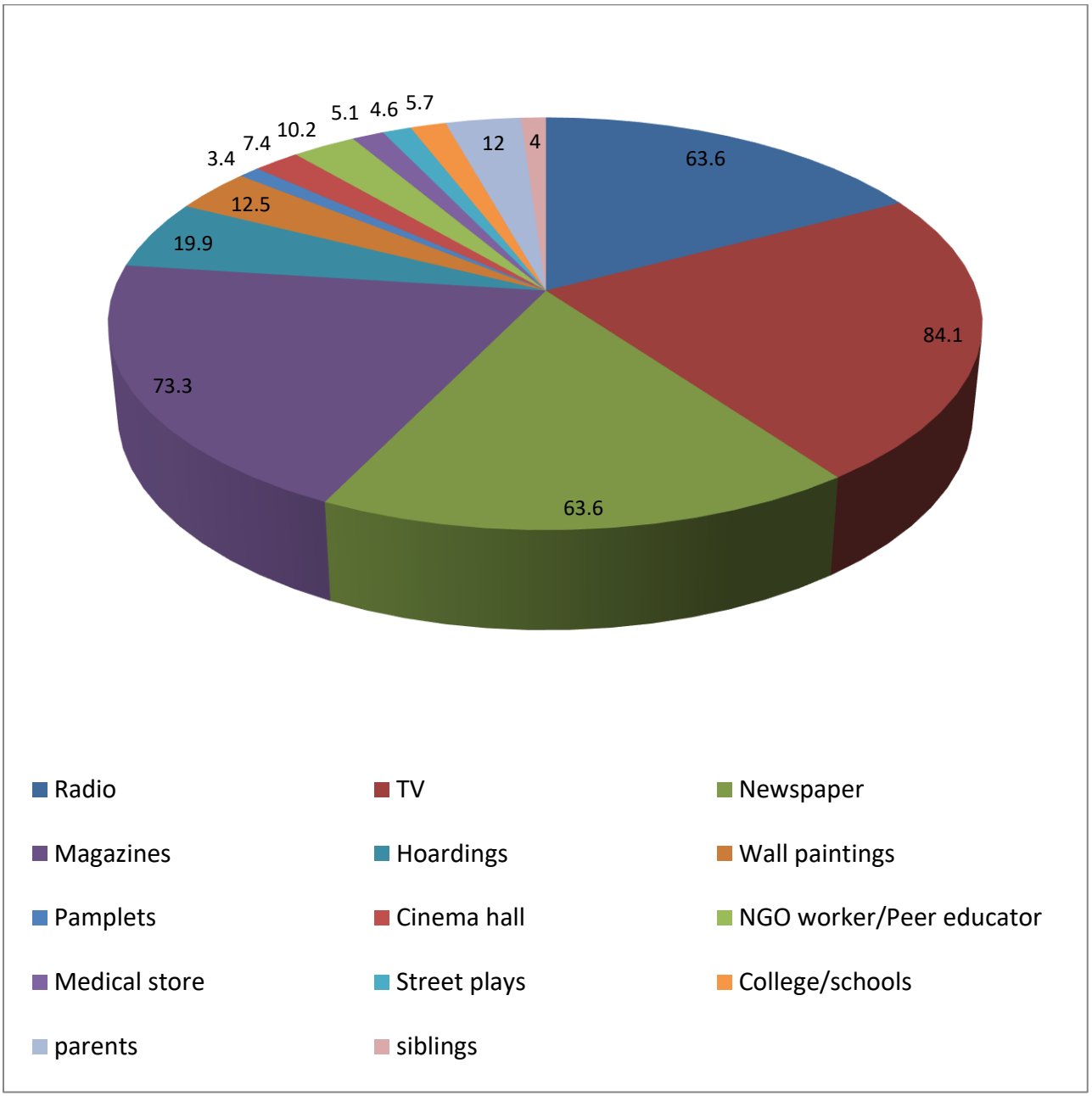
4.6 Leisure Time Activity:

On being asked about the preferred leisure time activities spending time on internet (25%) followed by Listen to music (19%) and then going for movies (18%) was the most preferred activity during leisure time.



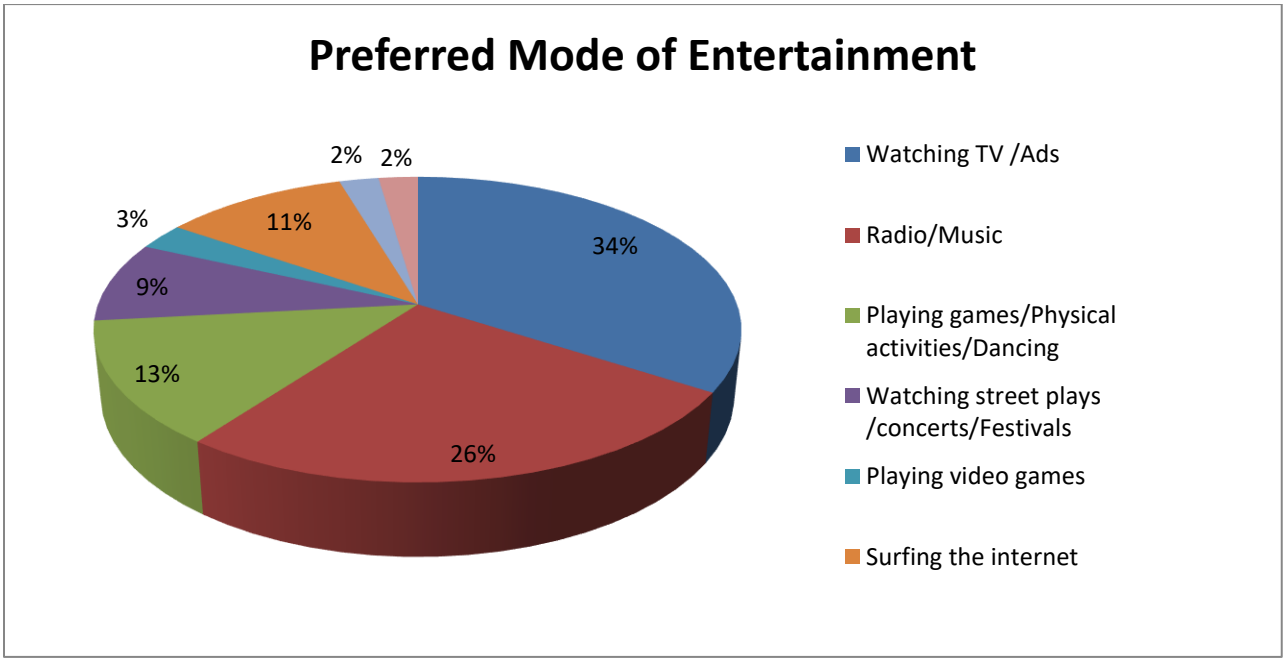
4.7 Source of HIV/AIDS:

Watching TV (84.1%) was the main source of getting information about HIV/AIDS followed by Magazines (73.3%) and Radio and News paper (63.6%) each. This shows if the interventions are designed on TV are reaching to the masses and should be further more worked upon.



4.8 Preferred Mode of Entertainment:

Watching TV (34%) was the most preferred mode entertainment followed by Radio (26%) and Physical excersice or Dancing (13%). This shows if the interventions are designed accordingly than a large group of the youth can be sensitized through these preferred modes of entertainment.



4.9 SPECIFIC FINDINGS

4.9.1 Gender:

Knowledge levels of females are higher than the males, which is shown as follows:

1. **Have you heard of STIs**

			have you heard of STIs			
			yes	no	don't know	Total
gender	male	Count	57	30	1	88
		% within gender	64.8%	34.1%	1.1%	100.0%
	female	Count	77	9	2	88
		% within gender	87.5%	10.2%	2.3%	100.0%
Total		Count	134	39	3	176
		% within gender	76.1%	22.2%	1.7%	100.0%

2. **Do you think STIs can be prevented**

			Do you think STIs can be prevented			
			yes	no	don't know	Total
gender	male	Count	54	16	17	87
		% within gender	62.1%	18.4%	19.5%	100.0%
	female	Count	75	3	10	88
		% within gender	85.2%	3.4%	11.4%	100.0%
Total		Count	129	19	27	175
		% within gender	73.7%	10.9%	15.4%	100.0%

3. **Have you heard about HIV/AIDS**

			have you heard about HIV/AIDS			
			yes	no	don't know	Total
gender	male	Count	75	12	1	88
		% within gender	85.2%	13.6%	1.1%	100.0%
	female	Count	87	0	1	88
		% within gender	98.9%	.0%	1.1%	100.0%
Total		Count	162	12	2	176
		% within gender	92.0%	6.8%	1.1%	100.0%

4. **Having HIV means that person will die**

			having HIV means that person will die			
			yes	no	don't know	Total
gender	male	Count	27	40	21	88
		% within gender	30.7%	45.5%	23.9%	100.0%
	female	Count	17	61	10	88
		% within gender	19.3%	69.3%	11.4%	100.0%
Total		Count	44	101	31	176
		% within gender	25.0%	57.4%	17.6%	100.0%

5. **If someone looks healthy, then he /she cannot have HIV**

			if someone looks healthy, then he /she cannot have HIV			
			yes	no	don't know	Total
gender	male	Count	27	45	16	88
		% within gender	30.7%	51.1%	18.2%	100.0%
	female	Count	4	80	4	88
		% within gender	4.5%	90.9%	4.5%	100.0%
Total		Count	31	125	20	176
		% within gender	17.6%	71.0%	11.4%	100.0%

6. **HIV can be treated with certain drugs/medicines**

			HIV can be treated withcertain drugs/medicines			
			yes	no	don't know	Total
gender	male	Count	38	27	23	88
		% within gender	43.2%	30.7%	26.1%	100.0%
	female	Count	46	18	24	88
		% within gender	52.3%	20.5%	27.3%	100.0%
Total		Count	84	45	47	176
		% within gender	47.7%	25.6%	26.7%	100.0%

7. **HIV can be diagnosed by a test**

			HIV can be diagnosed by a test			
			yes	no	don't know	Total
gender	male	Count	50	11	27	88
		% within gender	56.8%	12.5%	30.7%	100.0%
	female	Count	76	3	9	88
		% within gender	86.4%	3.4%	10.2%	100.0%
Total		Count	126	14	36	176
		% within gender	71.6%	8.0%	20.5%	100.0%

8. **If a person have HIV,they will always develop AIDS**

			If a person have HIV,they will always develop AIDS			
			yes	no	don't know	Total
gender	male	Count	27	35	26	88
		% within gender	30.7%	39.8%	29.5%	100.0%
	female	Count	18	49	21	88
		% within gender	20.5%	55.7%	23.9%	100.0%
Total		Count	45	84	47	176
		% within gender	25.6%	47.7%	26.7%	100.0%

9. **HIV can be controlled but cannot be completely cured**

			HIV can be controlled but cannot be completely cured			
			yes	no	don't know	Total
gender	male	Count	43	20	25	88
		% within gender	48.9%	22.7%	28.4%	100.0%
	female	Count	52	16	20	88
		% within gender	59.1%	18.2%	22.7%	100.0%
Total		Count	95	36	45	176
		% within gender	54.0%	20.5%	25.6%	100.0%

10. **Some traditional healers have power to cure AIDS**

			Some traditional healers have power to cure AIDS			
			yes	no	don't know	Total
gender	male	Count	22	36	30	88
		% within gender	25.0%	40.9%	34.1%	100.0%
	female	Count	11	42	35	88
		% within gender	12.5%	47.7%	39.8%	100.0%
Total		Count	33	78	65	176
		% within gender	18.8%	44.3%	36.9%	100.0%

11. **A person can get HIV infection from sharing needles used to inject drugs**

			A person can get HIV infection from sharing needles used to inject drugs			
			yes	no	don't know	Total
gender	male	Count	65	7	16	88
		% within gender	73.9%	8.0%	18.2%	100.0%
	female	Count	77	4	7	88
		% within gender	87.5%	4.5%	8.0%	100.0%
Total		Count	142	11	23	176
		% within gender	80.7%	6.2%	13.1%	100.0%

12. **HIV can be transmitted by anal sex**

			HIV can be transmitted by anal sex			
			yes	no	don't know	Total
gender	male	Count	50	19	19	88
		% within gender	56.8%	21.6%	21.6%	100.0%
	female	Count	38	16	34	88
		% within gender	43.2%	18.2%	38.6%	100.0%
Total		Count	88	35	53	176
		% within gender	50.0%	19.9%	30.1%	100.0%

13. **HIV can be transmitted by oral sex Crosstabulation**

			HIV can be transmitted by oral sex			
			yes	no	don't know	Total
gender	male	Count	24	39	25	88
		% within gender	27.3%	44.3%	28.4%	100.0%
	female	Count	27	34	27	88
		% within gender	30.7%	38.6%	30.7%	100.0%
Total		Count	51	73	52	176
		% within gender	29.0%	41.5%	29.5%	100.0%

EDUCATION LEVEL:

The more the education level increases the better the knowledge about HIV/AIDS increases which is shown in the table:

14. **Have you heard of STIs**

			have you heard of STIs			
			yes	no	don't know	Total
education	illiterate	Count	1	8	0	9
		% within education	11.1%	88.9%	.0%	100.0%
	Primary	Count	3	18	0	21
		% within education	14.3%	85.7%	.0%	100.0%
	High School	Count	2	0	0	2
		% within education	100.0%	.0%	.0%	100.0%
	Graduation	Count	104	11	3	118
		% within education	88.1%	9.3%	2.5%	100.0%
	Post Graduation	Count	24	2	0	26
		% within education	92.3%	7.7%	.0%	100.0%
Total		Count	134	39	3	176
		% within education	76.1%	22.2%	1.7%	100.0%

15. **Do you think STIs can be prevented**

			Do you think STIs can be prevented			
			yes	no	don't know	Total
education	illiterate	Count	0	5	4	9
		% within education	.0%	55.6%	44.4%	100.0%
	Primary	Count	4	9	8	21
		% within education	19.0%	42.9%	38.1%	100.0%
	High School	Count	2	0	0	2
		% within education	100.0%	.0%	.0%	100.0%
	Graduation	Count	100	4	13	117
		% within education	85.5%	3.4%	11.1%	100.0%

	Post Graduation	Count	23	1	2	26
		% within education	88.5%	3.8%	7.7%	100.0%
Total		Count	129	19	27	175
		% within education	73.7%	10.9%	15.4%	100.0%

16. **Have you heard about HIV/AIDS**

			have you heard about HIV/AIDS			
			yes	no	don't know	Total
education	illiterate	Count	7	2	0	9
		% within education	77.8%	22.2%	.0%	100.0%
	Primary	Count	12	9	0	21
		% within education	57.1%	42.9%	.0%	100.0%
	High School	Count	2	0	0	2
		% within education	100.0%	.0%	.0%	100.0%
	Graduation	Count	115	1	2	118
		% within education	97.5%	.8%	1.7%	100.0%
	Post Graduation	Count	26	0	0	26
		% within education	100.0%	.0%	.0%	100.0%
Total		Count	162	12	2	176
		% within education	92.0%	6.8%	1.1%	100.0%

ENTERTAINMENT PREFERENCES AND ECONOMIC STATUS

- Lower Economic class- Watching TV (38.5%)
- Lower Middle Economic class- Radio/Listening Music (34.8%)
- Upper Middle Economic class- Watching TV (40.7%)
- Higher Economic Class- Watching TV (31%)

5. CONCLUSION & KNOWLEDGE CONTRIBUTION:

- Females have higher level of knowledge as compared to males.
- Males (62%) are more sexually active than females (25%).
- 26-29 yrs youth are more sexually active and 15-17 yrs is least.
- The Higher the education level the higher the knowledge level about STI's and HIV/AIDS.
- Attending cultural fests/concerts/nukkad natak then playing cards are the preferred leisure time activity of the lower economic class.
- Muslims have higher level of knowledge regarding not using two condoms at the same time during sexual intercourse (66.7%)

The present study highlights the need to design interventions for educating youth using the preferred entertainment formats as a vehicle and recommends that policy makers increase use of entertainment for educating populations about HIV/AIDS. It will educate the youth on the basic knowledge of HIV/AIDS by increasing their curiosity to know more about it and will also strengthen their will to use condom with their sex partners.

Limitations

- Biasness in filling up about sexual practices.
- Small sample size because of limited resources.
- More technical guidance is required to hold the data.
- Same numbers of the different genre' respondents were not present to have expressed equally in the study.
- Schools students were not much in no's because authorities were not providing support..

DISCUSSION:

Based on the literature review done, the study has contributed the following:

1. There is no recent KAP study done in the last two years on the youth of Delhi which gives the perfect picture of the Knowledge levels they have, Attitudes the youth carry and

practices which they follow. As the next phase of NACP i.e. NACP IV which is about to start needs data on the youth especially to design interventions accordingly and keeping in mind the loop holes present which has not sensitized the youth in the last phase. It definitely acts as a new resource of the fresh data available which can be utilized as a baseline for the NACP IV phase.

2. The study pinpoints the effect of economy, education and age as a major reason which is proportional to the knowledge levels, attitudes and the practices of the youth. The more they are the better the knowledge, attitude and practices prevails. There is no study done which has shown the relation.

3. There is no study done in the world which has given the stats of the preferences in the entertainment, leisure time activities and that to genre' specific. It gives a great source to the policy makers to design interventions accordingly to the youth that has low level of knowledge, wrong attitude & practices. The study solves two purposes in the finding the question and at the same time answering it through a better solution which is: finding out the low knowledge levels, attitudes and practices of that genre's of the youth and also finding out what they like in entertainment which can be utilized for the increasing the levels of Knowledge and changing the attitudes and practices.

4. The study acts as a bridge between the last stats which are found in the literature to the present scenario. It also combines the EE to the HIV/AIDS to be thought at the same time to have better reach to the youth. It surely encourages finding more about what does youth think about entertainment and how do they connect with it, which will surely add a lot to the EE literature (research in progress by me).

5. It also emphasizes on the importance of changing the content of HIV/AIDS and STI knowledge provided in the schools and colleges curriculum as a part of sexual & reproductive health. The curriculum should be designed in a way to answer more about what they don't know like using two condom during the intercourse can lead to problem or HIV can be transmitted by Oral sex rather than telling the basic knowledge which will

surely reduce the cases. This study also acts a source of the knowledge questions which needs to be included in the curriculum which youth of that specific group was not able to answer. It also holds the attitudes which need to be changed and the most important thing that is the high risk practices in which they are getting into.

6. During the survey the study has given youth a food for thought to explore more about the questions which they were not sure of or they were wrongly practicing. The major questions which were asked were very new to some of the groups which they had never ever heard of, which in turn has sensitized and educated them to explore more about it.

6. RECOMMENDATIONS

- Large scale EE interventions should be designed at the policy level according to the preferences of the genre specific audience.
- Sexual Education should be a part of course curriculum at the School and College level.
- Teachers should counsel students on sexual and reproductive health without any hesitations and should burst the myths and misconceptions.
- Condom vending machines should be made available outside the colleges, pubs and market places.
- Harm reduction campaigns should be introduced more and more for the IDU's.
- PLHIV's should be introduced with youth through EE.

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ANNEXURES

(01) SAMPLE QUESTIONNAIRE

FORM NO._____

My name is Abhimanyu Singh Tomar and I am here on the behalf of Center for Human Progress, New Delhi. We are conducting a survey to understand "**WHAT ARE THE KNOWLEDGE, ATTITUDE, PRACTICES OF DELHI YOUTH TOWARDS HIV/AIDS AND THEIR PREFERENCES IN ENTERTAINMENT"**. The survey usually takes about 15-20 minutes to complete. Whatever information you provide will be kept strictly confidential. Participation in this survey is voluntary and you can choose not to answer any question or all of the questions. As you represent the youth, we value your views and suggestions; we hope that you will participate in this survey.

Consent to participate: Yes/No

A. Background Information

1. Name

2. Education
   - Illiterate……1
   - Primary……2
   - Intermediate……3
   - High School……4
   - Graduation……5
   - Post Graduation……6
   - Other(specify)……7

3. Age:
   - 15-17 yrs ……1
   - 18-21 yrs……2
   - 22-25 yrs……3
   - 26-29 yrs……4

4. Gender
   - Male……1
   - Female……2

5. Religion
   - Hindu……1
   - Muslim ……2
   - Sikh ……3
   - Christian ……4
   - Others……5

6. Approximate family income (monthly):

< ₹ 9453……..1
₹ 9453 to ₹ 18906……2
₹ 18906 to ₹ 28359 ……3
>₹28359……..4

7. Marital status

Married……1

Unmarried……2

8. Employment status:

Working……1

Non working……2

9. Do you have access to the following

Newspaper……1

Magazine……2

Radio……3

Cinema house……4

Television……5

B. KNOWLEDGE

Q10.	Have you heard of STI's (Sexually Tranmitted Infections)	Yes ……1 No……2 Don't know ……3	If no/don't know then move to Q.No.12
Q11.	Do you think STI can be prevented:	Yes ……1 No……2 Don't know……3	
Q12.	Have you ever heard of HIV/AIDS	Yes ……1 No……2 Don't know……3	

Q13.	Please answer the following:	Yes (1)	No (2)	Don't Know (3)
1.	Having HIV means that the person will die:			
2.	If someone looks healthy, then he or she cannot have HIV:			
3.	HIV can be treated with certain drugs/medicines:			
4.	HIV can be diagnosed by a test:			
5.	If a person have HIV, they will always develop AIDS :			
6.	HIV can be controlled but not completely cured:			
7.	Some traditional healers have the power to cure AIDS:			
8.	A person can get HIV infection from sharing needles used to inject drugs			
9.	HIV can be transmitted by Anal sex			
10.	HIV can be transmitted by Oral sex			
11.	HIV can be transmitted by Vaginal sex			

Q14.	What are the ways in which HIV/AIDS can be transmitted?	Mode of transmission		Yes (1)	No (2)	Don't Know (3)
		1.	Having sex without condoms			
		2.	Having multiple partners			
		3.	Having sex with commercial sex workers			
		4.	Sharing needles			
		5.	Infected blood transfusion			
		6.	Pregnant woman to unborn child			
		7.	Sharing meals with someone infected			
		8.	Through Mosquito bites			
		9.	Kissing someone			
		10.	Tattooing and ear piercing			

Q15.	What are the ways in which HIV/AIDS can be prevented	Mode of Prevention		Yes (1)	No (2)	Don't Know (3)
		1.	Always use condom while engaging in sex			
		2.	Only have sex with regular partner			
		3.	Avoid sex with commercial sex workers			
		4.	Abstinence			
		5.	Avoid the use of shared needles			
		6.	Getting blood thoroughly checked/tested before transfusion			
		7.	Eat nutritious food			
		8.	Using two condoms at the same time of intercourse			
		9.	Exercising regularly			

Q16.	Are you aware that you could get a confidential test done to find out whether you are infected with HIV?	Yes ……1 No……2
Q17.	Have you ever heard of ICTC (Integrated Counseling and testing centre) or HIV testing centers?	Yes ……1 No……2
Q18.	Are you aware that HIV test in ICTC can be avail free of cost?	Yes ……1 No……2

B. ATTITUDE		**Yes (1)**	**No (2)**	**Probably Yes (3)**	**Probably No (4)**	**Don't know (5)**
Q19.	One should not take vegetables from the shopkeeper who is HIV+					
Q20.	My friends encourage me to have sex.					
Q21.	If you insisted on using a condom/rubber, do you think a steady partner would refuse to have sex with you?					
Q22.	Imagine that you used a condom/rubber the next time you had sex. Would you feel less sexual pleasure than if you didn't use one?					
Q23.	If you used a condom/rubber, would sex last longer than if you didn't use one?					
Q24.	If you used a condom/rubber, would you feel an emotional barrier with your sex partner?					
Q25.	Using a condom is a sign of not trusting your partner.					
Q26.	Girls who carry condoms are not respected.					

C. PRACTICES		Strongly Agree (1)	Agree (2)	Strongly Disagree (3)	Disagree (4)	Neither Agree nor disagree (5)
Q27.	I am sexually active					
Q28.	I had a non regular sexual partner in the last year					
Q29.	I think single person in non committed relationships should use a condom each time they have sexual intercourse.					
Q30.	I have contracted Sexually Transmitted Infection					
Q31.	I have received treatment for Sexually Transmitted Infection.					
Q32.	I always ask my partner to use protection while having sex					
Q33.	I regularly go for HIV testing					

INFORMATION SOURCES & PREFERENCES IN ENTERTAINMENT			
Q34.	People get information about HIV/AIDS from many different places. Please tell me **three different sources** from where you have received information on HIV/AIDS?	Radio	1.
		TV	2.
		News Paper	3.
		Magazines	4.
		Hoardings	5.
		Wall Paintings	6.
		Pamplets	7.
		Cinema Hall	8.
		NGO Worker/Peer Educator	9.
		Medical Store	10.
		Street Plays	11.
		College/Schools	12.
		Parents	13.
		Siblings	14.
Q35.	Which type of entertainment does you like the **most?**	Watching TV /Ads	1.
		Radio/Music	2.
		Playing games/Physical activities/Dancing	3.
		Watching street plays /concerts/Festivals	4.
		Playing video games	5.
		Surfing the internet	6.
		Reading Books/ Comics /Magazines	7.
		Movies	8.
Q36.	What activity do you like to do in your leisure time	Spend time on internet/PC	1.
		Go to the movies	2.

	mostly?	Doing sex with partner	3.
		Watch porn movies	4.
		Attend cultural events such as concerts, live theatre, exhibitions	5.
		Get together with relatives	6.
		Play cards or board games	7.
		Listen to music	8.
		Do physical activity such as sports, walk, gym	9.

(2) ELECTION COMMISSION OF INDIA

Launch Strategy

The launch of the Election Commission's (EC) Social Media campaign will take place on December 16, 2011 at the Election Commission of India office.

The launch will initiate the EC's social media campaign through the following sites:

1) Facebook
2) Twitter
3) Youtube
4) Google+

Content for each of these sites will be pre-screened and pre-prepared in the build-up to the launch event. The role of the core team as well as the social media strategy team (i.e., the 16 members of the supporting team to be hired by EC on December 10, 2011) will be critical for content selection and screening. Relevant content to be posted during the launch event will be prepared and waiting to be posted by the CEC in the presence of the media during the launch event.

A press conference will be held at the Election Commission of India office on December 16, 2011 as a key activity encompassing the launch strategy. Members of the press and media (English, Hindi, Vernacular, online, print, electronic) will be present at the press conference. A press release will be circulated along with other materials in a press kit.

The launch event will be initiated with a dynamic, visual presentation accompanied by a narration to be made by the CEC outlining key strategies which underpin the EC's work. This presentation will serve as the curtain raiser for the event.

The key components of the social media launch activity across the 4 chosen platforms will be as follows:

1) Facebook: announce a contest inviting entries from people around India to "Name the Campaign";
2) Youtube: launch Youtube channel which will feature videos in various languages;
3) Twitter: tweet to disseminate factual content on the launch event day. The first tweet will announce the launch of the ECI social media campaign;
4) Google+: similar to other social media platforms.

Each of these social media spaces will be launched in the presence of the media. The launch activity will be filmed and showcased in near real-time on Youtube.

Two essential elements associated with the launch will be addressed beforehand:

1. The core and social media strategy (16 new hires) teams would create a large enough repository of content ready for posting during and post the launch.

2. EC's state and local teams including the Chief Election Officers (CEOs) will be briefed for readiness of the social media campaign. They will need to be briefed regarding their own role/s and preparedness to respond to queries and postings in an accurate and time-sensitive manner.

More specifically, the states will be fully briefed regarding:

1) The modalities of posting online. They will be informed that the central platform for posting will be CEC (i.e., the CEC will be the central image and identity); as friends and members of social media sites encompassed by the strategy, such as Facebook they (i.e., the states) will play a critical role in supporting local responses to local issues;
2) The role of the social media strategy team. The social media strategy team will frequently follow up to obtain locally appropriate content and responses to written posts on social media sites;
3) The importance of cross-linkages between CEC social media spaces and state web sites, content and offline coordinates (e.g., phone numbers). The state teams will also be briefed that a number of responses to postings will be redirected to them on the web and through sharing of phone contacts. The importance of responding to local issues in a timely fashion will be underscored.

Furthermore, the states will be briefed of a medium-term plan to recruit local volunteers who will support the social media strategy together with their state managers and the central social media teams. The coordination required for the effectiveness of this process will be highlighted.

Post Launch strategies for SMC(Social Media Campaign)

The post launch strategies will be based on regular updates of content and interactive queries updated based on a schedule set by Priyanka and Team. These must be executed by new team set up during prelaunch under to keep the network engaged.

The first part of the campaign must focus on voter involvement and participation we must tune our online strategy Goals to run parallel with Promotions of National Voters day. Constant reminders and shootouts are "Proud to be a voter -- Ready to vote" This can be run in mix with the face book slogan contest which should also end on the 25th and you tube videos that convey the registration message.

We will have 5 campaigns ready pre launch that should be executed between launch and election time.

Some ideas given by the commission are

- **Engage** - Proud to be a voter -- Ready to vote -- Can you do write it better.
- **Ask and remind--** Do you know have your voter card
- **Educate and involve** --Vote when your 18
- **Promote** - National Voters day
- **Educate and involve** - Do your know BLO?

Further improvements

- Over a process of time the commission must link all state level SMP(Social Media Pages) to the
- We must improve the FAQ and set up a auto fill facility with search.
- The working team at EC Delhi will handle Q AND A in social media platforms or forums.
- An public archive of all questions and answers might be the key to more traffic with less questions.
- A blog must be created for static content.

Advertising Efforts

- Google plus recommendations are still to be added to this document.
- After the meeting with Google on the 30th of November and understanding their involvement in this process more SEO and SEM tactics can be revealed .

TASK TO BE TAKEN BY THE ECI CORE TEAM

Time : December to March

PRE-LAUNCH

1) Design a hiring process for the team
2) Prepare a multiple choice questionnaire for the first round of selection

3) Interview candidates
4) Prepare training content for the team
5) Train the new team on e-mediums, election commission and campaign implementation
6) Set up a Twitter account
7) Prepare 400 tweets for pre-launch for Twitter
8) Write a script for the videos
9) Work with Lady Irwin college to shoot videos
10) Prepare videos to be uploaded until December 2011 end
11) Set up a YouTube channel
12) Set up a Facebook page
13) Set up a contest for the page
14) Set up a Google+ account
15) Coordinate with CEOs of states for stories and facts about the Election Commission
16) Create 10 FAQ videos for the launch until December end

LAUNCH

1) To some extent train the states to work with the team on cross-linkages
2) Create a process to escalate questions to expedite answer time
3) Be prepared with all content to be uploaded

POST-LAUNCH

1) Oversee the team and run quality checks to ensure that all responses are in line with the process outlined
2) Constantly develop engaging strategies for all the mediums
3) Develop quizzes based on facts received from the ECI
4) Develop contests
5) Respond on a regular basis to all tweets/posts
6) Measure and Report
7) Submit a report every evening with the progress
8) Install codes to track performance on the website
9) Work closely with Google to keep updating and upgrading the YouTube channel

10) Monitor keywords closely
11) Create an AdWords account
12) Engage in display advertising
13) Create adverts with mass appeal on an online platform
14) Create atleast 30 FAQ videos and keep uploading them from time to time
15) Create a campaign for National Voters Day
16) Run a “Do you know your BLO” campaign
17) Install Facebook like, Google plus and Twitter on the website
18) Create a blog
19) Tweak the website per results from Analytics
20) Create Rich-media ads
21) On Twitter, aim at following the most influential people and have them follow back

(02) IKEA PROJECT

Red Ribbon on the Road

Supported by IKEA
Implemented by CHP

June, 2011

Background

Truck drivers keep the wheels of the economy moving

India's national highways span a length of 70,548 KMs & employ 5 million truck drivers

Source: NHAI, 2010

Objective

- To Promote the Health and Welfare of Truck Drivers
- To Promote Dialogue about HIV Vulnerabilities and Explore Practical Solutions for Vulnerability Reduction

Rationale

- Truck Drivers Are Critical Stakeholders in IKEA's Indian Business Operations
- Contribute to the Community and Economy
- Address Issues Beyond HIV to Encompass Health and Welfare of Truck Drivers

Methodology

- Pilot Test Red Ribbon on the Road at Dadri
- Implement Main Intervention Along IKEA's Key Trucking Route Points
- Integrate I-WAY Standards Throughout Intervention

Phase I: The Pilot

- Implement Pilot Intervention at Dadri for 12 Months
- Rationale for Pilot Location
  - Ease of Accessibility
  - Avoid Language Barriers
  - Greater Learning Potential (Due to Proximity)
  - Keep Pilot Expenses Minimal
  - Important IKEA Warehouse Location

Objectives of the Pilot

- Learn from Experience
- Test Project Design
- Integrate Feedback in Final Intervention

Components of Pilot: Field Activities

- Use Entertainment Education to Promote Health and Welfare & Dialogue About HIV Vulnerabilities
  - Magnet Theatre
  - Interpersonal Communication (IPC)
  - Film Screenings
  - Music
  - Quiz
  - Competitions

Components of Pilot: Linkages

- Establish Linkages with Services (e.g., for STI and HIV Testing and Others)
- Promote Exchange Between Truck Drivers and Stakeholders (E.g., Transporters; Service Providers; Local NGOs)

Components of Pilot: Consultations & Workshops

- Consultations with Truck Drivers, Stakeholders (for Input on Intervention Design and Components)
- Certified training Workshops with Truck Drivers on Use of Dialogue-Based Communication Tools (including Magnet Theatre, IPC)
- Certified training Workshops with Truck Drivers on Technical Issues (including Health and Human Rights - Integrating I-WAY Standards Throughout)
- Visits by IKEA, NACO, UNAIDS and Other Stakeholders

Components of Pilot: Documentation

- Document Pilot Using Film
  - Capture Lessons and Learning
  - Demonstrate Experience
  - Establish Baseline

Outcome of Pilot

- Experience and Learning Which Will Support Design of Final Intervention
- Needs Assessment Data
- Baseline Data
- Documentation (Film) to Capture Experience
- Design of RRR Training Curricula to be Replicated in Other Locations
- Cadre of Trained Community Members (and Allied Community Members) – In Technical Knowledge, Dialogue-Based Tools
- Local Service Mapping and Stakeholder Partnerships

Components of Pilot: Build in Sustainability

- Building Sustainability from the Beginning
  - Consultation with and Participation of Truck Drivers and Stakeholders
  - Linkage with Local Services and Sustainable Partnerships
  - Create Capacities of Local Truck Drivers (and/or Allied Communities) to Sustain Activities
  - Establish Center of Excellence at Dadri (Which will Support Cross-Location Exposure in the Future)